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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sandra Sawallisch,
Petitioner,

vs. NO: 14 WC 40313

18IWCC0474

Vulcan Materials Co.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability, and the nature and extent of the injury 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 generally affirms and adopts the findings and awards of the Arbitrator. However, Arbitrator Falcioni awarded Petitioner 10% loss of use of each hand, but did so based upon a value of 205 weeks per hand. Section 8(e)9 of the Act provides that a hand is valued at:

> 190 weeks if the accidental injury occurs on or after June 28, 2011 (the effective date of Public Act 97-18) and if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma . . . .

Accordingly, while the Commission affirms the award of the percentage loss to each hand, the permanency award is corrected to reflect a value of 190 weeks per hand; the total 52.4 weeks of disability awarded by Arbitrator Falcioni is therefore reduced to 49.4 weeks.

18IWCC0474

The other findings and awards of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $615.31 per week for a period of 17-1/7 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 $553.78 per week for a period of 49.4 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused permanent loss to the left hand to the extent of 10%, to the right hand to the extent of 10%, to the left thumb to the extent of 10%, and to the right thumb to the extent of 5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $44,977.06 for medical expenses under §8(a) of the Act, subject to the limits of §8.2 of the Act. Respondent shall be given credit of $21,062.50 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 by Section 8(j) of the Act.

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 $37,500. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 - 2018

o-07/25/18
jdl/mcp

Joshua D. Luskin

Charles J DeVriendt

DISSENT

I respectfully dissent from the Decision of the majority. I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain her burden of proving repetitive work-related activities caused her conditions of ill-being, and denied compensation.

Petitioner developed bilateral carpal tunnel syndrome and bilateral trigger finger of her thumbs. The Arbitrator found that she proved her work activities were the legal cause of her conditions. The Commission affirmed that decision. In so finding, the Arbitrator, and the Commission, relied on the causal opinion of her treating doctors, Dr. Kung and Dr. Muhammed. In my opinion, that reliance was misplaced.

It is important to note that during the course of their respective care of Petitioner, neither Dr. Muhammed nor Dr. Kung indicated in their records that Petitioner's conditions of ill-being were in any way related to her work activities. Their later opinions concerning causation were elicited only in response to an inquiry from Petitioner's lawyer and only after their respective treatment of Petitioner had long-since ended. Both treating doctors based their opinions on a job description provided by Petitioner. Neither doctor had reviewed videos of Petitioner's job activities, which showed a variety of tasks performed for short periods of time. In addition, Dr. Kung specifically noted that a basis of his opinion was his understanding that Petitioner used vibratory tools, an assumption that was incorrect.

On the contrary, I find the causation opinion of Dr. Biafora, Respondent's Section 12 medical examiner, more persuasive than those of Dr. Muhammed and Dr. Kung. First, Dr. Biafora actually viewed the videos of Petitioner's work activities and therefore had a better understanding of those activities. Second, Dr. Biafora considered co-morbidity factors which could contribute to Petitioner's condition, including her age, gender, history of smoking, and perhaps most notably thyroid disease. Neither Dr. Muhammed nor Dr. Kung considered those factors. Third, Petitioner testified that she primarily used her right hand in performing the allegedly offending work activities. The fact that both the conditions of ill-being of her wrists and the conditions of ill-being of her thumbs were bilateral while she predominantly used her right hand, suggests that her conditions were idiopathic or genetic, rather than work-related in nature.

In looking at the entire record before us, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain her burden of proving repetitive work-related activities caused her conditions of ill-being, and denied compensation. Therefore, I respectfully dissent from the majority.

Deborah L. Simpson

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SAWALLISCH, SANDRA
Employee/Petitioner

Case# **14WC040313**

VULCAN MATERIALS COMPANY
Employer/Respondent

18IWCC0474

On 11/14/2016, 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:

3269 SPIROS LAW PC
SANDRA K LOEB
2807 N VERMILION ST SUITE 3
DANVILLE, IL 61832

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT F DELANEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

- [ ] 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

Sandra Sawallisch
Employee/Petitioner

v.

Vulcan Materials Company
Employer/Respondent

Case # 14 WC 040313

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Kankakee**, on **Septmber 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **August 28, 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 **$47,994.44**; the average weekly wage was **$922.97**.

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

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

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

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

Respondent is entitled to a credit of **$21,062.50** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $44, 977.06, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $21,062.50 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 $615.31/week for 17 1/7 weeks, commencing 11/26/14 through 1/27/15 and 10/22/15 through 12/17/15, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, 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 left hand,10% loss of use of the right hand, 10% loss of use of the left thumb and 5% loss of use of the right thumb pursuant to §8(e) of the Act. Respondent shall pay petitioner permanent partial disability benefits of $553.78 for 52.4 weeks accordingly.

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

October 20, 2016

Date

NOV 14 2016

CASE NO. 14 WC 40313

FINDINGS OF FACT

On August 28, 2014, Petitioner was employed by Vulcan Materials Co. as a floater/ quality control technician and had been so employed since August 22, 2011. Petitioner's job duties as a quality control technician typically involved spending 4 to 5 hours in the lab testing various construction aggregates which, depending on the particular product tested, are materials resembling crushed stone, gravel or sand. Petitioner's job duties in the lab were depicted in a DVD video (PX18) as well as in 4 CD-Roms admitted into evidence (RX4, RX5). Her job duties in the lab were also consistently described in a written job description authored by Petitioner (PX4), a job analysis authored by Respondent's Vocational Consultant, Kathleen Dytrch, and by the testimony of the petitioner as well as by the testimony of Petitioner's supervisor, Daniel Barnstable at trial. Petitioner's work the lab involved constant use of her hands and included multiple activities that involved gripping, grasping and flexion of the wrists.

Dan Barnstable was the Petitioner's supervisor. He was familiar with her job and had performed many of the same duties on occasion. He agreed that the Petitioner became the only quality technician in July of 2014. He claimed that she was offered assistance because she did not have an assistant as before. He described that up to twelve buckets of stone samples were collected on many days but the assignment was shared by co-workers, or done with others' assistance after July of 2014. If quality technicians were collecting more than fifty pounds of samples they were encouraged to split them into two buckets to avoid lifting excessive weight. He also agreed the heaviest lifting was done outside the lab to collect and transport buckets of samples. Once in the lab the stones were broken down into smaller quantities and tested. He said even the heaviest lifting of buckets that could weigh as much as fifty pounds only occurred for a few seconds to transfer the bucket onto or away from a pick-up truck as shown on videos. Barnstable agreed with the overall description of the job and disagreed over some of the details. He did not believe sieves are shaken for thirty seconds at a time to separate stones. He also testified that the Petitioner received more assistance in July, August and September of 2014 then she described. He confirmed there is no vibrating equipment used for the job.

Kathleen Dytrych is a nurse case manager who prepared a job analysis and filmed the Petitioner performing the job. She met with the Petitioner, took a detailed account from the Petitioner of her job, and then filmed her doing the job. She spent two to three hours doing this assignment. Both parties offered a copy of the tape she filmed. The detailed job analysis was offered as Respondent's Exhibit 2 and the video as Exhibit 3. Respondent's personnel also prepared their own job demonstration video which involved the Petitioner performing the job (Respondent Exhibit 4a-c).

Both the Petitioner and her supervisor testified that the amount of time petitioner spent in the lab increased to approximately 6 hours per day on July 17, 2014, after a co-worker was let go and petitioner assumed responsibilities that are typically divided among two quality control technicians. Petitioner testified that she continued to work in this capacity through her claimed injury date of August 28, 2014 and until a new technician was hired on October 3, 2014.

On August 28, 2014 at approximately 10 AM, Petitioner testified that she developed a pain in both of her hands while shaking a sieve in the lab. She testified that she had never experienced this symptom before August 28, 2014. Petitioner testified that she completed her work day and continued to work in her full capacity despite the symptoms she continued to experience in her hands from that day forward. The exact job duty she was performing when this pain developed is depicted on PX18 at approximately the twenty five minute mark. Petitioner testified that her symptoms worsened over the next several weeks as she continued working. No evidence was introduced to contradict this testimony.

On September 30, 2014, petitioner presented to Dr. Kermit Muhammed at OAK Orthopedics with bilateral hand numbness and tingling as well as left thumb pain and inability to flex the thumb at the IP joint. (PX1, PX5) Though Dr. Muhammed's record for that date indicates that the Petitioner's symptoms had been "ongoing for several months," the same record also indicates, "Duration: 1 months [sic.]." (PX5) Dr. Muhammed found that petitioner had symptoms consistent with carpal tunnel syndrome as well as left trigger thumb. (PX1, PX5) He recommended that petitioner undergo an EMG/ nerve conduction study to rule out carpal tunnel syndrome. (PX5)

The parties stipulated at trial that Petitioner gave notice of her condition to her supervisor, Daniel Barnstable, on October 3, 2014. (ARBX1) October 3, 2104 is within the 45 day notice period which is mandated by the Act.

Petitioner underwent the prescribed EMG/nerve conduction testing on October 7, 2014. That testing revealed that Petitioner had moderate bilateral carpal tunnel syndrome, worse on the left side. (PX6)

On October 8, 2014, Petitioner completed a form called an "Employee Statement of Accident/ Injury" indicating that her hands started hurting on August 28, 2014 while shaking down samples and that her condition was getting worse day by day. (PX4)

Petitioner returned to Dr. Muhammed on October 14, 2014 for her EMG results and with no change in her symptoms other than she now had some triggering in her right thumb. (PX7) Dr. Muhammed recommended a left carpal tunnel release, left trigger thumb release and a right trigger thumb injection. (PX7) That procedure was subsequently performed by Dr. Muhammed on November 26, 2014 without complication. (PX8)

Petitioner underwent a post-operative course of physical therapy though January 27, 2015. (PX15) Her discharge summary indicates she was still complaining of pain and tingling in the fingers at her last therapy visit.(PX15, p. 80)

Dr. Muhammed released petitioner to return to work on January 27, 2015 with restrictions of no lifting over 10 pounds with the left upper extremity. (PX9, PX10) Petitioner testified that respondent accommodated her restrictions until she was later released by Dr. Muhammed to full duty work on March 2, 2015. (PX10).

Petitioner testified that she continued to work full duty for respondent as a quality control technician through the Spring and Summer of 2015. At respondent's request she saw Dr. Sam Biafora for a Section 12 examination on July 16, 2015. (RX1, Exh. No. 2) Dr. Biafora's report dated July 21, 2015 indicates that he reviewed petitioner's medical records to date, a written job analysis, and a disc labeled, "Job Analysis, Quality Control Technician, Vulcan Materials Company." (RX1, Exh. No. 2) His report also indicates that Dr. Biafora took a history from petitioner and performed a physical examination. (RX1, Exh. No. 2) Dr. Biafora opined that petitioner had resolved left carpal tunnel syndrome and left trigger thumb post-surgery and right carpal tunnel syndrome and resolved right trigger thumb. (RX1, Exh. No. 2) Dr. Biafora also opined that none of petitioner's conditions were either caused or aggravated by her job duties and instead, that their cause was idiopathic. (RX1, Exh. No. 2) According to Dr. Biafora, "activities that may cause or contribute to carpal tunnel would be those that involve forceful gripping on a repetitive or sustained basis for prolonged periods of time throughout one's shift" and "activities such as forceful pinching on a repetitive basis for prolonged periods of time may cause or contribute to" trigger thumb. (RX1, Exh. No. 2) Based on his review of the video job analysis, Dr. Biafora was of the opinion that the only activities petitioner performed that that could contribute to her carpal tunnel syndrome diagnosis was the gripping of a bucket handle, spatula, and putty knife. (RX1, Exh. No. 2) However, Dr. Biafora did not find that these activities were performed for the duration required in order for them to contribute to her condition in this case. (RX1, Exh. No. 2) Although, Dr. Biafora did not causally relate petitioner's condition to her work activities, he did agree that surgical intervention was appropriate in her case. (RX1, Exh. No. 2)

On September 17, 2015, petitioner presented to Dr. John Kung at Premier Orthopedic Hand Center. (PX11) Dr. Kung noted that she complained of right hand parathesias/numbness which had returned over the last several months and after her injection. (PX11) Dr. Kung also noted that petitioner had no more trigger thumb symptoms and no more left paresthesias/numbness. (PX11) During Dr. Kung's examination, he noted positive Phalen's and Tinel's tests on the right and diagnosed carpal tunnel syndrome. (PX11) Options for treating petitioner's condition, including carpal tunnel release surgery, were discussed. (PX11)

On October 22, 2015 Dr. Kung performed a right endoscopic carpal tunnel release and a left carpal tunnel injection. (PX12) Dr. Kung testified during his evidence deposition that he usually performs carpal tunnel injections because the patient has "a little bit of residual symptoms from the carpal tunnel. (PX2, p. 12)

Petitioner testified that Dr. Kung either held her off of work or restricted her ability to work until he released her to full duty on December 17, 2015. Petitioner testified that respondent did not offer her any light duty work during this period.

Petitioner testified that she continues to experience pain in her hands at the time of hearing. She did, however, testify that the condition of her hands improved after her surgeries in that her symptoms no longer woke her up at night. Petitioner did testify that she returned to full duty work on December 17, 2015 and continued to work in that capacity through September 16, 2016.

Dr. Kung testified in his evidence deposition that he reviewed the job description authored by the Petitioner and that he was of the opinion that petitioner's job "definitely aggravated [her carpal tunnel syndrome] or made the symptoms worse, whether it caused it or not." (PX2, p. 16) He also testified that petitioner's job duties aggravated her trigger finger syndrome. (PX2, p. 16) During his direct examination, Dr. Kung initially testified that his causation opinion was based on his understanding that petitioner's work is "heavy work involving machinery that can cause vibration and involves repetitive heavy gripping, [that] most likely involves repetitively putting her wrist in a flexed position all of which can aggravate both trigger finger and carpal tunnel." (PX2, p. 16) During cross examination, when asked about what specific job duties he thought were a factor in aggravating the Petitioner's condition, Dr. Kung stated, "Any activity involving heavy lifting, involving repetitive flexion of the wrist." (PX2, p.18) He furthermore opined that "[a]ny flexion of the wrist can aggravate carpal tunnel" and that both lifting and carrying activities require flexing the wrist. (PX2, pp 18-22)

Like Dr. Kung, after reviewing petitioner's job description, Dr. Muhammed opined in a narrative report that all of petitioner's conditions "could be caused or aggravated by her work duties." His report specifically states that "it is with definite certainty that I can say that at the very least her conditions were aggravated or worsened by her work, though I cannot say 100 percent that it was absolutely caused by her work. This is more than likely the case just from the nature of the heavy activities that are required." (PX1)

Dr. Biafora testified in his evidence deposition that although he agreed that petitioner had bilateral carpal tunnel syndrome and bilateral trigger thumb, he did not think that these conditions were either aggravated or caused by her work duties. According to Dr .Biafora, only those activities that involve sustained or repetitive forceful gripping for prolonged time periods would be sufficient to cause or aggravate carpal tunnel. (RX1, p.26) Though he found that some of petitioner's work activities to involve sufficient gripping, he did believe that these activities were performed for a sufficient portion of the Petitioner's work day.

On cross examination, Dr. Biafora admitted that he had no definition for what he considered to be a "prolonged period of time." (RX1, p. 26) He also admitted that the opinions

he offered in this case were based on the assumption that the Petitioner performed the job duties depicted in the video for a total of one and a half hours per day. (RX1, p. 32)

None of the physicians who testified or proffered opinions on causal connection could state with certainty that they knew exactly how long Petitioner performed any of the job duties presented to them, during her work day.

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 with Respondent and with respect to issue (F) Is the Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Based upon the Petitioner's testimony, the written and video evidence of Petitioner's job duties and the persuasive opinions of both of Petitioner's treating physicians, Dr. Kung and Dr. Muhammed, the Arbitrator finds that at the least, Petitioner's work activities aggravated or made symptomatic her bilateral carpal tunnel and trigger thumb conditions, which most likely preexisted her accident date but which were asymptomatic. Based on petitioner's testimony as to the onset of her condition and the accident report admitted into evidence, the Arbitrator also finds that Petitioner sustained an accidental injury that manifested on August 28, 2014. The Arbitrator further finds that the aforementioned conditions of ill-being are causally related to petitioner's job duties, specifically to the sieve shaking that she performed on August 28, 2014. In support of this finding, the Arbitrator notes that Petitioner testified that she felt an immediate onset of symptoms upon performing the sieve shaking on that date, that the symptoms did not subside, that she had been asymptomatic prior to that date, and that the symptoms continued to worsen as she worked over the next several weeks. Such evidence leads to an inescapable conclusion, despite the learned opinion of Dr. Biafora, that the sieve shaking did in fact aggravate or make symptomatic her probably pre existing conditions.

With respect to issue (K) What temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner testified that she was held off of work by Dr. Muhammed from the time of her November 26, 2014 surgery through her January 27, 2015 visit with him when he allowed her to return to work light duty. She also testified that she was either held off of work or given work restrictions by Dr. Kung from the time of her October 22, 2015 surgery through her December 17, 2015 release to return to full duty work. She also testified that respondent did not accommodate the light duty restrictions prescribed by Dr. Kung. No evidence contradicting the Petitioner's testimony was offered at trial.

Based on the above, the Arbitrator finds that petitioner was temporarily and totally disabled from November 16, 2014 through January 27, 2015 and from October 22, 2105 through December 17, 2015, for a total of 17 1/7 weeks.

With respect to issue (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary services, the Arbitrator finds as follows:

Having found the requisite causal relationship and that no evidence was introduced to dispute the necessity or reasonableness of the medical care rendered to Petitioner, the Arbitrator finds that respondent shall pay for the medical services set forth in petitioner's exhibit number 16 in the aggregate amount of $44,977.06, including $5,737.00 for bills incurred at OAK Orthopedics, $15,344.62 for bills incurred at Oak Surgical Institute, $5,852.00 for bills incurred at Premier Orthopedic & Hand Center S.C., $11,876.05 for bills incurred at Presence St. Mary's Hospital, and $6,167.39 in bills incurred at ATI Physical Therapy.

Respondent shall be given a credit of $21,062.50 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.

With respect to issue (L) What is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner sustained accidental injuries diagnosed as bilateral carpal tunnel syndrome and bilateral trigger thumb. Petitioner's bilateral carpal tunnel and left trigger thumb conditions were treated with surgical release and her right trigger thumb was treated with and injection. While consideration is not given to any single enumerated factor as the sole determinant, the Arbitrator relies on the following five factors pursuant to 820 ILCS 305/8.1(b).

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 quality control technician at the time of the accident and for several years prior. The Arbitrator also notes that though she *is* able to return to work in her prior capacity, her usual occupation requires nearly constant use of her hands. The Arbitrator therefore gives *greater* weight to his factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 52 years old at the time of the accident. Because of number of years she will likely work before retirement, the Arbitrator gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there was no evidence offered to suggest that petitioner's injury will

have an impact on her earning capacity. 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 Petitioner was a credible witness and that the medical records of her treating physicians corroborate her complaints related to her bilateral carpal tunnel syndrome and trigger thumbs. The Arbitrator therefore gives *greater* weight to this factor.

Wherefore based on the record as whole, the Arbitrator therefore finds that Petitioner sustained a loss of use of the right hand to the extent of 10% thereof, the left hand to the extent of 10%thereof, the right thumb to the extent of 5% thereof, and the left thumb to the extent of 10% thereof, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS ADAMSKI,

Petitioner,

vs.

NO: 15 WC 8301

HOME DEPOT,

18IWCC0475

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

The Commission affirms the decision of the Arbitrator with regards to the award of medical expenses and prospective medical treatment, however, clarifies the award for temporary total disability by the Arbitrator. As to temporary total disability, the parties stipulated at the Arbitration hearing that all temporary total disability had been paid between January 16, 2015 and June 30, 2016, and that the Respondent was therefore entitled to a credit. The Commission clarifies that the dates of temporary total disability awarded are January 16, 2015, through October 28, 2016, for a period of 93 1/7 weeks.

The Award of the Arbitrator is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 20, 2016, is hereby affirmed and adopted.

18IWCC0475

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $220.00 per week for a period of 93 1/7 weeks, from January 16, 2015 through October 28, 2016, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of Petitioner's causally related condition pursuant to §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 for the treatment and attendant care recommended by Drs. Khan and Schueler pursuant to §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,491.00. 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 6 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O:
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

ADAMSKI, THOMAS
Employee/Petitioner

Case# **15WC008301**

HOME DEPOT
Employer/Respondent

18IWCC0475

On 12/20/2016, 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 0.64% 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:

0339 LAW OFFICES OF EDWARD P GRAHAM
RYAN E LARSON
1245 DIRHL SUITE 105
NAPERVILLE, IL 60540

4136 ATB LAW
MARCY E BENNETT
125 S WACKER DR SUITE 1717
CHICAGO, IL 60606

18IWCC0475

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19B/8A

Thomas Adamski
Employee/Petitioner

v.

Home Depot
Employer/Respondent

Case # **15** WC **8301**

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 **10/28/16**. 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. xxx 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. xxx 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. xxx What temporary benefits are in dispute?
☐ TPD ☐ Maintenance xx TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other **Prospective medical care**

FINDINGS

On **1/15/15**, 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 **$15,537.33**; the average weekly wage was **$354.24**.

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 **$17,644.58** for TTD, **$116.98** for TPD, **$0** for maintenance, and **$880.00 ppd advance** for other benefits, for a total credit of **$18,641.56**.

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

ORDER

RESPONDENT SHALL PAY PETITIONER THE REASONABLE AND NECESSARY 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 TREATMENT AND ATTENDANT CARE RECOMMENDED BY DRS. KHAN AND SCHUELER PURSUANT TO SECTIONS 8 AND 8.2 OF THE ACT.

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 17-1/7 weeks, commencing 7/1/16 through 10/28/16, as provided in Section 8(b) of the Act.

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

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

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

Jacqueline M. Cheesy

Signature of Arbitrator

12/16/16

Date

ICArbDec p. 2

DEC 20 2016

FINDINGS OF FACT

The trial proceeded on Petitioner's 19B/8a request for prescribed medical treatment. At trial, the 51 year old Petitioner testified that he began working for the Respondent Home Depot in Bolingbrook Illinois in March 2014. He worked in the building materials and lumber department assisting customers. His duties included lifting and carrying materials up to and over 100 pounds constantly during this shift. He was also required to push, pull, kneel, squat, bend and stoop during his shift. Petitioner also drove a fork lift, stacked and straightened shelves and assisted customers with carry outs.

It is undisputed that Petitioner sustained an accident arising out of and in the course of his employment on 1/15/15. ARB EX 1. On that date, Petitioner was asked to come in and cover another employee's shift in the hardware department in which Petitioner was also certified to work. Petitioner testified that on that date he was taking a pallet to a pallet truck. Petitioner testified that the truck was parked at the loading dock and the inside of the truck trailer was illuminated by the dock light. It was dark at the time of the accident. Petitioner testified that he walked inside the truck trailer and placed the pallet on a stack. Petitioner testified that when he turned around to leave he was blinded by the bright dock lamp while trying to avoid the pallets on the floor of the truck. Petitioner testified that at that point he slipped and fell on ice which had formed where the trailer body meets the steel plate of the loading dock.

Ex D is a photo taken by Petitioner a few minutes after the fall. The photo depicts the ice and slush in the corner of the truck where Petitioner slipped as well as marks on the ice where Petitioner landed. Petitioner testified that he slipped very quickly. While falling towards the wall of the truck he tried to catch himself on the truck frame but could not. Petitioner testified that his body twisted while falling. He testified that he fell onto his left lower back hitting his right knee on the pallets and his left elbow on the right wall of the truck. Petitioner was helped up by another employee and immediately reported the incident to the store manager. Notice is not in dispute. Petitioner testified that he was in pain but did not call an ambulance. He testified that the store manager suggested he go home and relax to see if his pain improved.

Petitioner testified that he bruised his elbow, knees and a hand and that he had severe pain on the lower left side of his back. He testified that he did not have prior low back problems, injury or treatment and that he was able to full perform his job duties prior to this accident.

Petitioner tried to alleviate his pain initially with ice, heat and ibuprofen which did not help. Petitioner testified that he was instructed by his supervisor to go to Edward Occupational Health on 1/17/15. Petitioner testified that he sat at occupational health for several hours without being seen so he left and went the ER at Edward Hospital where he was treated by ER doctors and told to follow up at corporate health with Dr. Link. He was prescribed Norco at the ER. PX A.

Petitioner followed up with Dr. Link on 1/19/15 at Edward Health and reported lumbar pain on his left side. Petitioner was kept off work and medication was continued under a diagnosis of low back pain. The records reflect that Petitioner did not fill the NORCO prescription but continued to take ibuprofen. PX A. Petitioner saw Dr. Link on 1/21 and 1/26/15 and Dr. Link sent him to physical therapy and ordered an MRI. Petitioner was continued off work. PX A.

Petitioner attended PT at Accelerated Rehab on 15 occasions between January 28 and March 2015. He testified to receiving only temporary relief from the conservative treatment. Petitioner testified that PT was stopped in March 2015 as Respondent would not authorize additional treatment.

While attending PT, Petitioner returned to Dr. Link on 2/4/15. He reported that his primary lumbar pain was on the left with some radiation of pain to the right side. PT was continued. PX A. On 2/13/15, Petitioner returned to Dr. Link and reported continued left sided low back pain. Petitioner further reported that he had tried to return to work but could only work 3 to 4 hours and then had increased pain. PX A. Dr. Link noted little progress in PT as confirmed with the physical therapist so he took Petitioner off work while waiting for the MRI authorization and he recommended consult by a physical medicine and rehabilitation physician to determine the cause of continued pain following the failure of conservative care. PX A.

Petitioner then began treating on 2/23/15 with Dr. Fetzer at DuPage Medical on the referral of Dr. Link. Petitioner underwent an MRI on April 8 2015 which showed mild to moderate degenerative disc disease at L3-4 with disc bulging and bony spondylotic changes causing mild to moderate left sided neuroforaminal stenosis with mild central and right sided neural foraminal stenosis; mild L4-5 central and bilateral neural femoral stenosis with disc bulging diffusely and bony spondylotic changes; mild L5-S1 diffuse stenosis." PX F. Dr. Fetzer administered one lumbar epidural steroid injection on May 21 2015. Petitioner testified that he experienced immediate nausea and headache from the injection. Petitioner underwent a second injection at DuPage on June 29 2015. On this occasion, Petitioner received an SI joint injection on the left side performed by Dr. Manganelli. This injection provided temporary relief. PX F. Petitioner testified that he discontinued his care with Dr. Fetzer on 6/30/15 in that Petitioner felt Dr. Fetzer arbitrarily lifted his work restrictions and returned Petitioner to work. PX F.

Petitioner next saw his first choice of physicians, Dr. Khan, in July 2015. Petitioner complained of left lower back pain that spread to his right side and made worse by sitting, standing, bending and reaching. Dr Khan recommended epidural injections but could not obtain approval. In August 2015, Petitioner received bilateral SI injection from Dr. Khan without improvement.

In September 2015, Petitioner reported continued pain to Dr. Khan and Dr. Khan again recommended 2 more lumbar steroid injections. Petitioner testified that he received one of the two recommended injections in October 2015 and that his pain relief was immediate and greater than 90% but only lasted one day. On November 18, 2015, Petitioner reported the continued pain to Dr. Khan who again recommended a second lumbar injection. Following additional continued pain complaints in January 2016, Dr. Khan recommended 3 lumbar injections. Petitioner testified that he has not received any of the additionally recommended injections from Dr. Khan subsequent to the injection received in October 2015.

In March 2016, Dr. Khan made the same injection recommendations and also referred Petitioner to a neurosurgeon, Dr. Schueler who saw Petitioner in April 2016. Petitioner reported right and left sided pain made worse by movement. Dr. Schueler recommended lumbar injections and x-rays. No MRI was recommended.

Petitioner returned to Dr. Khan in June and July 2016 and received the same recommendation for 3 injections which were not administered. Petitioner's last visit with Dr. Khan was in July 2016.

Dr. Khan testified via evidence deposition taken on 5/11/16. Px C. Dr. Khan is board certified in pain management. He testified that he began treating Petitioner in July 2015. He noted that Petitioner had already received one lumbar epidural injection and an SI joint injection from DuPage Medical Group but that he had continued pain. Dr. Khan opined that these injections failed to provide relief in that they were not administered by pain specialist. P. 85. Dr. Khan performed an exam and reviewed the April MRI and determined that Petitioner had lumbar radiculopathy, degenerative disc disease and lumbar facet arthropathy. P. 19. He recommended epidural injection but explained that since the insurance company only authorized an SI injection, he performed a bilateral SI injection with radiofrequency ablation on August 3, 2015. P. 10-11, 21-22, 87.

On 9/11/15, Petitioner reported that the SI injection did not help. P. 24. Dr. Khan testified that on examination that day he documented radiating pain down both legs to the knee. He again recommended 2 lumbar epidural injections at L4 and L5. P. 25. P. 28. On October 8, 2015 he performed one lumbar epidural injection at L4-L5. P. 28. On 11/18/15, Petitioner reported 90% pain relief for 36 hours. P. 30. As a result of the short lived relief, Dr. Khan recommended performing the second injection back to back. P. 30. Petitioner reported during exam on that date that he had numbness and tingling on the right leg and left leg numbness. P. 37. Dr. Khan again recommended the second lumbar steroid epidural injection be performed. P. 40.

In January 2016, the exam was unchanged and Petitioner was prescribed Gabapentin for neuropathic pain. P. 42. Dr. Khan testified that due to the passage of time since he administered the one out of 2 recommended lumbar epidural injections in October 2015, he now recommended a new series of three epidural injections to be scheduled once a week for three weeks in an attempt to get lasting improvement. P. 44,87. He would have performed the first of those three injections immediately if approval were obtained. p.44. Dr. Khan wanted to administer all three injections at L4-L5 level. P. 45. Because he was unable to further treat Petitioner's pain, Dr. Khan referred Petitioner to a neurosurgeon, Dr. Schueler, in an attempt to provide Petitioner with additional pain relief options. P. 48.

Dr. Khan opined that he continues to recommend three epidural steroid injections at L4-5 for Petitioner to see if his pain can be managed non-surgically. P. 53. Px h. He opined that Petitioner's condition is the result of the January 2015 fall at work. P. 58-60.

On June 16, 2016, Petitioner attended a Section 12 exam with Dr. Phillips. Petitioner testified that the exam was short, painful and not thorough. In his report, Dr. Phillips indicated that he had previously performed a records review regarding Petitioner. The Arbitrator notes that records review performed by Dr. Phillips was not offered or admitted at trial. In his Section 12 report, Dr. Phillips indicated that subsequent to the records reviewed he received new records from Dr. Khan dated 3/30/16 and Dr. Schueler dated 4/21/16. The records of 3/30/16 document Petitioner's receipt of an epidural injection which provided 90% relief, recommendation for additional lumbar epidural injections and a referral to neurosurgeon. Dr. Schueler's 4/21/16 record indicates his order for additional epidural steroid injections, possible trigger point

injections and x-rays. Both Drs. Khan and Schueler note the lumbar MRI taken in April 2015 indicates stenosis multilevel, mild to moderate disc bulge L4-5. Petitioner presented complaints of non-radiating low back pain right to left. The lumbar epidural injections were recommended.

Dr. Phillips notes that Petitioner reported left paralumbar back pain of constant nature following his fall at work. Dr. Phillips noted that as of his exam in June 2016, Petitioner had received 5 injections one of which provided temporary relief and one of which was an SI injection which provided no relief. He noted on exam that Petitioner was pain focused with low back tightness on straight leg raise and tenderness of the left paralumbar region. He reviewed the April 2015 MRI and noted "no evidence of any significant structural injury." Dr. Phillips opined that Petitioner had "clearly plateaued with conservative treatment. Obviously, he has had no lasting relief with more than 5 injections. I see no indication to continue with injections, and I therefore believe he has indeed reached MMI with regard to the injury in question." He diagnosed Petitioner with a lumbar sprain/strain on January 15, 2015 and that his subjective complaints in June 2016 after 5 injections and therapy outweigh the objective findings. He again placed Petitioner at MMI and recommended a return to work full duty.

Respondent submitted 6 UR reports. April 23, 2015 report decertified Dr. Fetzer's recommendation for a left L3-4 transforaminal epidural steroid injection made in April 2015 not medically necessary as there was no evidence of radicular pain. RX 1. RX 6 is a UR dated July 2015, decertifying a request for 2 additional multi-level epidural steroid injection based on the failure of an L4-5 lumbar epidural steroid injection on June 29, 2015 and the failed SI joint injection and that no more than two nerve root levels should be injected.

On September 30, 2015, another UR report documented Dr. Khan's treatment of Petitioner including one failed SI injection and one prior epidural injection from DuPage which provided no relief. The UR report decertified Dr. Khan's request for a repeat series of 2 lumbar epidural injections based on a lack of radicular complaints and objective evidence of radiculopathy. RX 2. The UR reports of 12/16/15 and January 2016 again decertifies Dr. Khan's request for a transforaminal epidural steroid injection on the same basis of no radicular pain and no lasting relief from prior injections administered as both diagnostic and therapeutic. RX 3, RX 4. RX 5 is a UR dated May 2016 decertifying Dr. Schueler's recommendation for flexion and extension x-rays as not recommended or necessary in the "absence of red flags" on the objective MRI.

At trial, Petitioner is requesting the series of three lumbar epidural steroid injections recommended by Dr. Khan and would like to undergo the procedures including the x-rays recommended by Dr. Schueler. Currently, Petitioner testified to no change in his pain. He testified that before the accident he was active riding a bike, walking his dog, hiking, and offshore sailboat racing. He testified that he is unable to currently perform those activities and that he has pain bending, reaching and getting in and out of his car. He testified to having pain when sitting over 30 minutes. He further testified that he is currently unable to work his job with Respondent or a similar job due to his condition.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

F. Is Petitioner's current condition causally related to the injury? O. Is Petitioner entitled to recommended prospective medical care?

Based on the record in its entirety, and specifically on the testimony of Dr. Khan, the Arbitrator finds that Petitioner's current continued complaints of lower lumbar pain are causally related to the undisputed accident and injury of 1/15/15 and that he is entitled to receive the injections recommended by Dr. Khan. In so finding, the Arbitrator notes that Petitioner's complaints of low back symptoms were immediate and continuous following the fall at work. He sought immediate care and his treatment has been consistent and without interruption.

The Arbitrator notes that prior to treating with Dr. Khan, Petitioner received one lumbar epidural injection and one SI injection from Drs. Fetzer and Manganelli at DuPage. At the time Petitioner chose to stop treating at DuPage, the only approved recommendation was for a second SI injection which Petitioner chose not to receive from that physician group as of 6/30/15. PX F. The Arbitrator notes that Petitioner's symptoms were ongoing at that time as buttressed by the recommended second SI injection. Petitioner was within his right to choose another physician for treatment and he chose Dr. Khan.

Dr. Khan attempted to obtain authorization for additional lumbar epidural injections based on the same MRI results from April 2015. Dr. Khan was authorized only to perform another SI injection which he did and which provided no relief. Dr. Khan then again recommended 2 lumbar epidural injections of which he administered one injection resulting in 90% temporary relief. Dr. Khan was unable to obtain authorization for the second injection, which he felt would have provided additional relief if it could have been done in a timely manner. Since it was not done timely, Dr. Khan now recommends a new series of three lumbar epidural injections to be administered back to back in an attempt to further diagnose and treat Petitioner's pain complaints. Based on Dr. Khan's testimony, and placing greater weight on the opinion of Dr. Khan over that of Dr. Phillips and the UR reviews, the Arbitrator find that Petitioner is entitled to receive these recommended injections along with any further x-rays recommended by Dr. Schueler, and that Respondent shall authorize and pay for these recommended injections and x-rays and the attendant care, pursuant to Sections 8 and 8.2 of the Act.

J. Were the medical services provided to Petitioner reasonable and necessary? Has Respondent paid for all reasonable and necessary medical services?

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of his causally related condition in his low back pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

K. What temporary benefits are in dispute? TTD

The Arbitrator notes that Respondent paid TTD and some TPD benefits prior to 7/1/16. At trial, Petitioner requests additional TTD commencing 7/1/6 through trial on 10/28/16. Based on the findings on the issue of causal connection and prospective medical care, the Arbitrator finds that

Petitioner is entitled to the requested TTD commencing 7/1/16 through 10/28/16 a period of 17-1/7 weeks. Respondent shall receive credit for any amounts paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARCELINA MARCHAN,

Petitioner,

vs. NO: 14 WC 31153

FLYING FOOD GROUP, LLC,

Respondent,

18IWCC0476

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical expenses, and penalties and, being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Statement of Facts contained in the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission finds that Petitioner met her burden of proof regarding accident. The Commission reverses the Arbitrator regarding accident and finds that Petitioner's aggravation of her first hernia is causally related to her alleged work accident, and that she is entitled to medical expenses and temporary total disability benefits. The Commission finds that Petitioner did not prove causal connection in regard to her second hernia surgery or back injury.

Petitioner credibly testified that she sustained a slip and fall accident on a banana peel on or about August 14, 2014. The occurrence of the actual accident is corroborated by the accident report and Illinois Form 45 report completed on August 15, 2014 and August 26, 2014, respectively. (Rx1 and Rx2) The Commission finds that the testimony of Ray Hutchinson that there was another Marcelina Marchan who sustained the exact injury at the exact time was not credible. Although there appear to be inconsistencies with whether the accident took place on August 14, 2014 or

18IWCC0476

August 15, 2014, Petitioner's overall testimony was credible and supported by Respondent's exhibits as to the accident taking place. Further, the mechanism of injury was consistently described throughout the medical records and on the accident reports, and her treating physician, Dr. Jain, related her current complaints to the work accident. The accident arose out of and in the course of employment. Petitioner slipped on a banana peel in an area where food waste was coming out of trolleys and off of trays to be placed in the trash. It is reasonable that an errant food item would have made its way to the floor where Petitioner was working, thus causing her to fall.

Petitioner presented to US MercyWorks, Respondent's occupational health clinic, on August 22, 2014. At that time, she complained of slipping on a banana peel at work. She described that she did the equivalent of the splits and complained of pain in her lower back and right abdomen. She had no previous history of back problems. US MercyWorks performed x-rays on the lumbar spine, which were negative and discharged her with the diagnosis of strain. However, her right abdominal hernia, which was pre-existing, was more pressing, so she was instructed to see a general surgeon. Although she presented to the ER on July 26, 2014, with complaints of pain from the hernia, as well as pain radiating down her right leg, at that time, there were no signs of incarceration or strangulation. When she presented to US MercyWorks following her work accident, the hernia had become incarcerated, requiring more immediate medical attention. Based on the medical records and testimony, Petitioner suffered an aggravation of her existing hernia, as well as a lower back strain. The lower back strain resolved by the time Petitioner healed from her treatment for her hernia.

The Commission denies treatment regarding the second hernia as well as to Petitioner's back. Petitioner did not prove a causal connection between either of these conditions to her slip and fall accident of August 14, 2014. The medical records support that whatever back strain Petitioner endured from the work-related incident was resolved by the time Petitioner reached maximum medical improvement from the first hernia. The second hernia is in a different location and there is no medical opinion causally linking the second hernia to the first hernia.

Petitioner appears to have last worked on August 15, 2014. She has been off of work since that time. However, she was released to return to work without restrictions following her hernia surgery as of January 28, 2015. As the slip and fall caused an aggravation of Petitioner's hernia, she should be awarded temporary total disability from August 16, 2014 through January 28, 2015.

Finally, Petitioner should be awarded medical expenses with regards to the first hernia surgery and connected treatment. Petitioner did not prove her case regarding the second hernia surgery, nor did she prove that the back treatment, including the recommended injections, were causally connected or reasonable and necessary, so prospective medical treatment is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $246.93 per week for a period of 23 5/7 weeks, from August 16, 2014 through January 28, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $27,772.86 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $33,729.00. 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 6 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 062718
49

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

MARCHAN, MARCELINA
Employee/Petitioner

Case# **14WC031153**

FLYING FOOD GROUP LLC
Employer/Respondent

18IWCC0476

On 12/15/2016, 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 0.64% 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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4866 KNELL & O'CONNOR
KURT V WAKEFIELD
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

18IWCC0476

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)

MARCELINA MARCHAN
Employee/Petitioner

v.

FLYING FOOD GROUP, LLC.
Employer/Respondent

Case # **14** WC **31153**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 27, 2016 and 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

18IWCC0476

On the date of accident, **8/14/2014**, 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 not* sustain an accident that arose out of and in the course of employment.

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

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

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

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

ORDER

Denial of benefits

The Arbitrator finds that the Petitioner did not sustain an accident that arose out of and in the course of her employment by the Respondent and further finds that the Petitioner's current condition of ill-being of her abdomen/hernia or her lumbar spine is not causally related to any incident at work on August 14, 2014. Therefore, compensation is hereby denied. All other issues have been 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

December 15, 2016
Date

ICArbDec19(b)

DEC 15 2016

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

Marcelina Marchan
Employee/Petitioner

v.

Case # 14 WC 31153

Flying Food Group
Employer/Respondent

FINDINGS OF FACT

Petitioner's Testimony

The Petitioner testified through an interpreter. The last employer for whom she worked was the Respondent. She had been employed by the Respondent for approximately 9 years. The Respondent was engaged in the business of catering meals for international flights, and employed between three and four hundred people at any given time at its Schiller Park Facility. When the Petitioner began working for the Respondent, she helped to prepare the food, but did not elaborate on the dates worked or the duties performed in that position.

On August 14, 2014, the Petitioner worked in the dishwashing area of the Respondent's Schiller Park facility. She worked as a dishwasher. She placed dirty serving and dining ware from international flights on a large conveyer belt that went through a dishwashing machine. On August 14, 2014, she earned $9.26/hour and worked 40 hours a week. She worked overtime hours. The overtime hours were not obligatory, but voluntary.

The Petitioner's responsibilities were to set up the dishes, "toss and catch" the china, and process the spoons. In the room where the dishes are washed, workers empty out food items

from trays that are on trolleys. Sometimes pieces of food, skins, and other debris fall to the floor. Occasionally, the floor gets wet. On August 14, 2014 at 11:00 a.m., while the Petitioner was walking beside one of the dishwashing machines and on her way to wash the trolleys, she slipped on a banana peel and fell to the cement floor. She fell into a splits-style position with her right leg extended behind her and her left leg extended in front of her. There was much garbage on the floor.

Right after she fell, she got up because she had fallen backwards. There were two women there who said that they were going to help her. At that time, her supervisor, Kevin, walked by and asked her how she was doing and she told him that she was okay.

On the following day, that she experienced much pain. Actually, the night of the accident she felt pain all the way down to her right foot. She felt pain from her hip to her arm and then down her back. She also felt pain in the pelvic area. Everything hurt: her arm, her foot, her leg. The next day she went to work and it was her turn to "catch" the china. To do that job, she had to bend and stoop. China is porcelain and she must bend over to catch it. She has to pack the china in one place and then place the trays into the trolleys. She and her co-workers stacked 25 trays and inserted them. She felt pain in her right inner thigh and the right side of her back. On that day, August 15th, when she started feeling the pain, she reported it to Kevin and he took her to the H.R. offices. Pearla, he secretary in the H.R. offices, took her to the doctor of the work site. The Petitioner did not recall the name of the nurse. The nurse examined the Petitioner in front of Pearla. The nurse examined the Petitioner's abdomen, the center and right side of her low back, and her right foot. The right leg was the leg on which she lost traction; it went backwards.

The clinic was near the Schiller Park facility. They walked there. The clinic was named U.S. HealthWorks. It was on Mannheim Road. At the clinic, they checked her out, examined

her and told her that she had to find a surgeon. They determined that the Petitioner needed an operation. She told the doctor at the clinic that she hurt very much "here." He said that if she is in a lot of pain, they are going to look into surgery. He told her that she could go to her primary care physician.

Before this accident, she had pain and a small bulge in the right side of her abdomen. She had this bulge for approximately 5 years. Prior to the accident of August 14, 2014, she never needed to have surgery for that bulge and was able to perform all of her job duties for the Respondent. She used to work very well and used to take on much overtime. When she fell, she felt that the lump got bigger and become inflamed. It was at that time that the doctor said she needed an operation. After the fall, she had increased pain in the abdomen and was not able to continue working. The doctor at U.S. HealthWorks told her to look for another doctor.

After August 16, 2014, she was off work. When she went off work for the first time, the H.R. people - - actually, the head of H.R., whose name she could not recall - - told her to go ahead and have the surgery and when she comes back, her job would be waiting for her.

On October 29, 2014, she underwent the surgery for the little ball on her right side at Cook County Hospital. She was off work for approximately 4 months. She was released to return to work with light-duty restrictions. She returned to the Respondent, but they would not accept her with light-duty restrictions. She spoke with Pearla and was told that she could reapply for the job. She also spoke with Ramone in H.R.

Post-operatively, she continued to experience discomfort in her abdomen.

She treated at Michigan Avenue Medical Associates for hip pain. She underwent physical therapy. The doctors have recommended an injection to her hip, but she has not received it.

On October 16, 2015, she underwent a second surgery on her abdomen for the same pain she had before the first surgery. She was advised not to work after the second surgery. The second surgery helped her.

Presently, she feels a bit delicate, but has no pain. She does not have any bulging anymore. When she visited Michigan Avenue Medical Associates, she was told to have an MRI of her lumbar spine. They prescribed medicine. They also prescribed an injection, but they did not give her the injection because the insurance company would not pay for it. Since the accident of August 14, 2014, she has not worked anywhere else. She has not received any compensation since that time. She has not received any unemployment benefits.

The type of pain that she feels at this time is very strong when she bends over, lays on her back, sits and mops. She feels pain in her hip. She feels pain from her hip to her right foot. She also feels pain from her shoulders down.

Prior to this accident, she had no pain in her hips or low back, never had pain from her upper back to her lower back (that she can recall), and lost no time from work as a result of the bump in her abdomen or the pain there.

On cross-examination, the Petitioner testified that she had the hernia problem at the time that she was processing food for the Respondent. However, she started to feel the pain in this area when she began her dishwashing duties. She went to the doctor in 2009 because she had a little pain down there, but she did not go back because she got better. At that time, she experienced inflammation and swelling and a bit of pain.

On July 26, 2014, she went to Stroger (Cook County) Hospital because of problems she was having with her hernia. She went there because she had a little bit of pain. She took medicine and she got better.

She experienced pain that radiated from her leg and her groin from the fall. When asked if she had no leg pain when she visited Stroger Hospital on July 26, 2014, she responded that after the operation, her right leg and her back at the waist began to hurt. When asked if she was denying that on July 26, 2014, the doctor wrote about pain down the right leg, she responded: "Well maybe - - yes - - but I don't remember at this point." When asked if the emergency room doctor asked her if she was numb in the leg, she responded that she did not recall. When asked if the doctor at Stroger Hospital instructed her to follow up with the surgical department, she respondent "Yes" but stated that she felt better after taking the medicine.

On August 22, 2014, her hernia was still painful and swollen. Pain was no longer radiating down her leg. After the fall, when she did the splits, even her toes hurt. When asked if she was aware that on August 22, 2014, the doctor wrote that she denied radiating pain to her legs, she responded that she only went there to see him because of the big ball she had in her groin.

When she returned to Stroger Hospital of September 29, 2016, to prepare for the hernia surgery, she did feel a bit better. Notwithstanding this improvement of her symptoms, she decided to proceed with the surgery. After she fell, she noticed that the big ball in her abdomen just popped out. When she went back to Stroger Hospital, the hernia was painful.

She has not worked since August 14, 2014.

When asked if she was aware that the October 29, 2014 records from Stroger Hospital indicate that her symptoms started 8 days ago, the Petitioner responded that she did not remember. When asked if the October 29, 2014 records from Stroger Hospital indicate that she has a long history of a hernia, she responded "No" and that she only went there once before.

When asked if she told the medical staff at Stroger Hospital that day that she has a long history of a hernia, she responded that she did not remember.

On November 13, 2014, she returned to Stroger Hospital for a post-surgical visit. At that time, she felt a bit better.

On February 28, 2015, she returned to Stroger Hospital. At that time, the pain and swelling around her hernia was better and she was cleared by her doctor to return to full-duty work, with no restrictions.

On June 11, 2015, she presented to Dr. Jain at Michigan Avenue Medical Associates because she was experiencing back pain, which included pain that was running down her leg. Before such visit, the Petitioner never treated with Dr. Jain.

The Petitioner denied that she fractured her hip about 10 years ago. When asked if something had happened to her hip, she responded that she had already told us about this - - it was from a long time ago.

Subsequently, she returned to Stroger Hospital because her hernia flared up. It was swollen and painful. At that time, she had not done any work since August 14, 2014.

With regard to the accident itself, the Petitioner testified that she slipped on a banana peel and fell in a split-style motion. One leg went one way and the other leg went the other way. She first thought her left foot slipped on the banana peel, but then testified that it was her right foot. Her right leg went backward and her left leg went forward. At that time, she struck one knee on the floor: her right knee. She was not carrying anything at the time she slipped and fell. She was going to get a trolley. Nothing was obstructing her vision at the time she slipped and fell.

When asked if she was aware that the accident report that was completed the next day only identifies the knee, the Petitioner responded that she told them that her waist hurt. She

did not know if the report states that she did the splits, but that is what she reported. She reported the accident to Kevin, her supervisor. She did not know Kevin's last name. With regard to the 2 ladies who helped her get up after she fell, one was named Kao, and the other was a Filipino. She did not know if witnesses were noted in the report that was completed the day after the accident. The punch cards of Kao and the Filipino lady were noted. Ray Hutchison was her supervisor at the time of the slip and fall. When she was asked what Kevin looks like, the Petitioner responded that he was tall, a little chubby with dark, short hair. Ray is tall, slender with short hair and maybe a beard.

On re-direct examination, with regard to the U.S. HealthWorks records of August 22, 2014, she testified that, yes, she had x-rays taken of her lumbar spine that day. The date of August 22, 2014 is shortly after the accident of August 14, 2014. She also received medication and treatment for her low back on that day. When asked if, when she visited Stroger Hospital, she had health insurance, she responded: "Yes - - I received many bills from the first hernia surgery, and received bills from the second hernia surgery, and received bills from Michigan Avenue Associates." To date, the medical bills total approximately $71,000.00. Not one of the bills has been paid. With regard to Kevin and Ray, on the date of the accident, Kevin was her supervisor. When Kevin was not at work, Ray would be her supervisor. So, either Kevin or Ray was her supervisor.

On re-cross examination, the Petitioner testified that on August 22, 2014, she received medical treatment for her back. The date of June 11, 2015 was the next time she received medical treatment for her back.

Raymond Hutchison's Testimony

Raymond Hutchison testified on behalf of the Respondent. The Respondent is a catering company for international airlines. They are located at 3330 Transworld Road in Schiller Park, Illinois. The Respondent does hiring by the season. In mid-September, they would have had about 300 employees.

Mr. Hutchison began working for the Respondent on March 1, 2002. In May 2015, he became Safety Manager. He is charged with preventing accidents and injuries. To become Safety Manager, he was required to attend safety seminars and OSHA seminars. If he sees a violation of a safety rule, he will educate the worker who violated the rule. He walks around the facility during the day. He spends about 1 hour per day in his office.

With regard to reporting an accident, there is a certain procedure. If it is an emergency, the supervisor is to send the injured worker to the hospital as soon as possible. The supervisor is supposed to complete an Incident Reporting & Treatment form, or IRT form. The supervisor is to take a statement from the worker involved in the accident and is to gather all the facts. Any potential witnesses would always be interviewed. Hutchison would create a report and it would be in the file with the IRT form. In completing the IRT form, one is to record the injured person's social security number and phone number, and to indicate how the accident happened and take photos. If the field in the IRT form for Witness Name is left blank, that would indicate that there was no witness. (RX 1) Mr. Hutchison also testified that in the IRT form, no medical treatment was ordered for the Petitioner. (RX 1)

Since Mr. Hutchison has been Safety Manager, he has had only 2 injuries reported to him, one of which included an employee who slipped on a piece of wood in the parking lot. He

has not had any other claims of a work injury in the dishwashing area. He has worked in every operational area of the facility for the Respondent.

On August 14, 2014, Mr. Hutchison was overseeing the equipment in the sanitation area. He works from 7:00 a.m. to 3:30 p.m. He oversees the dishwashing equipment set up, as well as the equipment runners and porters. On August 14, 2014, Hutchison was the Petitioner's direct supervisor that day. Will Powell was the Sanitation Supervisor that day. Will was involved in the investigation. Hutchison already knew the accident-reporting procedures from being with the company for a long time. The Safety Manager conducts briefings. There are 3 dishwashing machines: Hobart #1 (outside of area), Hobart #2 (middle, inside dish machine) and Hobart #3 (outer dish machine).

As a Safety Manager and former Sanitation Manager, Hutchison is responsible for that area. He makes sure that the employees work in a hazard-free environment. If Hutchison saw a banana peel or other debris on the floor, he would pick it up. Every employee knows that if he or she sees food on the floor, he or she is to pick it up. The dishwashing room is a busy, crowded area. Eating and drinking is not allowed in the dishwashing room. If any employee is caught eating in that area, that employee would lose her job. Employees are not to eat anything off the trays from the inbound flights because they might get sick or die. Employees are only to handle trays from the planes.

Respondent's Counsel showed Mr. Hutchison photos of the facility that were taken on June 24, 2016. (PX #21 – PX #28) Mr. Hutchison testified that these photos how this area of the facility would have looked on August 14, 2014. RX #21 is a photo of the front of Hobart #1. Employees are to remove food and other garbage from the inside the trolleys and throw it in the dumpster. Then they are to put the trays on a conveyor belt that goes through the blue flaps. RX

#24 depicts the Hobart #2 from a different angle. RX #26 shows a red trash can and the back of Hobart #1. Mr. Hutchison further testified that there should be no food or other waste in that area. He has never investigated any situation where an employee slips on food or other waste on the floor.

On August 15, 2014, Mr. Hutchison spoke with the Petitioner. The conversation took place in the morning near the dishwashing machine. No one else was present at the time of the conversation. He asked her what had happened. She said that she slipped on a banana peel and hurt her knee. He asked if she was okay, and she said "Yes." She did not say anything about her ability to do the job and did not ask if she could leave to see a doctor. She did not appear to be in any pain. At that time, Mr. Hutchison looked her over. Mr. Hutchison further testified that he spoke to another person that morning. He did not speak to this person who is sitting in the courtroom today. He did, however, speak to a different person who had the same name: Marcelina Marchan. She told Mr. Hutchison that she suffered a fall that was virtually identical to that claimed by the Petitioner - - in which she slipped on a banana peel and hurt her knee. Mr. Hutchison verified that no other parts of her body hurt and that she was able to work without medical attention.

Respondent's Counsel showed Mr. Hutchison RX #29. The small photo in the upper left hand corner of this exhibit is of the Marcelina Marchan with whom Hutchison spoke on August 15, 2014. The large photo is of an Instagram friend of *the other* Marcelina Marchan. Ms. Marchan sent a message to her friend that she is "Boreddd at work." The posting date here is 6 days after the alleged slip-and-fall accident.

On cross-examination, Mr. Hutchison testified that he has previously seen this woman who is sitting in the courtroom today. Her name is Marcelina Marchan. It is possible that there

are 2 women named Marcelina Marchan who work for the Respondent. There are 300 people employed by the Respondent. It is a 24-hour facility. Hutchison runs 3 shifts.

On August 15, 2014, Hutchison checked on Marcelina Marchan. Someone notified him that Marcelina Marchan had an accident. It was William Powell. The Petitioner does not speak English and Hutchison does not speak Spanish.

There are 2 or 3 nurses who work on site for the Respondent. The nurses deal not only with injuries, but with illnesses. Sheila is the nurse who is there the majority of the time. She is Caucasian with red hair and is about 5'8" tall and is in her 40s. She is full time. There is 1 other nurse.

The work shifts are typically from 10:00 a.m. to 6:00 p.m., 6:00 p.m. to 2:00 a.m., and 2:00 a.m. to 10:00 a.m.

Mr. Hutchison did not know if Sheila was working at the time the Petitioner injured herself.

Mr. Powell was the supervisor who completed the IRT form.

Kevin Collins was another Sanitation Supervisor. He was employed by the Respondent on August 14, 2014. Hutchison did not know if Kevin Collins was working that day.
Kevin Collins does not work for the Respondent now. Hutchison did not know where he currently works.

If there were an accident on August 14, 2014, Hutchison would have been the one who was called, not Kevin. Hutchison was not the Safety Manager until 2015.

Pearla is a Human Resources Manager who works for the Respondent. There is no Ramone or Raymond who works in H.R. for the Respondent. There is a James D. in H.R. for the Respondent, but he was not in the H.R. department on August 14, 2014. Michelle worked in

H.R. for the Respondent on August 14, 2014. Michelle is a Caucasian female with blonde hair who is about 5'7" tall.

Mr. Hutchison testified earlier that at the time he took the photos, employees would clean the trolleys from the inbound flights and dump trays of food into the garbage and wash the trays. It is possible that the waste would include orange peels or apple cores. Mr. Hutchison did not know how this debris would get to the back of the dishwashing machine when it was dumped out at the front of the machine.

Mr. Hutchison agreed that the bottom of PX #22 shows debris on the floor. It also shows that the floor is wet. There are 60-80 trolleys that come in per shift. Hutchison did not know how many trays are processed per shift because every flight has a different number of trays and he cannot give the number of trays per trolley.

Mr. Hutchison testified that that the individual sitting in the courtroom was employed by the Respondent. When he saw the Petitioner, he thought she was working normally. He did not know that she was injured. Sometimes an employee goes to the nurse on his or her own, that is, without Hutchison.

U.S. HealthWorks is a clinic. If the nurse sees someone whom she cannot treat, she will send that sick or hurt employee to U.S. HealthWorks.

On re-direct examination, Respondent's Counsel asked the witness to review the photos of the dishwashing machines and point to any debris that is the size of a banana peel. Mr. Hutchison responded that he did not think that any piece was that big because they train the employees to pick up debris. Mr. Hutchison further testified that there are more people working in this dishwashing area than are depicted in the photos. Perhaps the employees scattered a bit when Hutchison started taking photos. Employees are required to wear gloves and no-slip safety

shoes in order to prevent injuries. For the area shown in PX #21, one person is on this side and another person is on the opposite side. Hutchison thought that the person on this side went to get a mat. PX #26 displays the front and side of the machine. This is the location of the alleged accident. There would be a person in the front and a person in the back of the machine. The wall where the clock is hung is the front. The red trash can is on the side.

On re-cross examination, Mr. Hutchison testified that when he sends an employee to U.S. Healthworks, he will send that employee with a supervisor. Alternatively, Hutchison would accompany the employee.

IRT Form

The Incident and Reporting form (IRT) indicates that on August 15, 2014 at "1935," Marcelina Marchan sustained an injury when she slipped on a banana peel that was on the floor beside the Hobart #1 machine and hurt her knee "real bad." The Petitioner signed the form on August 15, 2014. (RX #1)

Medical Records and Reports

On June 20, 2009, the Petitioner presented to the Emergency Department at John H. Stroger, Jr. Hospital of Cook County in Chicago, Illinois, and stated she has a history of a hernia and complained of pain and swelling in her right groin area over the preceding 2 weeks. (RX #4) The Petitioner's medical records indicate that on October 23, 2009, she was scheduled to have a surgical consultation with regard to her right inguinal hernia. No surgery was performed. (RX #5)

The Petitioner again sought treatment in the Stroger Hospital Emergency Department for pain, swelling, and hardening of her right-sided inguinal hernia on July 26, 2014. (RX #6) She reported that she was experiencing pain radiating down her right leg, and was unable to bend over. (RX #6) She rated her pain at an intensity level of 8 out of 10. (RX #6) Francois Blumenfeld-Kouchner, D.O., noted that this is a 59-year-old Spanish speaking woman with history of right inguinal hernia presents for right groin growth and pain for 1 week. He further noted that this is likely an inguinal hernia without signs of incarceration or strangulation and that the differential diagnosis includes enlarged lymph node, though there is no weight loss or symptoms/signs of malignancy. Dr. Blumenfeld-Kouchner prescribed acetaminophen for pain control, and instructed the Petitioner to follow up with general surgery on July 30, 2014 at 2:00 PM. (RX #6, RX #7) The Petitioner skipped this appointment and continued to work without consulting a surgeon.

On August 22, 2014, the Petitioner then went to U.S. HealthWorks, where she was examined by Alan L. Sisson, M.D. In his report, Dr. Sisson wrote, *inter alia*, the following:

> "She states that she slipped on a banana peel at approximately 5:00 PM, on August 15, 2014. She states that she did the equivalent of the splits and since has felt pain in her lower back and right abdomen. She denies any radiation of pain to the lower extremities. She states that over the past three years she had had a lump in the right lower quadrant that is more painful now than it ever has been and is protruding more than it ever has. She has no previous history of back problems. There was no treatment prior to arrival."

The X-rays of her lumbar spine were unremarkable, and the only irregularity observed on physical exam was tenderness to palpation over the bilateral L4-L5 paravertebral muscle groups. (RX #8) Strength, reflexes, and range of motion were all normal. (RX #8) Dr. Sisson diagnosed the Petitioner with a lumbosacral muscular strain and an incarcerated direct inguinal hernia. (RX

#8) She was provided with a hot/cold pack and ThermaCare pads for her lower back and 40 tablets of Ibuprofen 200 mg, for no specified body part. (RX #8) She was also placed on modified-duty work status; she was to do predominantly sitting work with no heavy lifting, pushing or pulling, bending or stooping, climbing, using heavy equipment, or reaching overhead until her hernia could be further evaluated. Dr. Sisson also wrote: "Owing to the fact that this hernia and mass effect have been present for a period of three years, it is difficult to relate its presence and condition to the statement of injury as explained by Ms. Marchan." (RX #8)

The Petitioner's next appointment for her hernia was on September 3, 2014 in the surgical department at Stroger Hospital with Steven R. Bonomo, M.D. (RX #9) She reported that she was still experiencing pain in her right groin, and was scheduled to undergo hernia repair surgery on October 15, 2014 with a pre-surgical appointment on September 29, 2014. (RX #9) When the Petitioner presented for her pre-surgical consultation at Stroger Hospital on September 29, 2014, she reported to Zachary Jaffa, D.O., that her pain had improved from her last visit, but still wished to proceed with the surgery. In the Assessment/Plan section, Dr. Jaffa opined that the Petitioner's right inguinal hernia was not strangulated or incarcerated. (RX #10)

The Petitioner returned to Stroger Hospital for hernia surgery on October 14, 2014, but the surgery was canceled, when, during a preliminary exam, Petitioner admitted to having 2 instances of exertional chest pain in the preceding week. (RX #12) She reported that the chest pain developed after walking between 1 and 3 blocks and that she felt short of breath after walking 1 - 2 flights of stairs. (RX #12)

On October 17, 2014, the Petitioner presented to cardiologist Bosko Margeta, M.D., at Stroger Hospital and underwent an EKG that was unremarkable. (RX #13) She was released and scheduled to undergo a dobutamine stress echo cardiogram on October 31, 2014, and a

return to the clinic on November 7, 2014. It was noted that the Petitioner was unable to walk on a treadmill due to her hernia. (RX #13)

Before the Petitioner could undergo further cardiac testing, her hernia flared up again. On October 29, 2014, she presented to the Emergency Department at Stroger Hospital, with complaints that her hernia had become more painful and swollen over the preceding 7 or 8 days, and that it had not reduced on its own as it had in the past. (RX #14) A CT scan showed that the distal portion of her appendix had become contained within the hernia sac. (RX #14) Based on that finding, the decision was made to admit the Petitioner for emergency surgery: a hernia repair and appendectomy. (RX #14) John Cull, M.D. performed the surgery on October 30, 2014, which the Petitioner tolerated well with no complications. (RX #14) The post-operative diagnosis was incarcerated right inguinal hernia and appendicitis. (RX #14) She was released the next day with instructions to avoid heavy lifting for 4 - 6 weeks. (RX #14)

On November 13, 2014, the Petitioner returned to Stroger Hospital for a post-surgical follow-up with Harry M. Richter, M.D. (RX #15) He observed no sign of any infection or other complication from the surgery. (RX #15)

On December 11, 2014, the Petitioner presented to the Emergency Department at Stroger Hospital, stating that she had been suffering pain in her right lower abdomen, nausea, and vomiting over the preceding 1 or 2 days. (RX #16) Blood work was unremarkable and a CT scan of the abdomen and pelvis showed small seroma in the right groin without evidence of abscess formation. (RX #16) The Petitioner was given medication for pain and discharged. (RX #16)

The Petitioner's next surgical follow-up visit was on January 28, 2015 with Kristin Gross, M.D., at Stroger Hospital. (RX #17) The Petitioner reported that she was doing well with

only mild soreness in the right groin which was improving over time. (RX #17) Dr. Gross noted a well-healed right groin scar, no palpable masses, and no evidence of a recurrent hernia. (RX #17) The Petitioner stated that she wished to return to work and was released to return to full-duty work without any restrictions. (RX #17)

On June 11, 2015, the Petitioner began treating with Neeraj Jain, M.D., at Michigan Avenue Medical Associates for lower back and neck pain. (PX #5) Dr. Jain diagnosed the Petitioner with cervicalgia, lumbar and cervical discogenic pain, cervical and lumbar radiculopathy, and left shoulder pain. (PX #5) Dr. Jain ordered MRIs of the Petitioner's cervical and lumbar spines and physical therapy for her neck and back pain. (PX #5) He also ordered her off-work pending her next appointment on July 9, 2015. (PX #5)

On June 23, 2015, the Petitioner presented to Eugene Pai, M.D., at MRI Lincoln Imaging Center in Chicago for an MRI of the lumbar spine. (PX #5) Dr. Pai diagnosed the Petitioner with a central herniation at L4-L5, with the underlying bulge narrowing the foramina, a diffuse bulge at L3-L4 narrowing the foramina, a right-sided disc herniation at L1-L2, and a left-sided disc herniation at L2-L3. (PX #5) On July 9, 2015, the Petitioner underwent a Somatosensory Evoked Potential exam (SSEP) with Edward J. Herba, M.D. at Michigan Avenue Medical Associates and was diagnosed with radiculopathy at L5. (PX #5)

While at Michigan Avenue Medical Associates on July 9, 2015, the Petitioner also saw Dr. Jain. (PX #5) Dr. Jain wrote that the Petitioner had been attending physical therapy, and that it seemed to have benefited her neck, shoulder, and low back. (PX #5) Her worst problem now, however, was her low back pain, particularly the radiation of pain into both legs, with the right worse than the left. (PX #5) The Petitioner reported that her medications, Mobic, Prilosec, and Flexeril, were effective for her back and neck pain, but not for the radicular symptoms. (PX #5)

Dr. Jain noted the Petitioner's recent MRI and SSEP test results, and updated his prior diagnoses to cervicalgia, lumbar facet syndrome, lumbar discogenic pain, and lumbosacral radiculopathy. (PX #5) He also noted that the Petitioner's cervical discogenic pain and right shoulder pain had resolved. (PX #5) He recommended a bilateral L4-5 transforaminal epidural steroid injection and selective nerve root block, a compound cream with Gabapentin for the leg and foot pain, and continued physical therapy for the neck and back. (PX #5) He also continued the Petitioner's off-work status, pending either authorization of the injection, or her next follow-up appointment on August 6, 2015. (PX #5)

The Petitioner's next follow-up appointment with Dr. Jain was on August 6, 2015. (PX #5) At that time, the Petitioner again reported that physical therapy had been effective for her back and neck pain, but not for the radicular symptoms. (PX #5) She reported that the compound cream helped substantially with her foot pain. (PX #5) Dr. Jain declared that conservative treatment, which included physical therapy and medication management had been a failure, and renewed his recommendation for a bilateral L4-L5 transforaminal epidural steroid injection. (PX #5) He continued the Petitioner's prescriptions and off-work status pending approval of the injection, but recommended she transition from physical therapy to an at-home exercise program. (PX #5)

On August 13, 2015, the Petitioner presented to the Ambulatory Surgery Center at Stroger Hospital with a new episode of right lower abdominal pain and another mass in her right inguinal region. (PX #4) She reported at this time that the pain in her right lower abdomen was at a level of 8 out of 10. (PX #4) She was discharged that same day and ordered to schedule a pelvic ultrasound exam. (PX #4)

The Petitioner returned to Stroger Hospital the next day, August 14, 2015. This time, she visited the Emergency Department, with complaints of abdominal pain, constipation, and swelling of the right leg. (PX #4) She had her pelvic ultrasound set for September 28, 2015 and was directed to make an appointment with the General Surgery Department in the next one to two weeks. (PX #4) She was released the same day after receiving her follow-up instructions and dietary information to help her constipation. (PX #4)

The Petitioner presented to Ryan Knoper, M.D., in the General Surgery Department at Stroger Hospital on August 19, 2015. (PX #4) The Petitioner reported that sometime after her surgery, she noticed another bulge superior to her surgical scar and had been having associated intermittent pain and nausea symptoms. (PX #4) Dr. Knoper opined that the Petitioner likely had a recurrent inguinal hernia, and scheduled her for a second surgery, a recurrent hernia repair, on October 16, 2015. (PX #4)

On August 31, 2015, the Petitioner attended her next scheduled follow-up visit with Dr. Jain at Michigan Avenue Medical Associates. (PX #5) The Petitioner reiterated her complaints of lower back pain with radicular symptoms, more prominent on the right side, and said the intensity of her pain was 7 – 10 out of 10. (PX #5) Dr. Jain's report makes no mention of the Petitioner's abdominal pain or mass for which she treated approximately 2 weeks prior. (PX #5) She said that she felt her medications were not effective, so she discontinued taking them after she stopped attending physical therapy. She noticed an increase in her pain after discontinuing the medication. (PX #5) Dr. Jain renewed the prescription for the compound cream. (PX #5) The Petitioner also told Dr. Jain that her right ankle was bothering her with any prolonged standing or walking. (PX #5) Dr. Jain opined that it was most likely due to lumbosacral radiculopathy, but ordered a right ankle MRI to rule out an independent orthopedic issue. (PX

#5) He then continued the Petitioner's off-work status pending approval of a transforaminal epidural steroid injection. (PX #5)

The Petitioner underwent the ordered right ankle MRI on September 3, 2015 with Dr. Pai at MRI Lincoln Imaging Center, which revealed a completely normal ankle. (PX #5)

On September 28, 2015, the Petitioner underwent her scheduled pelvic ultrasound exam with Kallolini Tailor, M.D., at Stroger Hospital. (PX #4) She was observed to have fibroids of the uterus, a simple right ovarian/paraovarian cyst measuring 7 x 6 x 7 mm, and a fluid collection in the right groin measuring approximately 3.5 x 1.7 x 2.5 cm. (PX #4) This fluid buildup was observed to be consistent with that observed on the ultrasound exam of December 11, 2014. (PX #4)

On October 1, 2015, the Petitioner attended her next scheduled follow-up appointment with Dr. Jain at Michigan Avenue Medical Associates. (PX #5) Dr. Jain's report noted the Petitioner's recent negative right ankle MRI, but again made no mention of her ongoing treatment for abdominal or groin pain, including her recent ultrasound and upcoming scheduled hernia repair surgery. (PX #5) Dr. Jain reported that the Petitioner was in severe pain. She rated her pain at 9 out of 10. Dr. Jain reiterated his recommendation for a transforaminal epidural steroid injection. (PX #5) (Petitioner's Ex. 5). He diagnosed the Petitioner with a disc herniation at L4-L5, nerve root impingement, and lumbosacral radiculopathy. He renewed her off-work status pending approval of the injection. (PX #5)

On October 16, 2015, the Petitioner presented to Richard Jacobsen, M.D. in the General Surgery Department at Stroger Hospital for her planned hernia repair surgery. (PX #4) During the procedure, it was discovered that the Petitioner's hernia was femoral, not inguinal as her previous hernia had been. (PX #4) An inguinal hernia occurs in the groin; a femoral hernia

occurs just below the groin. (PX #4) The operation was more extensive than the planned inguinal hernia repair, so the decision was made to keep her overnight. (PX #4) The Petitioner was discharged the following day with minimal pain complaints and no signs of post-operative complications. (PX #4) Like after her first surgery, the Petitioner was advised to avoid heavy lifting for 4 - 6 weeks. (PX #4)

On October 26, 2015, the Petitioner returned to Dr. Jain at Michigan Avenue Medical Associates, and reported that she still had severe low back pain with radicular symptoms. (PX #5) She also told Dr. Jain that the medications she received after her recent surgery, Norco and Ibuprofen, along with the compound cream she had been using over the past several months, helped significantly with both her back and leg pain. (PX #5) Nonetheless, Dr. Jain continued her off-work status pending a steroid injection. (PX #5)

On November 9, 2015, the Petitioner underwent a Section 12 examination with Kern Singh, M.D. at Rush Medical Center, Midwest Orthopedics, in Chicago, Illinois. (RX #19) The Petitioner stated at that time that she had severe pain in her neck, upper back, and lower back, which she rated 10 out of 10. (RX #19) She claimed that her pain extended down her entire right side from her right shoulder to her right thorax, right flank, left flank, buttocks, and all the way down the entire right leg. (RX #19) She reported that she was only able to sit, stand, or walk for five minutes at a time, that the pain increased with standing, climbing stairs, bending forward, and lying on her back, and that nothing decreased the discomfort. (RX #19) She also claimed that the physical therapy and electrical stimulation she had undergone provided only minimal relief. (RX #19)

As part of his examination, Dr. Singh reviewed the Petitioner's relevant diagnostic testing. (RX #19) After analyzing the Petitioner's June 23, 2015 lumbar MRI, he agreed with

Dr. Pai only insofar as the Petitioner had a herniated disc at L4-L5. (RX #19) His analysis of the Petitioner's July 9, 2015, SSEP led him to disagree with Dr. Herba; Dr. Singh saw no evidence of motor conduction delays or lumbosacral radiculopathy. (RX #19)

Dr. Singh concluded that any back-related symptoms were unrelated to the alleged work injury, because the complaints did not arise until approximately 10 months after the alleged date of injury. (RX #19) Furthermore, he noted that the Petitioner's pain complaints were not consistent with any findings from physical exam or any diagnostic imaging. (RX #19) He disagreed with Dr. Jain's repeated recommendation of an L4-L5 transforaminal epidural steroid injection because there was no evidence of neural impingement. (RX #19) He also opined that the Petitioner's treatment had been excessive; a low back strain should have required no more than 12 physical therapy sessions, and that the Petitioner engaged in self-limiting and symptom magnification throughout the exam. (RX #19) Dr. Singh declared the Petitioner to be at maximum medical improvement ("MMI") and stated that she could return to work without any restrictions. (RX #19)

The Petitioner next presented to Dr. Jain on November 19, 2015. (RX #5) She complained of low back pain with radiation down the legs, greater on the right than the left, and indicated that "activity" was an exacerbating factor. (RX #5) Dr. Jain wrote that he disagreed with Dr. Singh's findings, particularly that there was no radiculopathy present, and that the back complaints arose 10 months after the work injury. (RX #5) Dr. Jain noted that the Petitioner did mention back pain when she first treated at U.S. HealthWorks on August 22, 2014, and claimed that the medications the Petitioner received after her hernia surgery effectively controlled her back pain. (RX #5) Dr. Jain renewed the Petitioner's off-work status pending approval of a

transforaminal epidural steroid injection. (RX #5) By all accounts, this was the last instance of medical treatment received prior to trial on June 27, 2016.

CONCLUSIONS OF LAW

C. In support of the Arbitrator's decision as to whether the Petitioner sustained an accident that arose out of and in the course of her employment by the Respondent, the Arbitrator makes the following findings:

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence all of the elements of her claim. *Peoria County Belwood Nursing Home v. Indus. Comm'n.*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). An injury is accidental within the meaning of the Workers' Compensation Act when it is traceable to a definite time, place, and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v. Industrial Board*, 284 Ill. 378, 120 N.E. 249, 251 (1918)

The Petitioner testified that at approximately 11:00 AM on August 14, 2014, she slipped and fell on a banana peel at work.

The Petitioner provided unrebutted testimony that at that time, her supervisor, Kevin, walked by and asked her how she was doing and she told him that she was okay. The Petitioner also provided unrebutted testimony that the day after she slipped and fell, Kevin, her supervisor, took her to Human Resources, and H.R. sent her to the Respondent's on-site nurse, who examined her abdomen, low back and right foot.

However, with regard to the date and time of the alleged slip-and-fall injury, the Petitioner's testimony is inconsistent with the Incident Reporting & Treatment form (IRT) and the U.S. HealthWorks records.

The IRT form indicates that the Petitioner's slip on a banana peel occurred on August 15, 2014 at 7:35 PM ("1935"). (RX #1) The only injured body part identified on this document is the Petitioner's knee, which she said "hurt real bad." The Petitioner testified that there were 2 witnesses to her slip-and-fall, Kao and a Filipino lady. Yet, she apparently she did not tell Will Powell about any witnesses because he did not enter either name on the IRT. Neither of these alleged witnesses was called to testify at trial. Although the Arbitrator is not a handwriting expert, he notes that the Petitioner's signature on the IRT form (RX #1) is very similar to her signature on the Application for Adjustment of Claim. (RX #3) The Petitioner raised no objection to the admission of RX #1, but commented that the document was completed by Will Powell and signed by the Petitioner.

The U.S. HealthWorks records, dated August 22, 2014, indicate that the Petitioner slipped on a banana peel at approximately 5:00 PM on August 15, 2014. (RX #8) At the time she presented to U.S. HealthWorks on August 22, 2014, she complained of pain in the low back and right abdomen, but denied radiation of the pain to the lower extremities. (RX #8)

The Petitioner testified that she only experienced right leg pain after the slip-and-fall accident of August 14, 2014. Yet, when she visited Stroger Hospital on July 26, 2014, which was 19 days earlier, she complained of pain, swelling, and hardening of her right-sided inguinal hernia as well as pain radiating down her right leg. (RX #6)

During direct examination, when she was asked what the nurse recommended after she examined the Petitioner on August 15, 2014, the Petitioner responded that they took her to a nearby clinic - - a clinic to which she and an unknown supervisor walked. Such clinic was U.S. HealthWorks, which is where the Petitioner treated on one date, August 22, 2014. (Tr. of 6/27/16, pp. 22-25, RX #8)

The Petitioner's testimony suggests that a supervisor walked her over to U.S. HealthWorks on the day that the nurse examined her, not a week later. The Petitioner did not provide any evidence of the activities she performed between the date of the alleged accident and August 22, 2014.

The Petitioner testified twice that she has not worked since August 14, 2014. Yet, the handwritten section of RX #8 indicates that she did not lose any time from work.

When asked about her visit to the Stroger Hospital Emergency Department on July 26, 2014, she testified that she "just had a little bit of pain" around her inguinal hernia. However, records from that encounter reveal that she rated her pain at an intensity level of 8 out of 10 and that she was unable to bend over. (RX #6) After the alleged accident and prior to surgery, the Petitioner's hernia pain apparently improved and she was in no acute distress in any part of her body at her September 29, 2014 appointment. (RX #10) At trial, however, she claimed to have felt only "a bit better" at that time. When she presented to the Emergency Department on October 29, 2014, she claimed that her then-existing hernia symptoms began 7 or 8 days before the encounter. (RX #14) At trial, she had no recollection of when she said her symptoms began, or even if she reported her extensive history of hernia at all.

At the Petitioner's first post-surgical appointment, she was apparently making a good recovery, and reported being in no pain. (RX #15) At trial, however, she claimed again that she felt only "a bit better" at that encounter.

Finally, the Petitioner claimed that at the time of trial, she was suffering from "very strong" pain when she bent over, lay on her back, sat, or mopped. She claimed that the pain was present in her hip all the way down to her right foot and in her back "from the shoulders down." Such complaints served to support the Petitioner's off-work claim based on her extreme pain.

(PX #1) However, the Arbitrator observed the Petitioner as she testified and as Mr. Hutchison testified. Petitioner sat in a chair during this time. At no point did the Petitioner appear to be in any distress.

The Petitioner's credibility was called into question by two different physicians who identified self-limitation during examinations. Surgical resident Brett Fair noted that the Petitioner was "likely self-limiting" during her December 11, 2014 Emergency Department visit, and Dr. Singh noted in his Section 12 report that the Petitioner self-limited her ranges of motion. (RX #16, RX #19) The Petitioner's records from Michigan Avenue Medical Associates corroborate this observation. At the Section 12 examination on November 9, 2015, she self-limited her lumbar ranges of motion with flexion, extension, and axial rotation to 5° each. (RX #19) Then, 10 days later, at Michigan Avenue Medical Associates, she exhibited ranges of motion of 45° with flexion and 15° with extension; axial rotation was apparently not measured. (PX #5)

Furthermore, Dr. Singh found 5 positive Waddell's signs, as well as negative results for the Hoffman's test, the Inverted Brachioradialis test, and the Spurling's sign. (RX #19)

The Arbitrator also considers Mr. Hutchison's testimony that the only part of the dishwashing area that would contain food waste would be at the front of the dishwashing machine where food waste is removed from trays and disposed of prior to the trays being sent through the machine. The Petitioner's alleged slip-and-fall accident occurred at the side and toward the back of the dishwashing machine. Finally, Ray Hutchison noted that in August 2014, 2 women named Marcelina Marchan worked for the Respondent at the Schiller Park facility. On or about the time of the alleged slip-and-fall injury, Mr. Hutchison had a conversation with *the*

other Marcelina Marchan, and she reported that she suffered a fall that was virtually identical to that claimed by the Petitioner.

The Arbitrator finds that the Petitioner is not credible.

Based on the foregoing, the Arbitrator finds, by the preponderance of the evidence, that the Petitioner failed to prove that on August 14, 2014, she sustained an accident that arose out of and in the course of her employment by the Respondent.

F. In support of the Arbitrator's decision as to whether the Petitioner's present condition of ill-being is causally-related to the injury, the Arbitrator makes the following findings:

A claimant must show that an injury is due to a cause connected with her employment to establish that it arose out of employment, and can accordingly be compensable. *Elliot v. Indus. Comm'n*, 153 Ill.App.3d 238, 242 (1987) In order to recover under the Act for aggravation of a pre-existing condition, a claimant must prove that a work-related accidental injury aggravated or accelerated the pre-existing disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the pre-existing condition. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 204-05 (2003) The issue of causal relationship is a question of fact for the Commission to decide, and the claimant always bears the burden to prove that his employment was a causative factor of his physical disability. *Westinghouse Electric Co. v. Indus. Comm'n*, 64 Ill.2d 244, 249 (1976)

With regard to the Petitioner's recurrent hernia, the Arbitrator begins by examining the only expert opinion on this issue submitted by the parties. The Arbitrator notes that the Petitioner has failed to present a medical opinion that either of her two claimed hernia

aggravations was causally related to the alleged workplace accident. The only medical professional to address the issue was Dr. Sisson, who wrote, in his August 22, 2014 report, the following: "Owing to the fact that this hernia and mass effect have been present for a period of three years, it is difficult to relate its presence and condition to the statement of injury as explained by Ms. Marchan." (PX #1) This opinion, even when looked at in the light most favorable to the Petitioner, is inconclusive, and does nothing to help her meet her burden of proving causation.

The Petitioner sought treatment for her hernia 19 days before the alleged accident. She reported pain of 8 out of 10 and an inability to bend over. She was instructed to follow up with general surgery on July 30, 2014 at 2:00 PM, but chose not to do so.

With regard to the Petitioner's alleged injury to her lumbar spine, she testified that prior to the slip-and-fall accident at bar, she had no pain in her hips or low back and never had pain from her upper back to her lower back (that she can recall). However, the Arbitrator notes that for 2 work injuries to her body, the Petitioner settled the following 2 workers' compensation claims: 98 WC 27810 and 99 WC 41398. (RX #3)

The weight accorded to an expert opinion is measured by the facts supporting it and the reasons given for it; an expert opinion cannot be based on guess, surmise, or conjecture. *Wilfert v. Retirement Board*, 318 Ill.App.3d 507, 514-15 (1st Dist. 2000) A finder of fact is not bound by an expert opinion on an ultimate issue, but may look behind the opinion to examine the underlying facts. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87 (2003)

The Arbitrator finds the opinions of Dr. Singh to be more persuasive than those of Dr. Jain. Dr. Jain first offered an opinion regarding causal connection at the Petitioner's initial consultation on June 11, 2015. (PX #1) It is difficult, if not impossible, to follow Dr. Jain's

logic. He wrote in his report that the Petitioner slipped on a banana peel, but did not mention onto what body part or parts she fell. (PX #1) It is not clear if he even asked the Petitioner. If Dr. Jain obtained or reviewed any of the Petitioner's prior medical records, he did not indicate that in any of his reports. (PX #1) He seems to support his causation opinion with the Petitioner's contention that she had been experiencing constant low back pain, as well as constant neck pain that radiates to the top of her shoulders, since the date of the alleged accident. (PX #1) The Petitioner's contention was verifiably untrue, however, and the credibility of an opinion based on untrue facts will suffer.

Specifically, there is no evidence that Dr. Jain reviewed the IRT form, in which the Petitioner reported, at least 30 hours after the slip-and-fall injury occurred (per her testimony), only knee pain. Moreover, there is no evidence that he reviewed the U.S. HealthWorks records of August 22, 2014, in which Dr. Sisson, after taking a history and conducting a physical examination, makes no mention of neck or shoulder pain.

It is true that with the exception of the MRI and SSEP, there is no evidence that Dr. Singh reviewed the Petitioner's medical records. It is also true that Dr. Singh wrote that the Petitioner slipped on a banana peel and fell to the floor, but did not mention onto what body part or parts she fell. Yet, it is the Petitioner's burden of proof. Moreover, Dr. Singh conducted Waddell testing, and Dr. Jain did not.

At her first documented, post-accident medical exam on August 22, 2014, the Petitioner claimed that she was experiencing "mild" low back pain and received a hot/cold pack. (PX #1) As she treated for her pre-existing hernia over the next five months, she reported to her treating doctors many other complaints including constipation and leg swelling, but never mentioned a problem with back pain. (PX #2, PX #3)

Dr. Jain wrote in his November 19, 2015 treating record, apparently in an attempt to bolster his causation opinion, that the Petitioner was able to control her back pain with the medications she received after her hernia surgery, which is to explain why she went for 10 months without seeking treatment for back pain. (PX #4) This claim also falls apart under scrutiny. When the Petitioner was discharged from care on January 28, 2015, she was prescribed only 14 Ibuprofen pills, and went approximately 4-1/2 months from that date without any prescription pain medication until she complained of back pain on June 11, 2015. (PX #3, PX #5)

If the Petitioner truly had experienced ongoing back pain, it is unclear why she did not seek treatment for the pain if she did not have medication to alleviate it. Dr. Jain bases his causation opinion on an incomplete understanding of the Petitioner's medical history and an inaccurate account provided by the Petitioner. Accordingly, the Arbitrator gives Dr. Jain's opinion little weight.

Dr. Singh noted that the Petitioner has several co-morbidities, which include hypothyroidism, osteoporosis, and blood clots, and a surgical history, which includes hernia repairs. (RX #19) His physical examination revealed signs of self-limitation and symptom magnification. The Petitioner reported pain throughout her body at a 10 out of 10 level, which was the most severe pain that she reported at any point throughout her treatment. She also drastically self-limited her ranges of motion as compared with the ranges of motion she exhibited to Dr. Jain. Dr. Singh properly concluded that the Petitioner was not credible, and offered a sound medical opinion as to the cause of her back pain. He found the Petitioner's then-existing back condition to be unrelated to the alleged workplace accident because it arose 10 months later

and was not supported by the diagnostic tests or physical examination. He diagnosed her with a resolved lumbar muscular strain. (RX #19)

The Petitioner apparently intended to use her testimony to create a narrative that minimized her pre-injury symptoms, embellished her post-injury symptoms, and made her recovery and current pain seem more intense than they actually were.

Based on a preponderance of the evidence, the Arbitrator finds that the Petitioner has failed to prove that her current condition of ill-being of her abdomen/hernia or her lumbar spine is causally related to any work incident on August 14, 2014.

Brian T. Cronin 12-15-2016

Brian Cronin
Arbitrator

Date

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

Verne Schulte,
Petitioner,
vs.

NO: 08WC 17952

Monterey Coal Company,
Respondent,

18IWCC0477

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 occupational disease, 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 November 11, 2017 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 $28,400. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 6 - 2018

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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LEC/rlc
043

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHULTE, VERNE
Employee/Petitioner

Case# **08WC017952**

MONTEREY COAL COMPANY
Employer/Respondent

18IWCC0477

On 11/6/2017, 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 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST
SPRINGFIELD, IL 62705

18IWCC0477

NSTATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

VERNE SCHULTE
Employee/Petitioner

v.

MONTEREY COAL COMPANY
Employer/Respondent

Case # **08** WC **17952**

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 29, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Disease/exposure, causation, Sections 1(d)-(f), 19(d).**

FINDINGS

On **12/31/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$45,209.76(48 wks)**; the average weekly wage was **$941.87**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **1** dependent child.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$565.12/week** for **50 weeks**, because the injuries sustained caused the **10% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

October 28, 2017
Date

NOV 6 - 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner began working underground in the coal mines around 1978.

Petitioner presented to Dr. Jain on February 14, 2007 to establish care. For the last several years Petitioner had been a patient of Dr. Fishman, his endocrinologist. His chronic medical problems included hyperlipidemia, diabetes type 2, hypertension, and obesity. Petitioner had been encouraged to undergo a sleep study as he had a tendency to fall asleep and was having problems with chronic rhinitis. He had not undergone any age-appropriate screenings and worked hard as a coal miner but did not exercise regularly. Petitioner denied any chest pain, shortness of breath, or chronic sinus congestion. A general discussion regarding Petitioner's health was noted with appropriate recommendations being made. (PX 5)

Petitioner returned to see Dr. Jain in February and March of 2007 for follow-up on an injury to his left little finger. No other problems were noted. (PX 5)

On April 18, 2007 Petitioner presented to Dr. Jain regarding a marked "hacky cough and congestion" of three to four days' duration. Petitioner was noted to work in a coal mine. Petitioner's chest x-ray was difficult to interpret given Petitioner's COPD, but possible right lower lobe infiltrate and a small patch were noted. Dr. Jain suspected small early pneumonitis with the reactive airways and an exacerbation of COPD. Medication was prescribed and Petitioner was taken off work till the following Monday. (PX 5)

Petitioner returned to see Dr. Jain on April 23, 2007 at which time he was feeling better. Petitioner told the doctor that if he resumed work he would have to work with either diesel fumes or in cold dust. Dr. Jain instructed Petitioner to finish his antibiotics and continue with the inhaler. He had stopped smoking for a week and was told to stay off work for another week and then return to see if he was ready for work. (PX 5)

On April 30, 2007 Petitioner was re-examined by Dr. Jain for his acute exacerbation of COPD. His wheezing and shortness of breath were better but he now had severe pain in his left posterior chest which hurt everytime he took a deep breath. Dr. Jain's diagnoses were acute sinusitis (resolving), COPD exacerbation, and possible pleurisy. He was to stay off work and was given medications to take. (PX 5)

Dr. Jain re-examined Petitioner on May 5, 2007 at which point Petitioner was feeling very good. He hadn't smoked in four weeks and denied any congestion, chest pain or shortness of breath. Spirometry was obtained that day and was within the normal range though probable early obstruction was indicated by a reduced FEV1%. He was released to return to work the next day. (PX 5)

Petitioner again presented to Dr. Jain on June 14, 2007. It was noted that Petitioner needed a pneumovax. He needed a stress test because he would get dyspneic with exertion

though no specific chest pain was noted. He had not been smoking for two months and was, overall, feeling much better as far as his chronic cough-related symptoms were concerned. (PX 5)

On June 19, 2007 Dr. Jain authored an office note stating Petitioner, age 52, had been seen multiple times in the clinic with acute exacerbations of COPD. To the doctor's knowledge Petitioner had never undergone a baseline spirometry before. His clinical exam was consistent with tobacco-related lung disease with an acute exacerbation of COPD. Once his acute symptoms subsided, spirometry was obtained to assess the extent of his obstructive lung disease and reactive airways. This would help in managing his COPD with appropriate medications and lifestyle changes. (PX 5)

On July 23, 2007 Petitioner saw Dr. Jain regarding labs and uncontrolled diabetes. He had a mild chronic hacky cough which he noticed mostly in some gusty environment. Medications for his diabetes were addressed. Weight loss and better control of the diabetes were discussed. Petitioner was also told to be more compliant with his inhalers and to try and use his protective mask when working in the coal mine or around dust and fumes. (PX 5)

Petitioner was evaluated by Dr. Berarducci at Community Memorial Hospital on July 30, 2007 regarding coronary artery disease. Dr. Berarducci indicated in his history that Petitioner was formally a heavy smoker but now was only smoking two to three cigarettes several days a week. Petitioner advised the doctor that he worked in a coal mine and carried a tool belt weighing 45 pounds. He noted he often had to carry tools up to 100 pounds for 200 to 300 yards. He indicated he walked a lot during the day. Petitioner advised that he had no change in his ability to do his work. Petitioner denied any shortness of breath with exertion (PX5, p. 52).

Dr. Jain met with Petitioner on August 10, 2007 regarding Petitioner's sleep study which had shown severe obstructive sleep apnea. His labs for diabetes were better. His stress test had been normal. (PX 5)

On October 1, 2007 Petitioner presented to Dr. Jain with chronic rhinitis, sinusitis and COPD. He had recently quit smoking and was being seen with an acute productive cough getting worse with sinus congestion over the last five to seven days. He denied any chest pain. He was taken off work for a few days and given medications. The diagnosis was acute sinusitis and bronchitis with COPD. (PX 5) As of October 5, 2007 Petitioner was still symptomatic with a severe headache and drainage. Additional medication was given. Petitioner was kept off work. (PX 5)

Petitioner presented to Dr. Jain on October 30, 2007 regarding his hypertension and diabetic neuropathy. He was given Pneumovax and Fluvax and told to follow up in six months. (PX 5)

Petitioner stopped working for Respondent on December 31, 2007 when Respondent closed its mine.

On February 3, 2008, and at Petitioner's request, b-reader Dr. Henry K. Smith reviewed a grade 1 chest x-ray dated January 8, 2008. Dr. Smith found interstitial fibrosis s/s, mid to lower zones, 1/0. Bilateral chest wall plaques, A/3 noted. There were slight thickened interlobar fissures. Heart size was normal. There was mild mid lower dorsal spondylosis. Dr. Smith's

impression was pneumoconiosis with interstitial fibrosis s/s, mid to lower zones, 1/0 with bilateral chest wall plaques, A/3. (PX 3)

On March 16, 2008 Petitioner signed his Application for Adjustment of Claim herein. (AX 2)

Petitioner was examined by Dr. Jain on April 10, 2008. Petitioner reported losing his job and was unsure how long he could continue paying for his CPAP machine. He also reported that he might not have health insurance the next year. Petitioner had not been watching his diet as closely and had gain weight. He was not smoking and denied any chest pain or shortness of breath. The doctor also noted, "He apparently went down somewhere to the south and was diagnosed with black lung." Dr. Jain had a general discussion with Petitioner regarding medical issues and was to return in three months. (PX 5)

On July 25, 2008, and at the request of his attorneys, Petitioner underwent an examination with Dr. Glennon Paul of the Central Illinois Allergy & Respiratory Service, Ltd. Dr. Paul authored a letter after the evaluation. (PX 1 – pet. dep. ex. 2) Dr. Paul noted Petitioner's history of working as a coal miner from "1978 to 2000" all of which was underground. Petitioner reported shortness of breath with exertion, coughing and wheezing. His shortness of breath occurred within three flights of stairs and with one mile. He had a long history of nasal congestion and rhinorrhea in the past along with frequent sinus infections. Petitioner had a history of smoking three cigarettes a day for the past ten years. Prior to that he had not smoked for ten years but then before that he had smoked about one pack of cigarettes per day for ten years. Petitioner's chest x-ray showed fibronodular lesions throughout all lung zones, with lower zones greater than the upper zones. Pulmonary function studies showed a mild obstruction with a positive Methacholine stimulation test and a mild decrease in the carbon oxide diffusion capacity. In summary, Dr. Paul felt Petitioner had "coworker's [sic] pneumoconiosis" complicated by asthma. (PX 1 – pet. dep. ex. 2)

Petitioner returned to see Dr. Jain on July 29, 2008. His diabetes was no better and he had not been exercising because his father was ill. Petitioner was encouraged to lose weight and exercise. (PX 5)

Petitioner had a routine appointment with Dr. Jain on August 4, 2008 with little or no change since the July 29th visit. (PX 5)

An office note from Staunton Clinic dated November 6, 2008, indicated that Petitioner had no shortness of breath (PX6, p.86).

Dr. Glennon Paul's Deposition

Dr. Glennon Paul testified by way of deposition, taken on April 13, 2009. Dr. Paul is the medical director of St. John's respiratory therapy and clinical assistant professor of medicine at SIU Medial School. Dr. Paul's teaching responsibilities include internal medicine and pulmonology. (px 1, p 6) Dr. Paul conducted an examination of Petitioner on July 25, 2008. Dr. Paul testified to a reasonable degree of medical certainty that Petitioner has coal worker's pneumoconiosis which was caused by coal dust. (px 1, p 34) Dr. Paul also testified to a reasonable degree of medical certainty that Petitioner has asthma, which in his opinion could or might have been aggravated, if not caused, by his coal mine exposure. (px 1, p 34) Dr. Paul testified that in order to have pneumoconiosis, in addition to having coal dust deposited in your

lungs, there must be a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. (px 1, p 10) That area of the lung at the site of the scarring cannot perform the function of normal healthy lung tissue. (px 1, p 11) By definition if a miner has coal worker's pneumoconiosis, it is true that he necessarily has some impairment of the lung at the site of the scarring whether it can be measured by spirometry or not. (PX1, p. 11) Dr. Paul went on to testify that it is possible to have injury or disease to the lung despite having normal pulmonary function test results. (PX 1, p 11) A person can have coal worker's pneumoconiosis that is radiographically significant and not have shortness of breath. (PX 1, p. 14) They can also have normal pulmonary function testing, normal blood gases, and normal physical examination of the chest. (PX 1, pp. 14 & 15) Dr. Paul testified that there is no cure for coal workers' pneumoconiosis and even if the miner ends his exposure to the coal mine the disease can still progress. (PX 1, pp. 15 & 16) He explained that if a coal miner has coal worker's pneumoconiosis, he should have no further exposure to the coal mine without endangering his health. (PX 1, p 16) Dr. Paul also testified that asthma is characterized by asthma attacks or responses to triggers. (PX 1, pp. 25-26) He explained that if one has asthma, it can be aggravated by the coal mine environment and, therefore, he felt Petitioner should have no further exposure to coal mine dust so as to avoid endangering his health. (PX 1, pp. 26, 35)

Dr. Paul testified that the pulmonary function studies he took demonstrated a mild degree of obstructive airway disease and a mild decrease in the carbon monoxide diffusing capacity. There was a mild decrease in the carbon monoxide diffusing capacity which would be compatible with coal workers' pneumoconiosis. Dr. Paul went on to say that obstructive airway disease goes along with Petitioner's diagnosis of asthma and his carbon monoxide diffusing capacity could be compatible with coal worker's pneumoconiosis and the presence of fibrosis in the lungs. Petitioner had a methacholine stimulation test and after one breath of 2.5% methacholine, he had a fall of 20%, which also went along with a rather significant reactive airway condition or asthma; reversed after bronchodilators, which again confirmed that the patient had asthma. He felt it " pretty well showed" that two processes were going on. (PX 1, p 29) Dr. Paul also said that the waxing and waning of the pulmonary function testing goes along with his diagnosis of asthma. (PX 1, p 29)

Dr. Paul further testified that various exposures aggravate asthma, such as fumes, odors, smells, and dust. He also mentioned viral infections and allergens. He noted that sometimes stress and sometimes exercise will aggravate asthma. He further noted that temperature changes can aggravate asthma. His physical examination of Petitioner's chest was normal. With asthma, some days there would be symptoms (PX1, p. 30). Dr. Paul testified that one uses the total lung capacity measurement with regard to diagnosing restrictive lung disease and Petitioner's value was 80% of predicted, which was at the lower limit of normal. Dr. Paul testified that it was more likely than not that Petitioner suffered from restrictive lung disease (PX1, p. 32). Dr. Paul went on to say that, in his opinion, Petitioner has clinically significant pulmonary impairment which was caused by the coal dust. (PX 1, pp. 35 & 36) The doctor further testified that Petitioner's asthma could have been caused or aggravated by coal mine exposure (PX1, p. 34). Dr. Paul testified that Petitioner was totally disabled from working as a coal miner (PX1, p. 37). The doctor also testified that this was because of the risk of a worsening of his diagnosed CWP with further exposure (PX1, p. 49). Dr. Paul testified that when Petitioner was not having asthma problems, he could do moderate manual labor (PX1, p. 37). With asthma going on, he would be limited to sedentary (PX1, p. 38).

Dr. Paul agreed that with Petitioner's height and weight, he was obese (PX1, pp. 46-47) and that he was obese enough that it would cause him to feel short of breath. The shortness of breath with exertion in the history would be consistent with the obesity (PX1, p. 47). The doctor also agreed that with Petitioner saying he could walk three flights of stairs and walk a mile, that sounded pretty good for someone his size (PX1, p. 47-48). The doctor acknowledged that the restrictive reduction on Petitioner's pulmonary function studies could be due to his obesity (PX1, pp. 48-49).

Dr. Paul further testified that Petitioner's shortness of breath with exertion and coughing and wheezing was due to asthma. He then testified that it can also be due to CWP. With regard to physiologically significant pulmonary impairment, he said asthma would at least play a part in that. The doctor further testified that the obstructive airways disease was confirmed by the Methacholine stimulation test (PX1, p.50). Dr. Paul further testified that Petitioner's reduced diffusing capacity was most likely caused by interstitial fibrosis and obesity would not cause a reduced diffusing capacity. (PX 1, p. 52) He agreed that the low FVC value from the pulmonary function study could be restrictive in nature and, therefore, could be affected by his obesity (PX1, p. 54).

Additional Medical

Petitioner presented to Staunton Clinic on July 1, 2009. He denied any shortness of breath (PX6, p. 94). The note from November 2, 2009 indicated no shortness of breath. It also indicated morbid obesity and COPD. Petitioner was feeling great and reported much more energy. (PX6, p. 96) A note from 5/10/10 indicated Petitioner was doing very well with no shortness of breath. The note also reflects that Petitioner is on the go 14 to 16 hours a day (PX6, p. 96). The note from 10/12/10 states that Petitioner was doing quite well and being active. He denied any shortness of breath or chronic cough. His diagnoses of morbid obesity and COPD were noted (PX6, p. 100). A note from 1/12/11 indicated no shortness of breath (PX6, p. 104).

Dr. Ettinger began seeing Petitioner in February of 2011 because Petitioner developed bilateral pulmonary emboli after surgery for a tumor on his pituitary gland. A chest CT scan (noted to be of poor quality by the doctor) was done on February 11, 2011. The radiologist, Dr. Berzins, noted bilateral pulmonary emboli and bilateral discoid atelectasis. There is no mention of pneumoconiosis or occupational lung disease. A follow-up CT scan was done on 3/16/11 and was read by a different radiologist, Dr. Mazzola, to be an unremarkable CT scan of the chest. There was no evidence of the pulmonary emboli anymore and no evidence of the bibasilar atelectasis. There were calcifications of old healed granulomatous disease. No mention was made of any coal workers' pneumoconiosis or occupational lung disease. At neither of the follow-up visits on 3/16/11 or 4/27/11 with Dr. Ettinger was there any mention made of other problems. As of 4/27/11, Petitioner reported his breathing had been fine. (RX 6)

The note from Staunton Clinic dated 11/07/11 note a persistent cough and dyspnea with moderate exertion (PX6, p. 16).

The note from Staunton Clinic dated 5/29/12 indicated persistent cough and dyspnea with moderate exertion. The note also reflected that Petitioner had chronic back pain when he walked more than one block (PX6, p. 44).

On September 20, 2012, and at Petitioner's request, b-reader Dr. Michael Alexander reviewed a grade 2 chest x-ray dated January 8, 2008. Dr. Alexander found the lung volumes were normal. Small round opacities were present bilaterally, consistent with pneumoconiosis, category p/q, 1/0. No areas of coalescence or large opacities were present. No chest wall pleural thickening or pleural calcifications were present. The costophrenic angles and diaphragms were clear. The cardiomediastinal structures and distribution of the pulmonary vasculature were normal. The bones were intact. Degenerative changes were present in the thoracic spine. Dr. Alexander's impression was coal worker's pneumoconiosis, category p/q, 1/0. (PX 4)

Dr. Rajneesh S. Jain's Deposition

Dr. Jain testified by way of deposition on October 31, 2012. Dr. Jain testified that throughout his practice he had occasion to treat coal miners and former coal miners. In his treatment of the miners he has treated them for COPD, rhinitis, chronic bronchitis, asthma, and sinusitis. (PX 2, p 6) Dr. Jain testified that Petitioner established himself as a patient on February 14th, 2007. Dr. Jain testified that in his opinion Petitioner has COPD and Petitioner's coal mining activity was possibly a causative factor in his COPD. Petitioner's COPD resulted in the impairment in his pulmonary function. In light of Petitioner's COPD if he were to return to the coal mine environment it would present a risk to his health in terms of potential worsening of his condition.

Dr. Jain testified that he had also diagnosed Petitioner with chronic rhinitis and sinusitis. He felt thoses conditions were possibly aggravated by his exposure to the coal mine. (PX 2, p 8) In light of the diagnosis of chronic rhinitis and sinusitis, if Petitioner were to return to the environment of the coal mine it would present a risk to his health in terms of further aggravation of the rhinitis and sinusitis. (PX 2, p 9) Dr. Jain also testified that due to the numerous entries in his medical records of COPD, cough, chronic cough and hacking cough Petitioner suffers from chronic bronchitis. (PX 2, p 9) Dr. Jain also testified that his records contained entries mentioning reactive airway disease, which is equivalent to a diagnosis of asthma. (PX 2, p 9) Dr. Jain testified the in light of his diagnoses, Mr. Schulte no longer has the pulmonary capacity to perform the work of the coal miner on a full- time basis. (PX 2, p 10) The doctor explained that when asthmatic patients get sinusitis, there is also a flare-up of their asthma (PX 2, p.13).

Dr. Jain further testified that Petitioner's total lung capacity and diffusing capacity in January of 2011 were within the normal range. He noted that there was a decrease in the obstruction 25% and 75% on the peak flow. That also changed so he felt there was some reversible component which would mean there is an asthmatic component (PX2, p. 17-18). The doctor testified that Petitioner's small airways were decreased on the FEF (or forced expiratory flow). He agreed that the FEF was 88% of predicted. He testified that he has to go by his clinical judgment as to whether the patient has obstructive disease (PX2, p. 18). The doctor noted that Petitioner had a pituitary tumor operation in 2011 and developed a pulmonary embolism thereafter. He was not aware of any residual problems (PX2, p. 19).

Dr. Jain acknowledged that his office note of June 19, 2007 indicated that Petitioner's clinical exam was consistent with tobacco-related lung disease with an acute exacerbation of COPD (PX2, p. 20); however, he would have to review his notes to determine why that note had been written. The doctor noted a reduced FEV1 would be consistent with tobacco-related lung disease. Additionally, Petitioner had been seen multiple times with an exacerbation. On the 4/18/07 visit, he noted rhonchi on the chest exam. On April 23, Petitioner was better but his

lungs still had some rhonchi (PX2, p. 21). A week later, he was seen and there were no rhonchi. Over two weeks, he was seen with some obstruction in the lower airways which resolved with treatment which suggested reactive airways disease. Dr. Jain agreed that, given Petitioner's history of tobacco use and being somewhat barrel-chested, his morphology was that of a guy with obstructive lung disease (PX2, p. 22). The doctor also agreed that cigarette smoking is the number one cause of COPD in the United States. It is also the number one cause of chronic bronchitis and emphysema and that cigarette smoking can affect asthma (PX2, p. 23). The doctor felt that Petitioner was about 100 pounds overweight. He said that would cause him to have exercise intolerance. He also felt that the overweight status would contribute to Petitioner feeling short of breath (PX2, p. 25). The note from 5/29/12 indicated that Petitioner had chronic musculoskeletal back pain when he walked more than a block. Petitioner had diabetes and peripheral neuropathy likely connected to the diabetes (PX2, p. 27).

Additional Medical

The note from Staunton Clinic dated 12/03/12 indicates Petitioner denied any dyspnea (PX6, p. 10). The note from 2/25/13 also indicates no dyspnea. However, Petitioner complained of a recent cough and had an upper respiratory infection at that time (PX6, p. 78). On 3/14/13, the note indicates no dyspnea (PX6, p. 76). As of 5/20/13, Petitioner was again complaining of dyspnea with moderate exertion and a cough (PX6, p. 55).

On January 30, 2014, and at Respondent's request, Petitioner was examined by Dr. Peter Tuteur. A written report followed. (RX 1 – resp. dep. ex. 2) which was the subject of Dr. Tuteur's subsequent deposition (to be discussed below).

On March 22, 2014 Dr. Smith issued a report to Petitioner's attorneys regarding 2 CT chest films dated 2/11/11 and 3/16/11. He felt the scans were of sufficient high quality technique for evaluation of CWP. He noted minimal degree of diffuse interstitial fibrosis with small opacities throughout the upper, mid and lower zones of the lungs. There were no chest wall plaques or calcification. There were calcifications related to old granulomatous process. The initial CT showed bibasilar atelectasis as well as findings consistent with multiple pulmonary emboli. In the second CT there was resolution of both of those processes. In summary, he felt both CT chest scans noted minimal interstitial fibrosis characteristic of radiographic type-P pneumoconiosis in the bilateral lungs. (PX 3)

On April 4, 2014, Dr. Smith also reviewed a grade 1 chest x-ray dated January 30, 2014. Dr. Smith found interstitial fibrosis of classification p/p, bilateral upper, mid and lower zones involved, of a profusion 1/0. There were no chest wall plaques or calcifications. There were thickened interlobar fissures. There were accentuated subpleural fat deposits laterally in both mid to lower lungs. Heart size is normal. There was mild thoracic atherosclerosis. There was moderate mid to lower dorsal degenerative vertebral spurring and calcification of the anterior longitudinal spinal ligaments. Dr. Smith's impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary p, upper, mid and lower zones bilaterally, profusion 1/0. (PX 3)

On April 26, 2014, Dr. Robert D. Tarver, b-reader, reviewed a chest x-ray dated January 30, 2014. The film quality was "1." He found no parenchymal abnormalities consistent with pneumoconiosis. There were no pleural abnormalities consistent with pneumoconiosis. Heart size was normal. The lungs were clear. (RX 2)

On April 26, 2014, Dr. Christopher Meyer, b-reader, reviewed a chest x-ray dated January 30, 2014. The film quality was "2, under-inflation, and under-exposed." The lung volumes were low with bronchovascular crowding at both bases. There were no small round, small irregular or larger opacities. The mediastinum, cardiac silhouette, bones and soft tissues were unremarkable. In summary, he found no radiographic findings of coal workers' pneumoconiosis. (RX 3)

On May 1, 2014 Dr. Christopher Meyer reviewed a CT scan dated February 11, 2011. He found no CT findings of coal workers' pneumoconiosis. While there were multiple pulmonary emboli, they were not a manifestation of coal dust exposure. (RX 5) Dr. Meyer also reviewed a CT scan dated March 16, 2011. The lungs were clear. There were no perilymphatic or centrilobular nodules or large opacities. There was a calcified right hilar lymph node. The heart was normal. A small hiatal hernia was present. In summary, the doctor found no CT evidence of coal workers' pneumoconiosis. (RX 5)

On the dates of 1/10/14 and 5/12/14/ Staunton Clinic records indicate that Petitioner complained of dyspnea with moderate exertion (PX6, p. 82, 64,)

On May 16, 2014 Dr. Danielle Seaman, a b-reader, reviewed a chest x-ray dated January 30, 2014. She found the film quality to be "2, under-exposed, under-inflated, and digital." She noted no small rounded or irregular opacities to suggest coals workers' pneumoconiosis. The lungs, pleural spaces, heart, mediastinum, bones and soft tissue were within normal limits. (RX 4)

On 11/06/14 Petitioner complained of dyspnea with moderate exertion (PX6, p. 82, 64, 19). On the 11/06/14 date, he was complaining of cough (PX6, p. 19).

As of 5/14/15, Petitioner complained of dyspnea with moderate exertion (PX6, p. 16).

Petitioner was examined by Dr. Ettinger on July 29, 2015 regarding intermittent shortness of breath and a history of a pulmonary embolism. The doctor had last seen Petitioner in 2011 after he had developed a pulmonary embolism after pituitary tumor surgery. Petitioner had also developed some hip discomfort but a surgeon wouldn't operate on him due to the history of the embolism. He was now undergoing a series of injections which were helping substantially but delaying surgery. Dr. Ettinger was being asked to see him for pre-operative clearance. According to the note, Petitioner's course of care with his first clot was complicated. He had underlying COPD and was hard to intubate. Petitioner was noted to be a former cigarette smoker until 1986. He had reportedly quit 29 years earlier. He did not generally report significant dyspnea with exertion but could get shortness of breath with exertion if he walked long distances. He readily admitted being significantly overweight at 297 lbs. and significantly deconditioned. His hip pain had not helped in that regard. Dr. Ettinger noted that Petitioner's pulmonary function tests revealed normal lung function despite his years of smoking. No other pulmonary contraindications to surgery were noted. He was to follow up as needed since surgery was currently off the table. (RX 6)

On October 19, 2015, Petitioner was seen at Staunton Clinic. He complained of dyspnea with moderate exertion, but there was no mention of any cough (PX6, p. 23). As of 4/04/16, there was no dyspnea noted, but a recent cough and a diagnosis of an upper respiratory infection was recorded.

Dr. Tuteur was deposed on April 25, 2016. (RX 1) Dr. Tuteur evaluated Petitioner on January 30, 2014. Dr. Tuteur is board certified in internal medicine and pulmonary diseases (RX1, p. 4). The doctor noted that Petitioner was morbidly obese. He was sufficiently obese to feel short of breath with activities. The Petitioner's oxygen saturation was measured at rest and with exercise and was normal (RX1, p. 7). During the test, the Petitioner's FEV1 was measured and it was stable. He did not show evidence of bronchial reactivity with the exercise. Dr. Tuteur reviewed chest x-ray films taken on that date and noted that the lung fields were clear with no active disease. There was no interstitial process such as coal workers' pneumoconiosis. There was abundant subpleural fat. The spirometry portion of the pulmonary function studies was within the normal range (RX1, p. 8). With the administration of a bronchodilator, there was no change, which would be expected if a person had bronchial reactivity. The arterial blood gas at rest and with exercise were within the normal range. Dr. Tuteur noted that generally in the spirometry portion of the pulmonary function study normal is considered to be 80% to 120% of predicted. However, the diffusing capacity is considered normal at 70% (RX1, p.9). Petitioner's DLCO of 24.1 was essentially normal for a man his age and height. The predicted values in that laboratory increase with weight, which is not a physiological phenomenon (RX1, p. 10). Dr. Tuteur reviewed chest CT films done in February and March of 2011. He felt there was no evidence of any occupational lung disease on the films. Based upon his evaluation, Dr. Tuteur indicated that there was no evidence to support a diagnosis of coal workers' pneumoconiosis in Petitioner. He did not find any evidence of chronic obstructive pulmonary disease. He also did not find evidence to support a diagnosis of bronchial reactivity (RX1, p. 11). With regard to Dr. Paul's Methacholine test, there was no "reproducibility," and, therefore, he felt the test was invalid with regard to the presence or absence of bronchial reactivity (RX1, p. 11-12). From a pulmonary standpoint, Dr. Tuteur saw no reason to restrict Petitioner's activities. From a pulmonary standpoint, he felt Petitioner could perform coal mine work or similar work.

Dr. Tuteur noted that with as many years of dust exposure as Petitioner had, he would not clear all of the dust that he had inhaled and some always remained (RX1, p. 13). Dr. Tutuer was asked, "So notwithstanding your readings of the radiographs here, it is possible that this man still could have coal worker's pneumoconiosis?" His answer, "It is possible to have tissue that fulfills the criteria for the diagnosis of pathologically or morphologically significant coal worker's pneumoconiosis even in the face of an asymptomatic person with a normal physical exam, totally normal pulmonary function studies, and normal chest x-rays all the way through to CT scans." (RX 1, p 14) Dr. Tuteur noted that the spirometry in his lab was greater than what Dr. Paul had measured years before. He felt one possible explanation for that was that Petitioner had reactive airways disease (RX1, p. 17). Petitioner reported triggers to Dr. Tuteur that could be consistent with reactive airways disease (RX1, p. 19). Dr. Tutuer testified that exposure to roof bolting glues would be something that could cause reactive airways disease or asthma. (RX 1, p 20) Dr. Tutuer testified that running a supply motor and removing broken glue tube containers is something that can also result in not-so-sudden-onset of asthma. (RX 1, p 20) An exposure to diesel fumes can aggravate reactive airway disease or asthma. Also using TrowelOn as a ceramic tile mason in a coal mine is something that can cause and aggravate reactive airway disease and

asthma. (RX 1, p 20) When asked the question, "Can the inhalation of coal mine dust result in shortness of breath and cough?" Dr. Tutuer's response was, "It can." (RX 1, p 22)

Dr. Tutuer was also asked, "Is it true that the chronic inhalation of coal mine dust may produce a clinical picture indistinguishable from cigarette smoke induced chronic obstructive pulmonary disease?" His answer, "That is a true statement." (RX 1, p 39)

Dr. Tuteur further noted that the better pulmonary function values found at his exam compared to Dr. Paul's five and a half years before could be because the 2008 results were invalid. Another possible explanation was that a reversible problem was going on with Petitioner at that time (RX1, p. 50). Coughing spells would be consistent with, but atypical for chronic bronchitis (RX1, p.19). Dr. Tuteur noted that the history of exposure to roof bolting glues could cause reactive airways disease. Exposure to diesel fumes could aggravate reactive airways disease. Using a strong seal and trowel-on can cause or aggravate reactive airways disease (RX1, p. 20). At the time Dr. Tuteur saw Petitioner, Petitioner was prescribed Albuterol, an inhaler. He agreed that if a person had reactive airways disease, the best thing for the person to do would be to leave any environment that could cause or aggravate reactive airways disease. Dr. Tuteur indicated that normal pulmonary function studies do not mean that the lungs are free of injury or disease (RX1, p. 30).

Additional Medical

Petitioner returned to Staunton Clinic on May 20, 2016. The note mentions dyspnea with moderate exertion (PX6, p. 56). The last office note from the Clinic is dated 5/26/16 when the Petitioner was seen for eye pain (PX6, p. 48). At that time, Petitioner was noted to be 5'11" and 311 pounds, morbidly obese (PX6, p. 49). There was no mention in that note of cough or shortness of breath.

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 29, 2017. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he was 62 years of age on the date of arbitration with a date of birth of April 19, 1955. He is married to Marcia Schulte. Petitioner testified that he graduated from Staunton High School and went on to Vatterott College for electrical training. Petitioner further testified that he worked approximately 27 and three quarters years in the coal mining industry, all of which were underground. In addition to coal dust he was regularly exposed to and breathed silica dust, roof bolting glue fumes, diesel fumes, and trowel-on.

Petitioner testified that he last worked in the mine on December 31, 2007 for Respondent at their #1 mine in Carlinville. He was 51 years of age with a job classification of underground repairman. He was exposed to coal dust on that day. That was his last day of work because the mine closed down. Petitioner decided not to look for other mining employment due to some concerns with his breathing. Petitioner testified that he had had trouble breathing for about the last ten years and decided that he had had enough and did not want to put another ten years of dust in his lungs. Since that time Petitioner has had no other employment.

Petitioner testified that he began his mining career in 1978 with Respondent and worked his entire coal mining career with it. He was hired in as a general laborer with job duties of shoveling coal onto the belts so that it could be taken out of the mine. Petitioner also described having to shovel the coal dust that had deposited itself on the floor near the belts at the end of each shift. Petitioner described taking a shovel and shoveling the dust over his head, which would fill the air with black dust. This was done to keep a fire from starting from friction with the roller of the belt. After 90 days Petitioner was transferred to a unit where his primary job was that of a roof bolter. Petitioner described a roof bolter as a person who takes an auger and drills a hole into the ceiling and then a bolt is inserted in the hole in order to support the roof. Petitioner described a lot of dust coming down like a fog from the ceiling where the hole was drilled. Petitioner described eventually using glue pins to support the roof bolts in the ceiling. A hole was drilled and then a glue tube was shoved into the hole and a roof bolt was put behind it. The bolt was then pushed up so that the glue pin would break and the glue would ooze into the cracks. Then the bolt was tightened and torqued down securely. Petitioner described that many times the glue tubes would bust and the smell that was emitted was toxic. It was strong enough to choke and gag a person. In addition to roof bolting, Petitioner described putting rock dust through a hopper and blowing it on the walls to turn the walls from black to white but the white dust was lime dust, which kept the fire from starting.

Petitioner testified that his next job was that of a shuttle car operator. The shuttle car operator is responsible for taking the coal from the face of the mine where it is cut and taking it to the belts so it can be removed from the mine. Petitioner described a lot of coal dust behind the continuous miner machine that was cutting the coal from the face of the mine. Petitioner testified that he was a shuttle car operator for two or three years. Petitioner testified that he next became a supply man. As a supply man he drove diesel equipment and transported supplies such as glue pins, rock dust, and trowel-on, to areas of the mine that needed these supplies. Sometimes the glue pins had already busted and Petitioner described having to smell that glue all the way down as he would take the supplies into the mine. Petitioner testified that the roads that he drove on were dusty and that there was a blue haze of diesel fumes in the air. Petitioner explained that once he arrived at the units he would pick up old supplies such as, bad roof bolts, glue boxes, or any other type of garbage and would take it and load it onto the train car to send it out of the mine.

Petitioner's last job classification was mechanic/repairman. Petitioner explained that he was responsible for repairing broken down equipment along with keeping up with general repairs/maintenance. Petitioner testified that all of these repairs were done underground as opposed to the units being above ground for repair. According to Petitioner there was a tremendous amount of diesel fume exposure due to many of the machines still running while he was making repairs.

Petitioner testified that he first started noticing breathing problems in the last ten years before the mine closed. He noticed it was a little harder to catch his breath when walking and he couldn't carry the heavier things anymore without getting out of breath. From the time Petitioner first started noticing breathing problems until the time he left the mine they continued to worsen. From the time he left the mine until the time of trial, they have continued to worsen. Petitioner testified that he can walk approximately 30 to 40 feet before becoming short of breath. Petitioner also testified he can climb about six stairs before having to stop and rest. Petitioner testified that he does have an inhaler called ProAir but only uses it in the evenings as it helps him sleep.

Petitioner testified that his breathing difficulties effect his activities of daily living. He no longer rabbit and bird hunts with his son as he had done with his father. Petitioner describes owning several farms but cannot do any of the work on the farms due to his breathing. Petitioner's son comes over to cut the grass for him because he cannot.

Petitioner's treating doctor is Dr. Jain. Petitioner testified that he did discuss his breathing problems with his doctor and that the doctor was aware that he was a coal miner. Petitioner testified that he is not currently a smoker but acknowledged smoking from 1974 to May of 1986. He indicated he smoked about a half a pack a day. He has not had a cigarette in over 30 years. In addition to breathing problems Petitioner has diabetes and high blood pressure for which he takes medication. Petitioner had a hip replaced in November of 2016 and has had two tumors taken from his head and pituitary gland.

The Arbitrator had the opportunity to observe Petitioner during the hearing and noted he had several episodes of coughing.

The Arbitrator concludes:

Issues (C)and (O): Did Petitioner suffer a disease which arose out of and in the course of his employment by Respondent?

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

The Arbitrator resolves the issue of occupational disease and causation in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from coal workers' pneumoconiosis and COPD (including asthma and chronic bronchitis), all of which were either caused in part or aggravated by his exposures as a coal miner for over 27 years. As Petitioner had worked in coal mining for over ten years Section 1(d) of the Occupational Diseases Act creates a rebuttal presumption that Petitioner's CWP arose out of his coal mining employment.

Petitioner's testimony regarding his various jobs and exposure to coal dust, diesel fuel, roof bolting glue and other irritants was unrebutted.

The Arbitrator did note a discrepancy in Petitioner's testimony regarding his smoking history as he testified he had not smoked for 30 years prior to the date of arbitration. Reviewing Dr. Jain's records shows that was not true as Petitioner, in 2007 had relapsed and begun smoking again. He did, however, stop again. Despite this discrepancy, Petitioner was otherwise a very candid and credible witness, especially with regard to his description of his various jobs with Respondent and the irritants he was exposed to.

Petitioner's long-term primary physician is Dr. Jain, of Staunton, Illinois. He provided care and treatment to Petitioner for a year prior to Petitioner's date of last exposure as a coal miner through the date of arbitration. He diagnosed Petitioner with COPD, chronic bronchitis, and asthma, and he related each of those diagnoses to Petitioner's coal mine exposures. He also prescribed inhalers for Petitioner's breathing problems. Dr. Jain's records contain diagnoses of COPD and asthma in 2007, while Petitioner was still working as a coal miner. These diagnoses also predated Petitioner's examination by Dr. Paul. At various times, the doctor noted Petitioner's work in the coal mines and he, on occasion, cautioned Petitioner to make sure he

wore his paper mask while at the mine. While Dr. Jain's opinions were stated as possibilities, and he acknowledged that he was not a pulmonary specialist, the doctor credibly explained that he tended to see upper respiratory problems in those patients who worked more often in dusty environments, such as Petitioner did. (PX 2, pp. 8-9) Dr. Jain also testified that while smoking may have contributed to Petitioner's various respiratory diagnoses, his mining exposure did also. Thus, Petitioner's exposures to various irritants at the coal mine was a cause in his respiratory diseases.

Petitioner was also examined by Dr. Glennon Paul of Springfield on July 25, 2008, seven months following his date of last exposure, at the request of his counsel. Dr. Paul's credentials are noted by the Arbitrator. He served as the Medical Director of Respiratory Therapy at St. John's Hospital of Springfield for over 30 years, and for the first 10 of those, was also the Medical Director of Respiratory Therapy at Memorial Hospital, Springfield's other major hospital at that time. Dr. Paul also has examined miners for black lung for over 30 years, performing as many examinations at the request of Respondents as for Petitioners. Of the x-rays sent to him by Petitioner's counsel, Dr. Paul testified that he finds over half to be negative for CWP. He has also written a book on asthma. While not a b-reader, Dr. Paul has ample expertise and experience in upper respiratory conditions.

Dr. Paul found Petitioner to suffer from CWP complicated by asthma with an obstructive ventilatory defect and a reduced diffusing capacity. Dr. Paul was aware that Dr. Jain had diagnosed Petitioner with COPD and was treating him with bronchodilators. He agreed with Dr. Jain's treatment. Dr. Paul documented that Petitioner's FEV1 fell 20% with just one breath of methacholine, which he considered a significant condition of asthma. Dr. Paul was also aware of Petitioner's smoking history, including the fact that Petitioner had briefly relapsed into smoking for a period of time prior to the examination.

The Arbitrator further notes that Dr. Paul's diagnosis of CWP was supported by chest x-ray readings of b-reader/radiologist Dr. Henry Smith. Petitioner had two chest x-rays reviewed by b-readers retained by both parties. Petitioner's January 8, 2008 chest x-ray was only read by Petitioner's b-readers: Dr. Smith and Dr. Alexander. Dr. Smith found the x-ray to be of good quality and positive for coal workers' pneumoconiosis. Dr. Alexander found the film quality to be "2 (too light)." Nevertheless he read it as positive for CWP. Petitioner's January 30, 2014 chest x-ray was read by Dr. Smith (Petitioner's b-reader) and Dr. Meyer, Dr. Seaman, and Dr. Tarver (Respondent's b-readers). Dr. Meyer and Dr. Seaman found the x-rays to be of film quality 2, under-inflation, and under-exposed. They found the films negative for coal workers' pneumoconiosis. Dr. Tarver found found the chest x-ray to be of good quality and negative for pneumoconiosis. As the films read by Dr. Alexander, Dr. Meyer and Dr. Seaman were not of good quality, the Arbitrator assigns no weight to their findings. The Arbitrator finds that Petitioner has coal workers' pneumoconiosis based upon the film readings of Dr. Smith. None of Respondent's b-readers read the film from 2008. Thus, Dr. Smith's interpretation stands unrebutted.

Dr. Tuteur examined Petitioner on January 30, 2014 at the request of Respondent's counsel. He did not feel Petitioner had CWP or COPD. He testified that Petitioner's pulmonary function testing was within the range of normal; however, he testified that his lab considers the

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

Both Dr. Jain, Petitioner's long time treating physician, and Dr. Paul testified that due to his lung diseases and impairment, Petitioner no longer has the physical capacity to perform the labor required of a coal miner. Petitioner's lung diseases and his requirement for prescription medication for them are documented in Dr. Jain's treatment records prior to Petitioner's last day of work as a coal miner. Petitioner testified that he can walk approximately 30 to 40 feet before becoming short of breath. Petitioner also testified he can climb about six stairs before having to stop and rest. Petitioner testified that he does have an inhaler called ProAir but only uses it in the evenings as it helps him sleep. Petitioner testified that his breathing difficulties effect his activities of daily living. He no longer rabbit and bird hunts with his son as he had done with his father. Petitioner describes owning several farms but cannot do any of the work on the farms due to his breathing. Petitioner's son comes over to cut the grass for him because he cannot. He has taken prescription inhalers for his lung disease for over 10 years, and continues to do so through the date of arbitration. Petitioner is awarded 10% MAW.

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lower limits of normal for diffusing capacity to be 70%, rather than 80%. While Dr. Tuteur blamed Petitioner's obesity for his impaired diffusing capacity, he also acknowledged that exposure to roof bolting glues can cause asthma. He also testified that wearing a paper mask would not provide any protection from the fumes of roof bolting glues. He testified that running a supply motor and removing broken glue tube containers can result in "not-so-sudden-onset" asthma, that exposure to diesel fumes can aggravate reactive airways disease, and that using Strong Seal and Trowel On in a mine can cause and aggravate asthma. Petitioner's unrebutted testimony established his exposure to roof bolting glues, diesel fumes, and Trowel On in his coal mine work. Dr. Tuteur also testified that an Albuterol inhaler, which Petitioner was using at the time of his examination, can be used as a "rescue inhaler."

Dr. Tuteur also admitted that notwithstanding his readings of Petitioner's chest x-rays as negative, it was still possible that Petitioner could have CWP. When asked the question, "Can the inhalation of coal mine dust result in shortness of breath and cough?" Dr. Tutuer's response was, "It can." (RX 1, p 22) On cross-examination Dr. Tutuer was asked, "Is it true that the chronic inhalation of coal mine dust may produce a clinical picture indistinguishable from cigarette smoke induced chronic obstructive pulmonary disease?" His answer, "That is a true statement." (RX 1, p 39)

Dr. Tuteur testified that Petitioner had no evidence of bronchial reactivity, and he found Dr. Paul's methacholine challenge testing to be invalid. However, the Arbitrator notes that asthma was also diagnosed by Dr. Jain and that Dr. Jain was prescribing Levaquin and Combivent inhalers for Petitioner's lung diseases. Dr. Tuteur admitted that Petitioner had taken Albuterol on the day of his examination, and that this could have affected his post bronchodilator testing. He further admitted that if Petitioner did have asthma, such could account for the difference in the results of Petitioner's pulmonary function tests (PFT) taken by Dr. Paul and those taken at the time of his examination.

The Arbitrator has also considered Dr. Ettinger's office note of July 29, 2015 wherein the doctor found Petitioner's pulmonary function test of that date to reveal normal lung function. The Arbitrator does not discount the clinical findings noted by the doctor; however, those were the findings on just one occasion and Petitioner's various active medications were noted. Dr. Ettinger also noted Petitioner's medical history of COPD and asthma.

Dr. Jain testified that Petitioner does not have the pulmonary capacity to perform the manual labor required of a coal miner. Dr. Paul testified that as a result of his CWP and asthma, Petitioner has clinically significant, physiologically significant, and radiographically apparent pulmonary impairment, and that he is totally disabled from further work as a coal miner due to his pulmonary diseases. It was uncontroverted that a miner with CWP, COPD, chronic bronchitis, and/or asthma could not return to the environment of a coal mine without endangering his health. In addition, the PFTs of both Dr. Paul and Dr. Tuteur documented an impaired diffusing capacity. Both Dr. Paul and Dr. Tuteur testified that if a miner has CWP, by definition, he has an impairment in the function of his lungs at each site of scarring caused by the disease. The Arbitrator finds that Petitioner's work-related pulmonary diseases have caused disablement within the meaning 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 DOWN	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SARAH PITTMAN,

Petitioner,

vs.

NO: 13 WC 35895

PEORIA PUBLIC SCHOOL DISTRICT 150,

18IWCC0478

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 causation, medical expenses, temporary disability, and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the following typographical errors in the Arbitrator's decision:

1 – The first paragraph on page 3 and the sixth paragraph on page 5 note a June 13, 2013 accident date. The Commission corrects these paragraphs to reflect Petitioner's undisputed accident occurred on September 13, 2013.

2 – On page 6, the Commission corrects the Section 8.1b(b)(i) analysis to reflect the impairment report was prepared by Dr. Rhode.

3 – The Commission corrects the Order as well as the second full paragraph on page 7 to reflect Petitioner's wrist injury is categorized as a loss of use of the left hand under §8(e)9.

The Commission further modifies the medical expenses award. Petitioner incurred over $100,000 in medical expenses, the majority of which ($68,100.39) is for treatment at Orland

Park Orthopedics. PX17. The Commission has reviewed the Orland Park Orthopedics records in detail, and we find an inconsistency with Dr. Rhode's follow up recommendations and Petitioner's appointments.

On June 4, 2014, Dr. Rhode directed Petitioner to return for follow up in four weeks. PX7, p. 43, 45. Petitioner, however, presented to the clinic only two weeks later, on June 18, 2014. PX7, p. 46. The Commission notes Dr. Rhode reviewed Dr. Rotman's Section 12 report that day, but we do not find this represents a reasonable justification for accelerating the follow-up schedule. At the close of that June 18, 2014 appointment, Dr. Rhode directed Petitioner to return to the clinic in four weeks. PX7, p. 46, 48. Yet again, though, Petitioner returned just two weeks later, on July 2, 2014. This pattern continued through September: despite Dr. Rhode clearly recommending re-evaluations every four weeks, Petitioner continued to be seen every two weeks. The Commission finds the June 18, 2014; July 16, 2014; August 13, 2014; and September 10, 2014 dates of service do not comport with Dr. Rhode's follow-up recommendations and therefore are neither reasonable nor necessary. The Commission modifies the medical expenses award to deny the charges associated with those specific dates of service.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2017, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $240.45 per week for a period of 23 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 $240.45 per week for a period of 54.1 weeks, as provided in §§8(d)2 and 8(e)9 of the Act, for the reason that the left shoulder injury sustained caused the 10% loss of use of the person as a whole (50 weeks), and the left wrist injury sustained caused the 2% loss of use of the left hand (4.1 weeks).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $98,119.42 for medical expenses under §§8(a) and 8.2 of the Act. Respondent shall have credit for any amounts previously paid, and Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j).

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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file 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 6 - 2018

L. Elizabeth Coppoletti

LEC/mck

D: 6/6/18

43

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PITTMAN, SARAH
Employee/Petitioner

Case# 13WC035895

PEORIA PUBLIC SCHOOL DIST #150
Employer/Respondent

18IWCC0478

On 11/28/2017, 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 1.43% 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:

1824 STRONG LAW OFFICES
MICHAEL BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

18IWCC0478

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

Sarah Pittman
Employee/Petitioner

v.

Peoria Public School Dist. #150
Employer/Respondent

Case # **13** WC **35895**

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 **Peoria**, on **12/16/16**. 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 **9/13/13**, 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 **$12,503.40**; the average weekly wage was **$240.45**.

On the date of accident, Petitioner was **50** 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, **$0** for maintenance, and **$Any** for other benefits, for a total credit of **$Any**.

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 $100,213.42, as set forth in Petitioner's exhibit 17, 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 $240.45/week for 234/7 weeks, commencing 4/29/14 through 10/10/14, 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 **$240.45**/week for a further period of **54.1** weeks, as provided in Section **8(d)2 and 8(e)** of the Act, because the injuries sustained caused **10% loss of use of the person as a whole relative to the left shoulder (50 weeks) and 2% loss of use of the left wrist (4.1 weeks)**.

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

11/20/17
Date

ICArbDec p. 2

FINDINGS OF FACT

The Petitioner testified that she was employed on June 13, 2013 by the Respondent. She was working in the cafeteria that day. On that day, she went to get a case of fruit. The fruit was in a box that was stacked high over her head. When she grabbed the case, she noticed a twist to her left wrist and she felt a pop in her left shoulder. She informed her supervisor but she was told to finish the work day.

After she finished working, the Petitioner went to IWIRC at the request of her employer. She was examined and was prescribed medication and given a wrist brace and a sling. She went to IWIRC through October 22, 2013. During that time period, the Petitioner underwent physical therapy and underwent an MRI of the left shoulder on October 5, 2013. The impression from the MRI was moderate supraspinatus and a mild tendinosis with articular sided fraying at the anterior supraspinatus with no discreet tear with small to moderate joint effusion.

The medical records from IWIRC indicated that the Petitioner was picking up a case of fruit and as the case started to fall, she grabbed with her arm and her left shoulder popped. The initial diagnosis was a left shoulder strain and left wrist strain. The treatment at IWIRC consisted of mostly of physical therapy and recommended a home exercise therapy and recommended MRI of the left shoulder as well as the left wrist.

The Petitioner saw Dr. Rhode on November 6, 2013. The Petitioner indicated that she went there because her attorney recommended that she see Dr. Rhode. Dr. Rhode, following his examination and review of the shoulder MRI, stated that the Petitioner should be off work due to her injury and provided her with an injection into the left shoulder.

A previous MRI of the left wrist that was ordered by IWIRC took place on November 18, 2013. This MRI showed that the Petitioner had approximately a mid-dorsal capsular ganglion.

At a follow up visit with Dr. Rhode on November 20, 2013, he reviewed the MRI and physical therapy was recommended. The Petitioner noted that the medical records of Dr. Rhode indicated that the injection had helped. On December 18, 2013, due to continuous pain in the left wrist and shoulder, a recommendation for an arthroscopy of the left shoulder was made by Dr. Rhode.

The Petitioner was seen by Dr. Rotman on January 15, 2014 at the request of the Respondent. Following the examination by Dr. Rotman, Dr. Rhode's records indicated that if the Respondent could accommodate light duty then the Petitioner could work.

The Petitioner underwent surgery on her left shoulder on April 29, 2014. The post-operative diagnosis was a left shoulder impingement and a U shaped supraspinous rotator cuff tear. The surgery consisted of a left shoulder sub acromial decompression and an arthroscopic rotator cuff repair.

The deposition of Dr. Blair Rhode was taken. Dr. Rhode testified that the Petitioner was seen initially in his office on November 6, 2013. She provided a history of picking up a 45 lb. case of fruit when the box slipped. She tried to grab it and her wrist twisted and her shoulder popped but she continued to work. Her examination demonstrated mild range of motion loss to forward elevation of approximately 10 to 15 degrees. External rotation was mildly limited and she had mild strength loss to supraspinous isolation. The Petitioner had a positive impingement sign. She had a negative acromioclavicular finding. A diagnostic therapeutic

injection was given. The basis for the injection was the positive impingement sign as well as a positive O'Brien's maneuver. Dr. Rhode testified by performing the sub acromial injection, he could see if there was any rotator cuff pathology.. If the patient had at least temporary complete relief, it would suggest that it is a rotator cuff in nature. If the patient did not experience any relief, it would suggest labral in nature. A working diagnosis as of that date was a dorsal ganglion of the wrist and a rotator cuff strain. Dr. Rhode testified that he eventually performed surgery on April 29, 2014. It consisted of an arthroscopic left shoulder subacromial decompression and a rotator cuff repair of the small, 1 c.m. to 1.5 c.m. of a rotator tear cuff tear. There was no evidence of chondral changes to glenohumeral joint. The examination of the rotator cuff demonstrated a small rotator cuff tear. Following surgery, she was placed into physical therapy, eventually being placed at maximum medical improvement on December 3, 2014. Prior to that, a functional capacity evaluation took place. The functional capacity evaluation indicated that she was capable of floor to waist at medium duty with a waist to crown of 21 lbs. low frequency with a maximum of 31 lbs. Dr. Rhode placed permanent restrictions of modified duty upon the Petitioner.

Dr. Rhode, after reviewing the report of Dr. Rotman, the IME physician, indicated that he disagreed with Dr. Rotman's causation opinion. Dr. Rotman did not believe that there is any work activity at shoulder level and therefore, the accident could have not been a causative factor to the patient's symptoms. The accident, per the Petitioner's own testimony, indicated that there was overhead activity. On cross examination, Dr. Rhode testified that the Petitioner had undergone an MRI of the left wrist and this demonstrated dorsal ganglion but he did not feel it needed treatment. Also, Dr. Rhode testified that there appears to be temporal association of the dorsal wrist to the ganglion cyst. He further testified, under cross examination, that he did not know whether or not, that there was a pre-existing condition to the left shoulder or left wrist pre-dating September 13, 2013. He further conceded that it could affect his opinion if she was picking the box off the floor, waist level, or above the shoulder.

The deposition of Dr. Rotman was taken and he indicated that he is board certified in orthopedic surgery. He examined the Petitioner on one occasion on January 20, 2014. Following his examination, his diagnosis was a dorsal wrist ganglion, trauma sprain and some type of shoulder strain. He did not believe that there was a rotator cuff tear associated with overhead problems or a fall. He thought she could have strained her bicep. Dr. Rotman testified that the ganglion showed up immediately following the incident and that twisting the wrist could have caused it. His recommendations was to pop it. He further provided an opinion in regards to the left shoulder that he would recommend a diagnostic arthroscopy to see if there is evidence of an injury. He indicated that it would be causally related to the work injury if it is related to the bicep or labrum because of the mechanism involved. He stated that the mechanism involved would not have been the cause of the impingement of a rotator cuff problem. Dr. Rotman testified that he prepared an addendum report after reviewing additional records including the surgical report of Dr. Rhode from April 29, 2014. He stated that the surgery performed was not causally related to the accident because there was nothing wrong with the bicep or labrum.

The medical records from OSF indicate that any treatment relating to the left shoulder was completed prior to 2007; but there is no indication of any records for treatment on the left shoulder following that incident.

CONCLUSIONS

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

The Respondent has conceded that the Petitioner was involved in an accident that arose out of and in the course of her employment by them. The Petitioner testified that she injured her left wrist and left shoulder when she was attempting to lift a box of fruit from an overhead position. When she did so, she noticed a pop in her left shoulder with pain in her left wrist. The diagnostic studies, including an MRI, showed that the Petitioner had a mid-dorsal ganglion cyst on her left wrist. Dr. Rotman, the IME physician, provided an opinion that if the ganglion showed up immediately following the incident, the incident of twisting the wrist could have caused it. Dr. Rhode also provided causal connection as far as the development of the cyst as well.

Dr. Rhode provided his opinion that the incident of attempting to lift the fruit box from an overhead position was a causative factor of her left shoulder complaints. Dr. Rotman stated that it was his understanding that the Petitioner was not working overhead and if she was not working overhead than there would be no rotator cuff pathology. The Arbitrator finds Dr. Rotman's assumption in this regard was incorrect.

The Petitioner underwent surgery by Dr. Rhode on April 29, 2014, consisting of an arthroscopic left shoulder sub acromial decompression and rotator cuff tear.

The Petitioner candidly indicated that she had prior problems with the left shoulder many years ago, but she had no problems since 2007 until this accident in 2013.

The Arbitrator found the testimony and opinions of Dr. Rhode more persuasive than those of Dr. Rotman in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that the condition of ill-being of her left shoulder and left wrist are causally related to the undisputed accident of June 13, 2013.

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

Petitioner submitted medical expenses totaling $100,213.42. (PX 17)

The Arbitrator notes that even though Dr. Rotman testified that the surgery was not related to the accident, he did state that it was his opinion that a diagnostic arthroscopy should be done to determine the cause of the injury. Having found that the Petitioner's current condition of ill-being was causally related to the accident and that the testimony and opinions of Dr. Rhode are more persuasive than those of Dr. Rotman, the Arbitrator finds that all medical services rendered to the Petitioner were reasonable and necessary in light of the injuries sustained.

Respondent shall pay reasonable and necessary medical services of $100,213.42, as set forth in Petitioner's exhibit 17, 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.

18IWCC0478

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

The Petitioner indicated that she was off work from April 29, 2014 through October 10, 2014, when she underwent the functional capacity evaluation. The Respondent does not dispute the period of incapacity.

Having found that the Petitioner's current condition of ill-being was causally related to the accident and that the medical services rendered to the Petitioner were reasonable and necessary in light of the injuries sustained, the Arbitrator finds Respondent shall pay TTD benefits for the above period.

Respondent shall pay Petitioner temporary total disability benefits of $240.45/week for 234/7 weeks, commencing 4/29/14 through 10/10/14, as provided in Section 8(b) of the Act. Respondent shall have a credit for any non-occupational disability benefits paid.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 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 Dr. Rhotman provided an impairment rating of 5% loss of the upper extremity and 3% loss of a person as a whole. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes the Petitioner's occupation was as a cafeteria worker and she was still working in the same capacity as of the date of the hearing.. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of her injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. Furthermore. Petitioner has hand and arm intensive employment. 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 Petitioner's future earning capacity is impaired due to the permanent restrictions imposed by Dr. Rhode. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner developed a ganglion cyst in her left wrist that was not surgically repaired and she still had that condition as of the date of the hearing. According to the medical records and her testimony, the Petitioner developed a rotator cuff tear that required surgery and extensive physical therapy following the surgery. Dr. Rhode provided the Petitioner with permanent work restrictions for the shoulder due to her injury. As of the date of the hearing, the Petitioner testified that she is unable to lift her left arm over shoulder level and she has a loss of grip strength. Because the medical records

and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in her hands, 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 10% loss of use of the person as a whole relative to the left shoulder pursuant to §8(d)2 of the Act and 2% loss of use of the left hand pursuant to §8(e) of the Act.

Respondent shall pay Petitioner the sum of $240.45/week for a further period of 54.1 weeks, as provided in Section 8(d)2 and 8(e) of the Act, because the injuries sustained caused 10% loss of use of the person as a whole relative to the left shoulder (50 weeks) and 2% loss of use of the left wrist (4.1 weeks).

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 SANGAMON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Uriah C. Rawls,
Petitioner,

vs. NO: 15 WC 35087

Whelan Security Company,
Respondent.

18IWCC0479

DECISION AND OPINION ON REVIEW

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

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

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

DATED: AUG 6 - 2018

o-06/06/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

18IWCC0479

SPECIAL CONCURRING OPINION

I agree with the result reached by the majority. I write separately to further address the "in the course of" element as well as the "usual/customary or sole" route. Petitioner sustained injury to his ankle while traversing an access road. Although there is no direct testimony as to the ownership of the road, it can be inferred such road was part of Respondent's premises. "This court has recognized that accidental injuries sustained on employer's premises within a reasonable time before and after work are generally deemed to arise in the course of employment. [citations omitted]." *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 57, 541 N.E.2d 665 (1989). Petitioner's injury occurred in the course of his employment.

The Illinois Workers' Compensation Act also requires Petitioner to establish his injury arose out of his employment which Petitioner failed to prove. Petitioner was jogging along a road (a road which was not designed for pedestrian traffic (T. 66)) when he slipped on gravel. T. 22-23. There is absolutely no testimony the existence of gravel next to the paved roadway was defective or presented a special hazard. Petitioner stepped off the pavement onto gravel. There is nothing in the record which distinguishes this roadway from any other roadway which consists of both pavement and gravel. The fact Petitioner utilized the road as his customary route to work does not satisfy the arising out of element. As the court noted in *Caterpillar*,

> While the broad language of these cases might appear to imply that *any* accidental injury sustained on the employer's premises is compensable, that is not the law in this State. An examination of the cases indicates this court's continued adherence to the maxim that an injury is not compensable unless it is causally connected to the employment. Where liability has been imposed, the injury occurred either as a direct result of a hazardous condition on the employer's premises [citations omitted] or arose from some risk connected with, or incidental to, the employment [citations omitted]." *Caterpillar*, 129 Ill. 2d at 62.

The evidence does not support a finding of a hazard nor a risk connected to or incidental to Petitioner's employment. Not only is there a lack of employment risk, as the majority found in affirming and adopting the arbitrator's decision, Petitioner exposed himself to a personal risk.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAWLS, URIAH C
Employee/Petitioner

Case# **15WC035087**

WHELAN SECURITY CO
Employer/Respondent

18IWCC0479

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:

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0771 FEATHERSTUN GAUMER POSTLEWAIT
EDWARD F FLYNN
225 N WATER ST SUITE 200
DECATUR, IL 62523

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

URIAH C. RAWLS
Employee/Petitioner

v.

WHELAN SECURITY CO.
Employer/Respondent

Case # 15 WC 35087

Consolidated cases: _____

18IWCC0479

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **October 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 **October 21, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being N/A causally related to the accident.

In the year preceding the injury, Petitioner earned **$21,941.12**; the average weekly wage was **$421.94**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Based upon the careful review of the credible evidence introduced here, the Arbitrator finds that the Petitioner has failed to prove by a preponderance of credible evidence that an accident occurred that arose out of and in the course of Petitioner's employment by Respondent. Due to this finding, it is not necessary to address the remaining issues. Accordingly, Petitioner's claim for compensation and medical services herein 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.

D. Dylan McCarty

Signature of Arbitrator

11-10-2016
Date

ICArbDec p. 2

NOV 18 2016

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 WITH RESPONDENT?) THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner, Uriah Rawls, was hired to begin his employment with Whelan Security in January 2013, as a security officer. (R. 10, 11) As a security officer, Petitioner's responsibilities included logging vehicles, entering and exiting the Archer Daniels Midland (ADM) facilities and to keep a log of individuals and contractors entering the facility. (R. 11) There are twelve (12) different posts that security officers are assigned to work. (R. 12) Petitioner received a schedule in advance advising him of the post he was assigned to work. (R. 12, 13)

On October 21, 2014, Petitioner was assigned to work at Gate E-9. (R. 16) Prior to October 21, 2014, Petitioner had only been assigned to Gate E-9 one other time. (R. 17) For his work assignment on October 21, 2014, Petitioner's mother dropped him off at Gate E-9. Gate E-9 is located on Brenaman Road, the guard post is approximately a quarter of a mile from the intersection of Brenaman and Brush College Road. (R. 16) The guard post at E-9 consists of a very small building with a chair, a window and an air conditioner. (R. 13)

Brenaman Road is depicted in multiple photographs admitted herein by both Petitioner and Respondent. (See Exhibits admitted herein.) Petitioner testified that Gate E-9 is a gate that strictly monitored trucks entering and exiting the ADM facility. (R. 18) The Petitioner never observed any pedestrians or anyone walking on Brenaman Road. (R. 18) Petitioner also acknowledged that Gate E-9 does not have a parking lot. It has only a small designated parking space for the security employees working at Gate E-9. (R. 53) Petitioner also acknowledged that the other security posts had pedestrian traffic that would egress and ingress through those gates unlike Gate E-9 that did not have any pedestrian traffic. (R. 53)

Petitioner testified that at the end of his shift, he did not have a vehicle so he began to walk down Brenaman Road towards Brush College Road. Petitioner acknowledged that in addition to Gate E-9 not allowing pedestrian traffic, the photographs of Brenaman Road accurately portray that there is not a sidewalk or pedestrian path adjacent to Brenaman Road to walk down Brenaman Road to Brush College Road. (R. 17) While Petitioner was walking down Brenaman Road, he observed a couple of trucks turn off Brush College Road onto Brenaman Road toward Gate E-9. (R. 20) Petitioner moved off of Brenaman Road into the adjacent gravel area, Petitioner testified he was either walking fast or jogging. (R. 21) Petitioner claimed he was trying to get to a bus stop on Brush College Road. (R. 21) While the Petitioner was walking on the gravel area, he felt himself lose control and subsequently twisted his left ankle. Petitioner circled the areas on the photographs where he claimed the incident occurred. Petitioner claimed that he fell, got up and proceeded to Brush College Road, where he caught a City Bus to take him home. He further stated that after he fell, he noticed that the bus had stopped and was waiting for him. (R. 23)

Petitioner testified that this unwitnessed incident took place on October 21, 2014, between 7:50 and 8:00 a.m. Petitioner reported for work on October 22 and October 23 without reporting this incident. Then on October 24, 2014, Petitioner believed he reported this incident to only Tony Ditty. (R. 29)

The first time Petitioner sought medical treatment was at Decatur Memorial Hospital on October 24, 2014, at 5:51 p.m. (See Pet. Ex. 1, P. 2; DMH intake record) An x-ray of Petitioner's left foot revealed no foot fracture identified, mild lateral soft tissue swelling. (Pet. Ex. 1, P. 12) A subsequent x-ray report indicated lateral left tissue swelling with suspected small avulsion fracture with the site of origin uncertain. (See Pet. Ex. 2, P. 7)

Petitioner was examined and treated by Dr. Tyler Jones who diagnosed Petitioner's left ankle as an avulsion fracture. (Pet. Ex. 2, P. 20) Following physical therapy, he was released to return to work on November 25, 2014.

The Petitioner terminated his employment with Whelan Security in October 2015, to accept a position with Kelly Construction as a construction laborer. (R. 35) Petitioner acknowledged on cross-examination that his job at Kelly Construction paid $6.00 an hour more than his position with Whelan Security. (R. 51)

During his direct-examination, Petitioner claimed that he no longer plays sports because of his ankle pain. (R. 38) On cross-examination, he acknowledged that his job at Kelly Construction as a construction laborer is far more physically demanding. (R. 51) Prior to accepting his position at Kelly Construction, he successfully completed a post-job offer physical examination to perform the heavy duty lifting requirements of a laborer. (R. 52)

Kenneth Fleener, security supervisor for Whelan Security, testified that he was Petitioner's supervisor when Petitioner was employed by Whelan Security. (R. 58, 59) Mr. Fleener testified that the accident report submitted as Respondent's Exhibit 1 was prepared by him as a result of Petitioner reporting the incident to Mr. Fleener. Mr. Fleener testified that the second page of the report had three areas that Petitioner acknowledged by initialing that section. (R. 61) At the time that the report was made on October 24, 2014, Petitioner initialed the section that he refused any medical treatment.

Mr. Fleener went on to testify that he observed the area where Petitioner claimed he had been injured and did not observe anything that was hazardous or dangerous. (R. 64) He went on to state that pedestrians are not allowed to utilize Brenaman Road, the area where Petitioner claimed that he was injured. (R. 64) He further stated that there is a policy that the employees at Whelan Security arrive at work in a vehicle and that they have this vehicle for transportation to and from their duties. (R. 64) The position that Petitioner was assigned to on the date of the alleged injury has a designated area for Whelan's Security employees to park. (R. 65) Mr. Fleener went on to testify that he is familiar with the functions of Gate E-9 and that the sole purpose of Gate E-9 is for truck traffic and employee vehicle traffic that goes to the back portion of ADM to work at the water treatment plant. (R. 66) Mr. Fleener testified that the Petitioner's utilization of Brenaman Road as a pedestrian was not appropriate. (R. 66) He also testified that no safety or other work rules were violated by the Petitioner in his use of Brenaman Road or in not having his own vehicle to get to and from work.

FINDINGS OF LAW REGARDING THE ISSUE OF "C" (DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT)

"Arising out of" employment pertains to the origin or cause of the employee's injury *First Cash Financial Services v. Industrial Commission,* 367 Ill.App.3d 102 (1st Dist. 2006). For an injury to "arise out of" one's employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co.,* 129 Ill.2d at 58. Illinois courts categorize the risks to which an employee may be exposed into three general groups: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks that have no particular employment or personal characteristics. *Baldwin v Illinois Workers' Compensation Commission,* 409 Ill.App.3d 474, 478 (4th Dist. 2011); *First Cash Financial Services* 367 Ill.App.3d at 105; *Illinois Institute of Technology Research Institute v. Industrial Commission,* 314 Ill.App.3d 149, 162 (1st Dist. 2000).

The Arbitrator finds that the accident occurred as the result of a risk personal to the Petitioner. As such, the accident did not arise out of his employment.

The facts in the instant case are similar to those considered by the Appellate Court in the case of Dodson v. The Industrial Commission, 308 Ill. App. 3d 572 (5th Dist. 1999). In Dodson, the petitioner was leaving work to get something out of her vehicle located in the company parking lot. Instead of taking a route through her building, she elected to take a path which was wet and icy. The Court held that her subsequent fall was the result of her unnecessarily exposing herself to a danger separate from her employment. Taking the shortcut was not in her employer's interest and done strictly for her own convenience. Accordingly, the Court found the accident did not arise out of her employment.

In the instant case, the most important fact to the Arbitrator was that the Petitioner was walking fast or jogging to catch a bus to get home. He testified three times to that effect. (R 21, 23, 45) He wrote the same account on his written statement contained in his incident report. (RX 1) He said that he fell while in a hurry to catch a bus as he moved from the paved road to the gravel near the road depicted in all of the photographs. Had he not been jogging in a hurry, it is reasonable to assume that his risk of falling would have been greatly diminished.

The Petitioner's jogging to catch that particular City Bus to go home was not in his employer's interests. It represented a voluntary exposure to a personal danger similar to that taken by the petitioner in Dodson. Accordingly, his accidental fall did not arise out of his employment.

The petitioner who was injured in the case cited by the Respondent, Fermi National Accelerators Lab v. The Industrial Commission, 224 Ill. App. 3d 899 (2d. Dist. 1992), did not unnecessarily expose himself to a non work related danger. In Fermi, the petitioner simply stepped off a stoop onto a rock on his way to a smoke break. The Court found that the Commission could have inferred that his resulting ankle injury was due to a defect in the surface area, namely the rocks. Here, while the Petitioner testified that it felt like he slipped on a rock causing him to twist his ankle, his decision to jog from work to catch a bus ride home was a personal decision which increased his risk of injury.

The claim is denied, and all other issues become moot.

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

Terrance Schulte,
Petitioner,

vs. NO: 13 WC 26835

18IWCC0480

Tri County Coal, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review, having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent partial disability, Arbitrator denied all benefits, legal & Evidentiary error; Section 1(d)-(f) of the Occupational Disease Act and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 29, 2016 is hereby affirmed and adopted.

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

DATED: AUG 6 - 2018

o-06/06/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

SPECIAL CONCURRING OPINION

I concur with the result reached by the majority. I write separately to address certain arguments advanced by Petitioner. Petitioner argues CWP is a latent and progressive lung disease which may become detectable only after cessation of the exposure to coal dust. (see *20 C.F.R. §718.20(c)*). Further, Petitioner posits a negative x-ray cannot "rule out" the existence of CWP given studies which show long-term coal miners at autopsy show pathologic signs of CWP despite negative chest x-rays during their lifetime. In advancing such arguments, Petitioner is attempting to shift the burden to Respondent to prove a negative. Respondent does not bear the burden of "ruling out" the existence of CWP. It is Petitioner's burden to prove by a preponderance of the evidence the existence of an occupational disease which he failed to do in this matter.

In the present matter, Petitioner offered the opinions of Drs. Paul, Smith and Alexander in support of Petitioner's diagnosis of CWP. Respondent offered the opinions of Drs. Meyer and Rosenberg who contested such findings. The Commission affords greater weight to the opinions of Dr. Meyer and Dr. Rosenberg. The Commission does not simply add-up the number of experts on one side or the other nor does it weigh the specific credentials of the experts presented as such experts are qualified and well-known to the Commission. The Commission finds Dr. Meyer more persuasive given his detailed explanation regarding the lack of CWP and his bases for the same-opacities and lung zone. Such testimony was further supported by Dr. Rosenberg. Additionally, the medical records from Springfield Clinic evidence Petitioner suffered from and was treated for atrial fibrillation which caused shortness of breath. Petitioner failed to establish he suffers from an occupational disease- CWP.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHULTE, TERRANCE
Employee/Petitioner

Case# **13WC026835**

TRI COUNTY COAL LLC
Employer/Respondent

18IWCC0480

On 9/29/2016, 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 0.42% 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:

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

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

TERRENCE SCHULTE
Employee/Petitioner

v.

TRI COUNTY COAL, LLC
Employer/Respondent

Case # 13WC 026835

Consolidated cases: _____

18IWCC0480

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 **June 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 **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **July 15, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner's average weekly wage was **$1,087.89**.

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

Petitioner claims no medical.

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

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

ORDER

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.

Edwd Lee

Signature of Arbitrator

9/23/16

Date

SEP 29 2016

STATE OF ILLINOIS)
) SS:
COUNTY OF SANGAMON)

18IWCC0480

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terrance Schulte,
Employee/Petitioner

v.

Case #13 WC 026835

Tri County Coal Company,
Employer/Respondent

Findings of Fact:

Petitioner was 66 years old at the time of arbitration. He graduated from Kincaid High School. He attended Lincolnland College and received an Associate's Degree in applied science and horticulture. He served two years in the military from 1969 to 1971. He was in the infantry in Vietnam.

Petitioner worked for 36 years in the coal mines with 33 of them being underground. In addition to coal dust he was exposed to silica dust, roof bolting glue fumes and diesel fumes. Petitioner last worked a shift in coal mine employment on July 15, 2012, at Respondent's Crown III mine. Petitioner testified that he was 63½ (sic) years old when he retired. His job classification on that last day of employment was utility man. He testified that he was exposed to coal dust on his last day of employment. He testified that he quit working in the coal mine on that date because he figured he had had enough and for health reasons he wanted to call it quits so he retired. Petitioner did not work anywhere else after he left the coal mine.

Petitioner went to work for Freeman Coal in 1971 as a laborer. In that job he would haul bags of rock dust to the units and spread it on the floors, walls and ceiling. After a month at Freeman, the Crown I mine shut down and Petitioner went to work for Consolidated Coal as a laborer. Next he went to work at the face which is where they cut the coal out of the wall. While at Consolidated he also worked as a buggy runner, miner operator and roof bolter. As a miner operator, he ran the machine that cut the coal out of the face of the mine. He testified that there was a lot of coal dust with that job. The buggy runner drives the shuttle car that takes the coal from the face of the mine, where they are cutting it, to the belts. As a roof bolter, Petitioner would drill holes into the ceiling of the mine and insert a pin to help support it. In that job there was a lot of silica dust from the drilling. Petitioner testified that he worked for Consolidated Coal for seven or eight years and then went to Freeman's Crown III mine as a buggy runner. He worked in that position for six months until he bid on a job running the continuous miner. He did that job for two or three years and became an utility man which meant he filled in at the face area wherever a worker was needed. Petitioner worked at Crown III until 1987. There was a shutdown and a layoff and Petitioner went to work at Tourist. There he worked as secondary roof support, and he also operated a ram car. Petitioner testified that the ram

car pushed the coal out of the mine instead of having the conveyor chain to push it out. He testified that was a nasty job because of the diesel exhaust. Petitioner went back to Crown III in 1991 and worked there until his retirement. He worked primarily as an utility man from 1991 until his retirement.

Petitioner testified that he first noticed breathing problems at work when he was about 40 year old. He was working as a buggy runner or miner operator at the time. He noticed that he would have shortness of breath and when he did something he would really be breathing hard. Petitioner testified that from the time he first noticed breathing problems until he left the mine, the problems got worse. He testified that his breathing has gotten worse from the time he left the mine until the time of arbitration. Petitioner does not take any breathing medications.

Petitioner testified that he does not have the air to do his daily activities. He testified that he is tired all the time and thinks maybe it is because of black lung. Petitioner testified that he would walk about a block on level ground before becoming short of breath. He testified that he could climb one flight of stairs. Petitioner described a recent time at the park when he was going up and down the steps and would have to stop at the landings to rest. Petitioner testified that he gardens, but because of his breathing he does not do as much as he used to. He also does some bike riding, but he is limited. Petitioner testified that he rides his bike about a mile and a half once a week for exercise. He used to be able to swim across the pond but now would be afraid to try it.

Petitioner testified that his primary care physician is Dr. Beyers. He has not talked to Dr. Beyers about his breathing problems. Petitioner was not smoking as of the time of arbitration. He smoked from age 16 until about age 35. He smoked a pack and a half to two packs a day when he was smoking. In addition to his breathing difficulties, Petitioner has afib for which he takes medication. He also has high cholesterol and high blood pressure.

Petitioner signed a resignation from Respondent on July 16, 2012. With that resignation he severed all of his rights to employment with Respondent. He signed up for his pension at the same time. He had a sufficient number of years with the company and was of sufficient age that he was able to retire and receive his full retirement pension.

Petitioner testified that from time to time while he was a coal miner he underwent chest x-ray screenings by NIOSH for black lung. He testified that after the chest x-ray was taken they would send him a letter telling him what the film revealed. He did not take any of those letters to arbitration. Petitioner treated at Prairie Cardiovascular for his atrial fibrillation. He testified that he was always honest with the physicians at Prairie Cardiovascular about his symptoms and complaints.

Dr. Glennon Paul is the Director of St. John's Respiratory Therapy and a Clinical Assistant Professor of Medicine at SIU Medical School. (Petitioner's Exhibit No. 1, p. 6). Dr. Paul is the senior physician at the Central Illinois Allergy & Respiratory Clinic. Those physicians specialize in allergy and pulmonary diseases. They take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. Dr. Paul reads 15 to 20 chest x-rays per day. (Petitioner's Exhibit No. 1, pp. 7-8). He also interprets about the same number of pulmonary function tests. (Petitioner's Exhibit No. 1, p. 8). Dr. Paul is board certified in asthma, allergy and immunology. (Petitioner's Exhibit No. 1, p. 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972 there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease. (Petitioner's Exhibit No. 1, p. 10). Dr. Paul is not an A-reader of B-reader, and he is not board certified in pulmonary medicine. (Petitioner's Exhibit No. 1, pp. 39-40).

Dr. Paul examined Petitioner one time on October 24, 2013, at the request of his counsel. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2, p. 36). Dr. Paul has seen hundreds of individuals at the request of Petitioner's counsel. Dr. Paul noted in his report that Petitioner had shortness of breath going up one flight of stairs or walking half a mile. (Petitioner's Exhibit No. 1, pp. 11-12). Based on his examination of Petitioner, Dr. Paul concluded that he had coal workers' pneumoconiosis caused by inhalation of coal dust. Dr. Paul testified that in light of that diagnosis, Petitioner could have no further exposure to the environment of the coal mine without endangering his health. Dr. Paul testified that in order to have pneumoconiosis one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. Dr. Paul testified that by definition if one has coal workers' pneumoconiosis, he would have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (Petitioner's Exhibit No. 1, pp. 15-16).

On examination of Petitioner's chest, Dr. Paul did not hear any rales, rhonchi or wheezes. He testified that Petitioner's chest exam was normal. He testified that Petitioner was not taking any breathing medication and did not relate to him a history of ever having taken breathing medication. (Petitioner's Exhibit No. 1, pp. 36-37). Dr. Paul testified that Petitioner complained of dyspnea on exertion. He testified that one does not have to have lung disease to have dyspnea on exertion. Dr. Paul did not review medical records regarding Petitioner. He testified that Petitioner's spirometry was normal at the time he took it. In regard to the diffusing capacity that was performed, Dr. Paul did not know the inhalation time for the tracer gas. Also, he did not know the hold time or the inspiratory volume for the tracer gas. (Petitioner's Exhibit No. 1, pp. 37-38).

Dr. Paul testified that his sole diagnosis for Petitioner was coal workers' pneumoconiosis. This diagnosis was based upon Petitioner's history of exposure, Dr. Paul's interpretation of the chest x-ray and also an interpretation by a B-reader. Dr. Paul did not know what B-reader he relied upon. Dr. Paul did not know the date of the film that he reviewed. Dr. Paul testified that the opacity type on the chest x-ray was "coal." Dr. Paul did not give the film a profusion rating. (Petitioner's Exhibit No. 1, pp. 38-39). Petitioner did not tell Dr. Paul that he left work at the time he did on the advice of a physician or because of an inability to perform the duties of his last job. (Petitioner's Exhibit No. 1, p. 40).

Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray of August 22, 2013, as positive for pneumoconiosis, profusion 1/0 with P/S opacities in all lung zones. (Petitioner's Exhibit No. 2). Dr. Michael Alexander, board certified radiologist and B-reader, interpreted the August 22, 2013, chest x-ray as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. (Petitioner's Exhibit No. 3).

Records from NIOSH for the Coal Workers' Health Surveillance Program were admitted into evidence. A chest x-ray of October 1974 was interpreted by a B-reader as completely negative. (Respondent's Exhibit No. 3, p. 2). Two B-readers interpreted a chest x-ray dated September 18, 1987, as completely negative. Another B-reader interpreted the same chest x-ray as negative for pneumoconiosis with profusion 0/1 and Q/Q opacities in the upper and middle lung zones bilaterally. (Respondent's Exhibit No. 3, pp. 3-5). A chest x-ray of August 28, 2000, was interpreted by two NIOSH B-readers as completely negative. (Respondent's Exhibit No. 3, pp. 6-7). One B-reader interpreted the chest x-ray of September 26, 2005, as negative for pneumoconiosis not having any parenchymal or pleural abnormalities consistent with pneumoconiosis. Another B-reader interpreted this chest x-ray as negative for pneumoconiosis with abnormalities consistent with pneumoconiosis with profusion 0/1 with S/T opacities in the right, middle and lower lung zones. (Respondent's Exhibit No. 3, pp. 8-9). On a chest x-ray of May 8, 2007, one B-reader interpreted the films as negative for pneumoconiosis with abnormalities consistent with pneumoconiosis with profusion 0/1 with Q/T opacities in all lung zones. Another B-reader interpreted the same film as negative for pneumoconiosis not having any parenchymal or pleural abnormalities consistent with pneumoconiosis. (Respondent's Exhibit No. 3, pp. 12-15).

Dr. Cristopher Meyer reviewed a PA and lateral chest x-ray of Petitioner dated August 22, 2013. He testified that the chest x-ray was Quality 1. Dr. Meyer testified that there was a calcified right paratracheal lymphnode that was consistent with granulomatous disease. The film was otherwise normal. Dr. Meyer testified that there were no

radiographic findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, pp. 41-42).

Dr. Meyer has been board certified in radiology since 1992. (Respondent's Exhibit No. 1, p. 8). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit No. 1, p. 21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Wiot was part of the original committee that designed the training program which is called the B-reader program. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer has recently been asked to have a more active academic role with the B-reader program. Dr. Meyer is on the ACR Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. (Respondent's Exhibit No. 1, p. 33). Dr. Meyer testified that radiologists have about 10% higher pass rate on the B-reading exam than other specialities. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between a 0/1 and 1/0 film. (Respondent's Exhibit No. 1, pp. 35-36).

Dr. Meyer testified that the B-reader looks at the lung to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 1, pp. 23-24). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. (Respondent's Exhibit No. 1, pp. 29-30). The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. (Respondent's Exhibit No. 1, p. 24). The last component of the interpretation is the extent of the lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, pp. 24-25). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, pp. 31-32).

Dr. David Rosenberg conducted a review of medical records and films regarding Petitioner at the request of Respondent's counsel. (Respondent's Exhibit No. 2, p. 11). He has been board certified in internal medicine since 1977. After graduating from medical school he did a pulmonary fellowship at the National Institutes of Health in Bethesda, Maryland. He received his board certification in pulmonary disease in 1980. (Respondent's Exhibit No. 2, pp. 4-5). In 1995, he received his board certification in occupational medicine. (Respondent's Exhibit No. 2, p. 5). Dr. Rosenberg has been a B-reader since July 2000. Dr. Rosenberg is a member of the American Thoracic Society, the American College of Chest Physicians and the American College of Occupational and Environmental Medicine. (Respondent's Exhibit No. 2, p. 7). Dr. Rosenberg has

lectured by invitation on a number of subjects through the years. These topics would include interstitial lung disease, chronic obstructive lung disease, pulmonary stress testing, pulmonary function testing, exercise testing and occupational lung disease. (Respondent's Exhibit No. 2, pp. 9-10).

Dr. Rosenberg reviewed a chest x-ray of Petitioner dated August 22, 2013. Dr. Rosenberg found no micronodularity on the film. He noted some granulomatous changes. He found no abnormalities consistent with pneumoconiosis. (Respondent's Exhibit No. 2, p. 19, Deposition Exhibit B). Dr. Rosenberg testified that coal workers' pneumoconiosis is a tissue reaction to the coal dust in the airways or in the lung parenchyma. This tissue reaction can be called scarring or fibrosis. (Respondent's Exhibit No. 2, p. 31). Dr. Rosenberg testified that most individuals with simple pneumoconiosis have preserved lung function. On a microscopic basis, if scar tissue were laid down in normal structures, in a theoretical sense that area would not be working correctly. (Respondent's Exhibit No. 2, pp. 32-33). Dr. Rosenberg testified that Petitioner had a history of atrial fibrillation and cardiomyopathy. Petitioner had shortness of breath which was outlined in association with the atrial fibrillation. Dr. Rosenberg testified that Petitioner did not have chronic respiratory complaints outlined in the medical records that he reviewed. Dr. Rosenberg testified that Petitioner's pulmonary function tests revealed no obstruction or restriction and his diffusing capacity when corrected for lung volumes was normal. Dr. Rosenberg testified that the x-ray interpretations in the medical records he received did not outline micronodular changes. (Respondent's Exhibit No. 2, pp. 19-20).

Dr. Rosenberg testified that Petitioner developed a very fast heartbeat which was abnormal and put a very severe strain on the heart. The heart was not pumping well which is cardiomyopathy. He testified that the faster the heart would beat the less blood would flow resulting in further damage. He testified that once the heart is back into a normal rhythm, sometimes the heart muscle improves. Petitioner had a New York Heart Association Classification of III for his heart problem. This meant that with minimal exertion he would be symptomatic, predominantly with shortness of breath. (Respondent's Exhibit No. 2, pp. 20-21). Dr. Rosenberg testified that Petitioner had a 10 to 20% ejection fraction at the time of his diagnosis of atrial fibrillation. Once Petitioner went through his cardioversion, his condition improved. His ejection fraction slowly improved up to around 55%, which is essentially normal, as of the last echocardiogram in 2013. (Respondent's Exhibit No. 2, pp. 20-21). Dr. Rosenberg testified that Petitioner's subjective complaints of shortness of breath and exercise limitation improved after treatment of his heart condition. (Respondent's Exhibit No. 2, p. 22).

Dr. Rosenberg testified that based upon the pulmonary function test results obtained by Dr. Paul in October 2013, Petitioner was capable of heavy manual labor. He had no

impairment from a pulmonary perspective. There was no evidence of obstruction or restriction on that testing. Dr. Rosenberg also reviewed testing that was performed at Methodist Hospital on July 27, 2015. Dr. Rosenberg testified that there was no significant change between the tests of October 2013 and July 2015. (Respondent's Exhibit No. 2, p. 22).

Dr. Rosenberg testified that to do a proper reading of a film for the presence of black lung, one needs to have a quality film that is adequate for interpretation. The reader then looks at the lung fields to determine if there are any micronodular changes related to the past coal mine dust exposure. The reader is supposed to note the opacity type and the intensity of the change, which is called the profusion. Dr. Rosenberg testified that the profusion directly correlates with the extent of the disease, and it correlates generally with the amount of dust exposure which has taken place. (Respondent's Exhibit No. 2, pp. 23-24). Dr. Rosenberg testified that it is unlikely for a simple pneumoconiosis to progress once the exposure ceases. Dr. Rosenberg is in agreement with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. Dr. Rosenberg testified that there was not any pathologic evidence of pneumoconiosis in Petitioner. (Respondent's Exhibit No. 2, p. 24).

Dr. Rosenberg testified that in addition to his cardiac condition, Petitioner was obese. At the time of Dr. Paul's pulmonary function assessment in October of 2013, he weighed 242 pounds and was 69 inches tall resulting in a BMI of 35.7. Dr. Rosenberg testified that obesity is present when BMI is greater than 30. Dr. Rosenberg noted in the medical records that he reviewed that Petitioner's lungs were clear on auscultation. (Respondent's Exhibit No. 2, p. 25). Dr. Rosenberg testified that studies have shown that at autopsy on long term coal miners, a significant number have pathologically apparent coal workers' pneumoconiosis that had not been diagnosed by radiograph during their life. Dr. Rosenberg testified that notwithstanding the negative chest x-rays regarding Petitioner, it could not be ruled out that he could still have coal workers' pneumoconiosis pathologically. (Respondent's Exhibit No. 2, pp. 47-48). Dr. Rosenberg testified that with significant tobacco use, individuals develop linear opacities. He testified that the S, T and U are opacities that can be seen with significant smoking history. He testified that Petitioner had a significant smoking history in the past. He further testified that there is a direct correlation between emphysema and smoking. (Respondent's Exhibit No. 2, pp. 48-49).

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. An EKG was performed on Petitioner on January 18, 2010, and was interpreted as revealing an abnormality. (Respondent's Exhibit No. 5, p. 196). Petitioner was seen on February 9, 2010, at which time it was recorded that he had been experiencing chest

discomfort over the past several months. He denied any shortness of breath with the chest pain. The history noted he was a former smoker. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs to be clear to auscultation. The doctor reviewed the ECG and indicated that same was suggestive of an old inferior wall myocardial infarction. (Respondent's Exhibit No. 5, pp. 190-193).

An EKG on March 25, 2011, revealed atrial fibrillation. (Respondent's Exhibit No. 5, p. 184). Petitioner was seen on March 28, 2011. He reported a two month history of increasing shortness of breath. Petitioner's review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs were clear to auscultation. The diagnoses included atrial fibrillation, atrial flutter, shortness of breath and anti-coagulation. (Respondent's Exhibit No. 5, pp. 174-177). Petitioner underwent an echocardiogram on March 29, 2011, which revealed an ejection fraction of 35 to 40% with rapid atrial fibrillation. (Respondent's Exhibit No. 5, p. 172-173). Petitioner was seen on April 4, 2011. Although his medication to address the atrial fibrillation had been increased, Petitioner reported that over the prior week he felt like he had been gradually worsening in terms of shortness of breath. He reported that on minimal exertion he felt winded and had to stop and rest to recover his breath. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs to be clear to auscultation. The diagnoses were atrial fibrillation, shortness of breath and anti-coagulation. The doctor charted that he suspected Petitioner's cardiomyopathy was related to his rapid ventricular response. The doctor recommended proceeding with a transesophageal echocardiogram guided cardioversion. (Respondent's Exhibit No. 5, pp. 160-163).

Petitioner was admitted to St. John's Hospital on April 4, 2011. On April 5, 2011, a cardioversion was performed and atrial fibrillation occurred within one minute. A second electrical cardioversion was performed on April 6, 2011, and Petitioner was successfully converted to sinus rhythm. At the time of discharge on April 8, 2011, he was in sinus rhythm. (Respondent's Exhibit No. 5, pp. 148-150). Petitioner was restricted from work until May 9, 2011.. Dr. Issa completed an Attending Physician's Statement on April 11, 2011, indicating that Petitioner's diagnosis was atrial fibrillation and that same was not due to injury or sickness arising out of his employment. (Respondent's Exhibit No. 5, p. 134). On June 9, 2011, Petitioner reported that over the last few weeks he had been feeling much better than before. He was regaining his energy and was being more active without exertional chest pain or shortness of breath. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs were clear to auscultation. (Respondent's Exhibit No. 5, pp. 95-99). An echocardiogram was performed on June 13, 2011, and revealed that Petitioner had a normal ejection fraction in excess of 55%. (Respondent's Exhibit No. 5, pp. 93-94). Petitioner was seen on June 20, 2011, at which time it was charted that Petitioner had felt great since the cardioversion.

He denied shortness of breath. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs clear to auscultation. (Respondent's Exhibit No. 5, pp. 87-90).

Petitioner was seen on February 1, 2012. At that time it was charted that Petitioner was feeling quite well and had regained most of his energy. He was able to exercise and be active for 15 to 20 minutes at a time without shortness of breath. Physical examination of the chest revealed the lungs were clear to auscultation. (Respondent's Exhibit No. 5, pp. 75-78). Petitioner was seen on June 4, 2012. Petitioner described himself as being moderately active during work and in maintaining his property. Review of systems respiratory revealed no chronic cough. (Respondent's Exhibit No. 5, pp. 70-73). Petitioner was seen on April 16, 2013. He reported over the last year he had been doing well. He was not very active and had been gaining weight but denied shortness of breath. Review of systems respiratory revealed no chronic cough. Physical examination of the chest revealed the lungs were clear to auscultation. (Respondent's Exhibit No. 5, pp. 54-57). Petitioner returned for follow up on October 30, 2013. He remained active and was not limited by dyspnea or chest pain. On review of systems respiratory, Petitioner denied chronic cough. On examination his chest was clear to auscultation. (Respondent's Exhibit No. 5, pp. 33-36). Petitioner was seen for follow up on June 24, 2014. Overall he was doing well. He again denied chronic cough on review of systems respiratory. His chest was clear to auscultation. (Respondent's Exhibit No. 5, pp. 25-29). Petitioner returned for follow up on February 5, 2015. Over the last year Petitioner had been relatively active and denied any exertional chest pain or shortness of breath. He continued to deny any chronic cough and his chest was again clear to auscultation. (Respondent's Exhibit No. 5, pp. 16-19). Petitioner followed up on August 12, 2015. He reported feeling very well over the past several months. He stated he had started exercising to try to lose some weight. He denied any shortness of breath. His chest was clear on auscultation. (Respondent's Exhibit No. 5, pp. 7-10).

Medical records from Springfield Clinic were admitted into evidence. On February 10, 1981, Petitioner completed a patient questionnaire wherein he denied asthma or pneumonia. He did not indicate suffering from chronic cough or shortness of breath. He admitted to smoking a pack of cigarettes per day. Physical examination of the chest revealed the lungs to be clear. It was recommended that Petitioner stop smoking. (Respondent's Exhibit No. 6, pp. 402, 406-409). Petitioner was seen on January 21, 1982, with bronchitis symptoms. He had productive cough with yellow-green sputum. Petitioner had a few coarse rhonchi in both lung fields. The assessment was bronchitis secondary to smoking and working in a coal mine. (Respondent's Exhibit No. 6, p. 402). Petitioner was seen on January 15, 1985, at which time he complained of numbness in his right toes of two months duration. It was charted that he smoked a pack of cigarettes per day. (Respondent's Exhibit No. 6, p. 400). Petitioner was seen on December 1, 1997,

without any significant complaints. The doctor charted that he believed Petitioner was smoking at that time. Physical examination of the chest revealed the lungs were clear to percussion and auscultation. (Respondent's Exhibit No. 6, p. 396). Petitioner was seen on February 13, 2003, with an upper respiratory infection that he had had for one week. He related coughing occasionally, but no shortness of breath. He was noted to be a former smoker. Physical examination of the chest revealed the lungs were clear to auscultation. The assessment was sinusitis. (Respondent's Exhibit No. 6, p. 392).

Petitioner underwent a chest x-ray on October 3, 2006, at which time same was interpreted as revealing some subsegmental atelectasis in the left mid lung field but otherwise normal. (Respondent's Exhibit No. 6, p. 313). Petitioner underwent a chest x-ray on December 12, 2007. The impression was no acute pulmonary abnormality. (Respondent's Exhibit No. 6, p. 301). Petitioner was seen by Dr. Icaza for repeat colonoscopy on February 12, 2008. At that time physical examination of the chest revealed the lungs clear to auscultation and percussion. (Respondent's Exhibit No. 6, pp. 379-380). Petitioner completed a patient history on March 21, 2011, in which he denied smoking. He also denied asthma, bronchitis and emphysema. (Respondent's Exhibit No. 6, pp. 154-155).

Petitioner completed a Medical History Update on March 25, 2011, in which he related shortness of breath. (Respondent's Exhibit No. 6, p. 151). Petitioner was seen by Dr. Byers on said date, at which time Petitioner complained of shortness of breath and fatigue. He noticed this happening more over the last month. His shortness of breath was worse with exertion. Physical examination of the chest revealed the lungs to be clear. It was noted that Petitioner had an irregular heartrate and rhythm, but his EKG failed to reveal atrial fibrillation. The assessment was shortness of breath. (Respondent's Exhibit No. 6, pp. 149-150). A chest x-ray performed on the same was interpreted as revealing mild emphysema. (Respondent's Exhibit No. 6, p. 300). Petitioner was seen on December 30, 2011, with complaint of neck pain on the right side. He also related a runny nose and some facial pressure on the right side of his neck. Physical examination of the chest revealed the lungs were clear to auscultation bilaterally. Assessment was lumbago and acute cervical lymphadenitis. (Respondent's Exhibit No. 6, pp. 137-138). Petitioner was seen on May 4, 2012, regarding multiple medical issues. Petitioner denied shortness of breath. His lungs were clear on examination. (Respondent's Exhibit No. 6, pp. 130-131). Petitioner was seen on May 7, 2012, by Dr. Byers for what was stated to be a checkup of multiple health problems. The doctor charted that Petitioner was going to be retiring at the end of the summer and was in for a general checkup. He had no complaints. He no longer smoked cigarettes, which apparently he did for 40 years. He was quite vigorous trying to keep his acreage under control and thought he would be more than busy in retirement. (Respondent's Exhibit No. 6, pp. 128-129). Petitioner was seen by Dr. Byers on September 20, 2013, for a six month check of hypertension and other medical issues.

Review of systems was negative. He had no cough or shortness of breath. It was noted that he had been a two pack per day smoker but quit about 20 years prior. On examination the lungs were clear to auscultation. (Respondent's Exhibit No. 6, pp. 82-83). Petitioner was seen on September 23, 2014. Physical examination of the chest remained clear to auscultation. He was not smoking at that time. He was riding a bicycle and had dropped four pounds. (Respondent's Exhibit No. 6, pp. 35-36). Petitioner was seen on December 4, 2015, for a six month checkup. Overall, he was doing well. His lungs were clear to auscultation. (Respondent's Exhibit No. 6, pp. 18-19).

Conclusions of Law

Issue (c): Did an occupational disease occur that arose out of and in the course of Petitioner's employment with Respondent?

Issue (f): Is Petitioner's current condition of ill-being causally related to his occupational exposure?

Petitioner has failed to prove by a preponderance of the evidence that he has an occupational disease arising out of and in the course of his employment.

The only occupational diagnosis that Dr. Paul or any other expert made for Petitioner was pneumoconiosis. The diagnosis of coal workers' pneumoconiosis is made based on either an x-ray interpretation or pathological findings. In this case there was no pathology evidence so the Arbitrator must rely on the x-ray interpretations to determine whether Petitioner has proven the presence of coal workers' pneumoconiosis. The Arbitrator finds the x-ray interpretations by Dr. Meyer, Dr. Rosenberg and NIOSH to be more credible than the interpretations by Drs. Smith, Alexander and Paul. Dr. Paul's interpretation was simply not credible. He did not know the date of the film he reviewed or give it a profusion rating. Dr. Paul described the opacity type as "coal" and indicated that it could be different shapes. Dr. Paul is not board certified in pulmonary disease although said board certification was first recognized in the 1940s. Dr. Paul testified that there was not pulmonary fellowship at the time he did his fellowship in asthma, allergy and immunology. Dr. Paul is not an A-reader or B-reader. Dr. Rosenberg testified that to do a proper reading of a film for the presence of black lung, one should know the opacity type and the profusion. The opacity type refers to the shape of the abnormalities. Dr. Meyer testified that specific occupational lung diseases are described by specific opacity type. Coal workers' pneumoconiosis is characteristically described by round opacities. Coal workers' pneumoconiosis is a tissue reaction to coal dust in the lungs. It is the scarring caused by this tissue reaction that is observed on chest x-ray not the actual dust.

The chest x-rays reviewed by NIOSH spanned from 1974 to 2007. During that time three B-readers interpreted chest x-rays for Petitioner as having opacities consistent with coal workers' pneumoconiosis, however, they still found the chest x-rays to be negative, assigning an 0/1 profusion. Although the most recent NIOSH chest x-ray was taken more than five years before Petitioner's date of last exposure, same confirmed that Petitioner did not have coal workers' pneumoconiosis after 30 plus years of working in the coal mine. It is unlikely that he would develop same in the last five years of coal mine employment. The opacities seen by the B-readers on the chest x-rays of 2005 and 2007 were consistent with the linear opacities seen with a significant smoking history. Petitioner has produced no evidence to contradict the negative NIOSH B-readings. The Arbitrator notes that if the NIOSH B-readings are set aside, then the record contains two B-readings which are negative and two B-readings which are positive for pneumoconiosis. Petitioner must prove his claim by a preponderance of the evidence. Liability cannot rest upon a choice between two views equally compatible with the evidence. *Rittler v. Industrial Comm'n*, 351 ILL 338 (1933).

The treatment records admitted into evidence and that were reviewed by Dr. Rosenberg document Petitioner's extensive history of an underlying cardiac condition with atrial fibrillation and cardiomyopathy. Dr. Rosenberg testified that Petitioner's shortness of breath was related to this cardiac condition. No treating physician ever related Petitioner's pulmonary complaints to his exposures in the coal mine.

Issue (o): **Other: Whether Petitioner proved timely disablement pursuant to Sections 1(e) and (f) of the Occupational Diseases Act?**

The Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence a timely disablement as defined in Section 1(e) of the Occupational Diseases Act.

To prove disablement under the Act, Petitioner must show that he suffered an impairment in the function of the body or the event of becoming disabled from earning full wages as a coal miner as a result of an occupational disease. Petitioner must prove that but for his occupational lung disease, he would have continued in his coal mining employment. *Dawson v. Workers' Compensation Comm'n*, 382 Ill. App. 3d 581 (5th Dist. 2008). Petitioner was performing his job duties in the coal mine until he opted to take his retirement upon reaching age 62. There was no evidence in the record that any physician took Petitioner off work as a result of an occupational disease. Dr. Rosenberg testified that based on the pulmonary function test results that he reviewed, Petitioner would be capable of heavy manual labor.

Petitioner testified that he first noticed breathing problems about the age of 40. He testified that from the time he first noticed them until he left the mine his breathing

problems got worse. He testified that they have continued to worsen since leaving the coal mine. The spirometry performed on Petitioner by Dr. Paul and at Methodist Hospital were normal. Petitioner had the respiratory capacity to perform his previous coal mining employment duties. Dr. Rosenberg noted that Petitioner's complaints of shortness of breath and exercise limitations improved over time following his successful cardioversion.

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

At the time of Dr. Paul's examination Petitioner complained of shortness of breath going up one flight of stairs or walking half a mile. Dr. Paul testified that Petitioner's chest exam was normal. Dr. Paul testified that Petitioner's spirometry was normal. Dr. Rosenberg testified that based on the pulmonary function test results obtained by Dr. Paul in October 2013, Petitioner was capable of heavy manual labor. Dr. Rosenberg testified that there was no significant change between the testing in October 2013 and the testing performed at Methodist Hospital in July 2015. Dr. Rosenberg testified that Petitioner's pulmonary function tests revealed no obstruction or restriction and his diffusing capacity when corrected for lung volumes was normal.

Pursuant to Section 8.1b(b) of the Illinois Workers' Compensation Act, 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 shall render a permanent partial disability impairment rating which shall include an evaluation of medically defined and professionally appropriate measurements of impairment and any the other measurements that establish the nature and extent of the impairment. The most current condition 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) The Commission shall base its determination of permanent partial disability 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) The evidence of disability corroborated by the treating medical records.

The Act provides that no single enumerated factor shall be the sole determinant of disability. In accord with Section 8.1b(b) of the Act, the Arbitrator considered the following factors in reaching his decision regarding permanent partial disability benefits.

With regard to subsection (i) of Section 8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a coal miner at the time of his last exposure. No physician disabled him from working as a coal miner due to an occupational disease. The Arbitrator notes that Petitioner voluntarily retired from his work in coal mining and has not sought any type of employment since his retirement. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the Arbitrator notes that Petitioner was 62 years old at the time of his last exposure to the hazards of an occupational disease. Since Petitioner has reached retirement age and is not seeking employment, the Arbitrator gives no weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner voluntarily retired from his coal mining employment. Based on the objective testing, from a pulmonary standpoint Petitioner was capable of heavy manual labor. Because Petitioner has retired and is not seeking future employment, the Arbitrator gives no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the medical records do not reveal any prior or ongoing treatment related to an occupational lung disease. The Arbitrator notes that Petitioner's complaints of shortness of breath resolved with treatment of his cardiac condition. Because of the lack of corroborating treatment records, the Arbitrator gives no weight to this factor.

Based on the above factors and the record taken as a whole, the Arbitrator finds that Petitioner has failed to prove entitlement to permanent partial disability benefits.

Petitioner's claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martin Tate,
Petitioner,

vs. No. 12 WC 36788

YRC Worldwide,
Respondent.

18IWCC0481

DECISION AND OPINION ON REVIEW

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

On August 13, 2012, Petitioner, a 58-year-old over-the-road truck driver, was injured in a motor vehicle accident. At that time, Petitioner's partner was driving their truck and Petitioner was sleeping in a berth behind the driver's seat. Although Petitioner was covered by a safety net, he was tossed back and forth during the accident. As Petitioner tried to stand up, the truck stopped abruptly and he fell backward, striking his right hip and the back of his head. At the emergency room, Petitioner was diagnosed with a neck strain.

Subsequently, Petitioner complained of and was treated for pain to his neck, low back, knees and right hip. He also claimed he developed post-traumatic stress disorder ("PTSD") from the occurrence. He was prescribed medications, underwent physical therapy, and was referred to specialists. In addition to seeing his primary physician, Dr. Rose, Petitioner treated with Dr. Westin for his knee and right hip injuries. He saw psychologist Dr. Ideran, and neurologist Dr. Wright. He saw naprapath Dr. Greer, and orthopedic physician Dr. Gupta.

18 IWCC0481

Petitioner complained to Dr. Westin of being "messed up" psychologically. He developed a fear of being in a truck, and experienced anxieties, panic attacks and occasional crying spells. Although Petitioner had been previously diagnosed with PTSD related to his military service decades earlier, he claimed his work accident worsened that condition. Petitioner testified it took him two years after his accident before he was able to get behind the wheel of a car again.

At the time of his accident, Petitioner held bachelor's degrees in horticulture and industrial technology, and had received training as an aircraft mechanic and a chef. Following his accident, Petitioner returned to school and attained a bachelor's degree in psychology, and he expressed interest in pursuing an advanced degree. He testified that no treating doctors released him to full duty work, but he also testified that no doctors were keeping him off work.

In December 2012, Respondent offered Petitioner a job in a Transitional Work Program which would accommodate his restrictions. Petitioner declined that job offer because it was conditioned upon him authorizing Respondent's agents to have *ex parte* communications with his doctors, contrary to the holding of *Petrillo v. Syntex Laboratories, Inc.*, 148 Ill. App. 3d 581, 499 N.E.2d 952 (1st Dist. 1986). Because Petitioner refused to accept that offer, Respondent terminated his temporary total disability benefits. Petitioner has not worked or looked for work since his accident.

Prior to August 13, 2012, Petitioner was diagnosed with and treated for both mental and physical problems. Approximately one year before his accident, he had begun treatment at the Jesse Brown VA Medical Center for mental issues which included anger, PTSD, Adjustment Disorder and Recurrent Major Depressive Disorder. In his therapy sessions prior to his accident, Petitioner expressed anger and frustration with his employer and the stupidity of other drivers.

Some of Petitioner's physical problems date back to his time in the military. Petitioner admitted he experienced back pain going back to that time; he required a back injection in the 1990's. He has suffered from chronic neck pain since undergoing a cervical fusion in 1999. Petitioner provided a history to Dr. Cummings of left arm numbness and tingling, and right leg shooting pains and numbness, since 2003.

Petitioner also reported a history of chronic, sharp scrotal pain, dating back 25 years to an injury he sustained while in the military. He underwent scrotal surgery related to that injury in the 1990's, but that surgery only reduced his pain for a few years. In late 2011, Petitioner was referred to a pain management physician for his scrotal pain, which at that time Petitioner rated as being 8/10 baseline, occasionally escalating to 10/10. That pain was worsened with prolonged sitting and especially when he drove long distances. Prior to his August 2012 accident, Petitioner expressed a desire to quit his job and begin a new career.

Petitioner alleges the Arbitrator erred by: (1) finding that his mental health condition was not causally related to his work accident; (2) finding that his knee and right hip conditions were not causally related to his work accident, and (3) denying temporary total disability benefits after December 11, 2012. Petitioner also seeks medical expenses and additional permanent partial disability benefits relating to those denied injuries.

Petitioner's Mental Health Condition

The evidence is clear that prior to Petitioner's work accident, he was diagnosed with and was receiving treatment for mental health issues including anger, depression, panic disorder and PTSD. Petitioner himself admitted that prior to his work accident, he experienced trouble sleeping, nightmares, flashbacks, headaches and neck tension – symptoms which he claimed were caused or aggravated by his August 13, 2012 accident. The Commission finds Petitioner's work accident did not cause or aggravate these pre-existing conditions.

Petitioner did report anxiety about driving at some of his post-accident therapy sessions. However, those post-accident reports lessened in frequency and his sessions returned to discussion of the same issues he had been dealing with prior to his August 13, 2012 accident.

For the reasons stated by the Arbitrator, the Commission affirms the Arbitrator's finding that Petitioner failed to prove his PTSD and any personality change were caused or aggravated by his August 13, 2012 accident. In reaching this conclusion, the Commission has also considered Petitioner's questionable credibility. The medical histories he provided to his doctors contained exaggerations, misrepresentations and omissions. Petitioner failed to inform Dr. Brietzke of his significant prior mental health issues for which he was receiving treatment. He told Dr. Wright his headaches began after his August 13, 2012 accident and that he had no prior significant history of headaches. This is contradicted by Dr. Cummings record of February 20, 2013, documenting Petitioner's admission of experiencing three-times-a-week headaches for the past ten years. Petitioner also provided Dr. Gupta with an inaccurate history, telling that doctor that his pains in his back, leg, neck and arm began after a motor vehicle accident in which he was the driver.

In sum, Petitioner failed to accurately report all of his past medical symptoms and conditions to his treating doctors and medical experts, who based their causation opinions on the history Petitioner gave them. Because of that, the Commission finds their opinions unpersuasive.

Petitioner's Knee and Right Hip Conditions:

The Arbitrator found that Petitioner had significantly advanced, pre-existing degenerative changes in his knees. Neither the ambulance records nor the initial emergency room records on the day of accident documented any complaints of knee pain. The Arbitrator made no express causation finding regarding Petitioner's right hip condition. The Commission finds Petitioner had pre-existing problems not only with his knees, but also with his right hip, of which he complained of pain and swelling since he was in the military. Prior to his accident, Petitioner had also been diagnosed with hip arthralgia.

The Commission finds Petitioner proved he sustained temporary aggravations of his pre-existing bilateral degenerative knee conditions. Although he did not report knee pain on the day of his accident, he did so a few days later, at the University of Chicago Medical Center. Petitioner treated with Dr. Westin for his knee problems between September 10, 2012 and December 7, 2012. Dr. Westin diagnosed right knee medial compartment arthrosis aggravated by direct trauma, and prescribed physical therapy and a brace. He authorized Petitioner off work until January 21, 2013.

The Commission finds Petitioner proved he developed right hip bursitis and, based upon photographic evidence, a right hip contusion. Dr. Westin provided treatment to Petitioner's right hip, recommended therapy and administered an injection. Respondent's Section 12 expert, Dr. Troy, acknowledged that Petitioner's right hip greater trochanteric bursitis was traumatically induced, but he also found that it had resolved by November 13, 2012. The Commission finds Dr. Troy's opinion credible.

Petitioner's Medical Expenses:

The Arbitrator awarded Petitioner medical expenses from August 13, 2012 through December 24, 2012, except the costs associated with Petitioner's mental health treatment, for which the Arbitrator found Respondent not liable.

The Commission affirms the Arbitrator's award of medical expenses, for the reasons stated in the Arbitrator's decision. Treatment related to Petitioner's knees and right hip through December 2012 was reasonable and causally related to his accident. The Commission finds the conditions of Petitioner's knees and right hip after January 21, 2013 to not be related to his work accident.

Temporary Total Disability:

The Arbitrator awarded Petitioner temporary total disability benefits beginning on August 14, 2012 and ending on December 6, 2012, based upon Petitioner's refusal to accept light-duty work offered by Respondent on the latter date. However, the Commission finds Respondent's job offer, which was conditioned upon Petitioner agreeing to allow Respondent's agents to have *ex parte* communications with Petitioner's physicians, was not a *bona fide* offer. Petitioner's attorney sought to have this condition removed; however, Respondent did not respond to that request.

The Commission modifies the Arbitrator's award of temporary total disability benefits, and finds Respondent liable to pay Petitioner temporary total disability from August 14, 2012 through January 21, 2013 (22-6/7 weeks), the latter being the last date on which Dr. Westin reported Petitioner was unable to work. Petitioner never returned to see Dr. Westin after that. The Commission finds Petitioner attained maximum medical improvement on January 21, 2013. The Commission notes that shortly after that date, Dr. Troy opined Petitioner should be at MMI, and Dr. Hanlon also found Petitioner capable of working and likely capable of returning to his job in his former capacity.

Nature and Extent:

For the reasons stated in the Arbitrator's decision, the Commission affirms and adopts the Arbitrator's award of 15% loss of the right leg pursuant to §8(e), and 3% loss of the person as a whole pursuant to §8(d)2 of the Act. While the Commission has found that Petitioner did suffer aggravations of his bilateral knee conditions, those aggravations were temporary. The Commission finds the condition of Petitioner's knees after January 21, 2013 is not causally related to his August 13, 2012 work injury. Petitioner's right hip bursitis and contusion also resolved within approximately three months after his accident. Even after consideration of those injuries, the Commission finds the Arbitrator's award of permanent partial disability award to be appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed March 3, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is modified, and that Respondent pay Petitioner the sum of $901.93 per week, commencing on August 14, 2012 through January 21, 2013, totaling 22-6/7 weeks, that being the period of temporary total incapacity from work under §9(b) of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $39,800.00. 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 6, 2018

o-06/27/18
jdl/mcp
68

AUG 6 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

TATE, MARTIN
Employee/Petitioner

Case# **12WC036788**

YRC
Employer/Respondent

18IWCC0481

On 3/3/2017, 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:

1218 LAW OFFICES OF MARK SCHAFFNER
205 N MICHIGAN AVE
SUITE 2560
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
SUSAN E WALSH
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook) 18IWCC0481

☐ 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

Martin Tate
Employee/Petitioner

v.

YRC
Employer/Respondent

Case # **12** WC **36788**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **6/10/2016**. 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 **8/13/2012**, 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 **in part** to the accident.

In the year preceding the injury, Petitioner earned **$70,350.54**; the average weekly wage was **$1,352.90**.

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

Petitioner ***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 **$14,559.72** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,559.72**.

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d) 2 and 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 47.25 weeks, because the injuries sustained caused the 15% loss of the right leg and the 3% loss of the person as a whole, as provided in Sections 8(d)2 and 8(e) of the Act.

Respondent shall pay the Petitioner 16 3/7 weeks TTD, from August 14, 2012 through December 11, 2012, at the rate of $901.93 per week. Respondent will be given credit for any amounts previously paid.

Respondent shall pay for the medical treatment from August 13, 2012 through December 24, 2012, as it has been determined to be reasonably related and necessary medical treatment. The Respondent is not liable for costs associated with Petitioner's mental health treatment.

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

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

Deborah L. Simpson

Signature of Arbitrator

February 22, 2017
Date

MAR 3 - 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martin Tate,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 36788**
	)	
YRC Worldwide,	)	
	)	18IWCC0481
Respondent.	)	
	)	

CORRECTED FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 13, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury or was last exposed to an occupational disease that arose out of and in the course of the employment. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act. In the year preceding the injury the Petitioner earned $70,350.54, and his average weekly wage calculated pursuant to Section 10 of the Act was $1,352.90. The Respondent paid $14,559.72 in TTD benefits.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Were all the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid the appropriate costs for the reasonable and necessary medical services that were provided to the Petitioner; (3) Is the Petitioner entitled to TTD from August 14, 2012 through August 3, 2014 and maintenance from August 4, 2014 through April 28, 2016; (4) What is the nature and extent of the injury; and (5) Is the Petitioner entitled to penalties and attorney's fees.

STATEMENT OF FACTS

The petitioner was employed by Yellow Trucking beginning in 2003. Yellow merged with Roadway and became respondent YRC. Petitioner has been employed by respondent since the merger as an over the road truck driver. The Petitioner primarily drives 53 foot trailers. Occasionally he also drives trailers with "pups," he transports a dolly to hook the pup up to the trailer.

The petitioner testified that the duties of his job involved operating a large semitrailer truck, driving over the road long distances, climbing in and out of the truck and operating dollies in order to connect and disconnect trailers. Petitioner drives to a terminal to deliver the trailer or pick up a pup. He has to get out of the truck in the yard, disconnect the hoses, lower the dolly by cranking it up or down, disconnect the trailer and then get back in the truck and pull it away from the trailer. He then locates his next trailer and backs the tractor up to it, gets out of the truck and hooks the hoses and trailers to the tractor. The petitioner describes the operation of the trailers as being very heavy work.

On August 13, 2012 the petitioner was asleep in the sleeping berth located behind the driver's seat of the semi he and his partner were driving to California. The truck was being driven on Interstate 80 by his partner. Petitioner testified to being woken up as he was being tossed back and forth in the sleeping berth of the cab. It took him some time to orient himself as to what was happening. There was a net over him and he had difficulty getting out at first. He remembers trying to stand up and reach for the curtain. He was standing with his leg bent. He hit his head and his back. He finally got the curtain open and saw glass all over from the broken windshield. He stated he had his right foot planted on the ground; they hit something and came to an abrupt stop. Petitioner fell and hit his right hip on the berth, then fell back and hit the back of the truck with his head and back. Petitioner said he finally found his partner, who told him they were in an accident.

The petitioner was asleep when the accident happened so he did not know how the accident occurred. The petitioner offered into evidence the Iowa Department of Transportation Report of Motor Vehicle Accident. (PX 8) The report indicates that the truck in which petitioner was sleeping was pushed off the road by another motorist causing it to strike construction obstacles and barriers. Pictures taken following the accident demonstrate that there was damage to the truck, including a shattered window primarily the half of the windshield in front of the driver. Most of the glass remains intact but shattered, there appears to be a small amount of glass fragments on the dashboard in the second photo, the front bumper is torn off on the driver's side but appears to still be attached on the passenger side of the truck. The second trailer that was being hauled is laying on it's side on the road, but the trailer closest to the cab of the truck is still upright and appears to be hooked up. (PX 1)

The petitioner was transported by ambulance to the University of Iowa Hospital, where he was examined, x-rayed and subsequently released with instructions to follow up with his primary care physician when he returned to Chicago. According to the petitioner he complained only of his head and neck at the hospital and not his knee because he was lying down. The petitioner testified it took him several days to return to Chicago, as he had to wait for his employer to provide transportation from Iowa City to Chicago.

When he returned to Chicago, the petitioner sought further medical treatment at the University of Chicago Hospital emergency room on August 15, 2012. At the emergency room, the petitioner complained of pain in his right hip, right knee and low back. According to petitioner the pain was exacerbated by movement. X-rays were taken and the petitioner was released home with instructions to follow up with his physician. Petitioner noticed a bruise on his right hip and had a photo taken of the bruise. (PX 2)

On August 31, 2012, Dr. Purnendu Gupta saw the petitioner. The petitioner continued under the care of Dr. Gupta through October 12, 2013. Dr. Gupta first sent petitioner for physical therapy (August 31, 2012) then after a follow-up appointment on October 20, 2012 he ordered an MRI of his lumbar spine. Dr. Gupta also referred the petitioner for a neurology consultation, referred the petitioner for pain management treatment, referred the petitioner for physical therapy and finally, based upon the doctor's notation of possible Post Traumatic Stress Disorder (PTSD) referred the petitioner for psychiatric treatment. The petitioner testified that he stopped seeing Dr. Gupta in October 2013 when the respondent stopped paying for his treatment or benefits.

Dr. Gupta reported that in his opinion the petitioner suffered from a cervical thoracic and lumbar whiplash syndrome, with a C4-5 disc herniation. (PX 16) He further reported a diagnosis of PTSD, ataxia and headaches related to the motor vehicle accident. As of the date of the doctor's report, March 4, 2014, Dr. Gupta did not believe that the petitioner could return to work. The doctor's opinion was based, in part, on the doctor's conclusion that the petitioner was not yet at maximum medical improvement and required additional medical treatment. (PX 16)

Petitioner testified that while Dr. Gupta was treating the petitioner for his back injury, Dr. Craig Westin saw him for complaints of right knee and right hip pain. Dr. Westin first saw the petitioner on September 10, 2012. (PX 11) Dr. Westin ordered a period of physical therapy, which was completed at Illinois Bone and Joint Institute, recommended a knee brace for the right knee and on September 12, 2012 injected both the right knee and the right hip with xylocaine and kenalog. (PX 11)

According to the Petitioner, before the accident he could do his job. He could get up and drive, he did not think about the military or war when he was driving. After the accident, he did not drive, when he saw a truck or an accident he would freak out. He stated that he did not even drive a car for two years after the accident. According to the petitioner Dr. Gupta also referred petitioner for psychiatric treatment so petitioner contacted Genesis Therapy and was seen on one occasion by Michael Ideran. Michael Ideran saw the petitioner on November 27, 2012, at that time petitioner complained of inability to sleep, nightmares about the accident, and waking up in a cold sweat. He further reported being agitated while driving with others and feeling uncomfortable driving the family car. Michael Ideran concluded that petitioner was not

recovering well from the truck accident, which is triggering memories of previous accidents 15 years prior. Mr. Ideran referred the petitioner to a psychologist who specializes in PTSD. As of that date Michael Ideran recommended the petitioner not return to work. (PX 12)

After Mr. Ideran, the petitioner next went to Hope Enrichment Center, where he received treatment from December 19, 2012 through October 2, 2013. The petitioner complained to the therapist, Carrie Cherep that he had phobic responses to driving and to semi-trucks. He also complained of sporadic changes in mood and demeanor. The records of Hope Enrichment Center report that the petitioner reported increased fear of driving, tearfulness, moodiness, irritability, decreased sleep and hyper vigilance, among other symptoms. After initial evaluation, the therapist concluded that the petitioner was currently experiencing multiple symptoms of PTSD more than once a day. (PX 17) According to the petitioner therapy continued at Hope Enrichment Center until the workers' compensation carrier denied coverage and the petitioner's employer refused to pay for treatment at Hope Enrichment Center.

Based on the recommendations of the treating doctors, petitioner was also evaluated by Dr. Hilliard Slavich, a neurosurgeon on February 15, 2013. Petitioner testified that he saw him one time. Petitioner also saw Dr. Xie on August 21, 2013 and September 4, 2013 for evaluation of headaches, neck and back pain. Petitioner also had a consultation with Dr. Russell Wright at Rush University Medical Center for evaluation of his headaches.

After Dr. Gupta finished treating the petitioner due to petitioner having no insurance Petitioner was treated by Dr. Charles Greer at Sky Alternative Medicine and Laser Clinic between February 15, 2014 and September 12, 2014. The petitioner was seen by the doctor for low back pain and his right knee pain. According to the Petitioner he was seen there for thirty six sessions in which the doctor manipulated his back, massaged his lower back and stretched out his leg so he could move.

Petitioner testified that he had a fusion in his neck in 1999 but has had no treatment for his neck since recovering from that surgery until the accident in August of 2012. Petitioner testified that he had problems with his low back in the early 1990s and he had an injection for it. He stated that he has not had any issues with his back since 2000, until the accident in August of 2012. With respect to his right knee and hip he has had no previous treatment or lost time for injuries to those body parts.

Petitioner testified that he received a transitional work offer from the Respondent in December of 2012. This offer came after the petitioner had been examined by Dr. Daniel Troy at Midwest Orthopedics Consultants at the request of the respondent pursuant to Section 12 of the Act. The petitioner said he did not respond to it, he gave it to his attorney to handle. He did not accept the offer at the time, he was still under care from several doctors who had taken him

off of work. (PX 3, 4) Petitioner's attorney informed the respondent that the petitioner would not be reporting to work for the light duty that respondent was offering because his doctors did not recommend return to any work at the time due to petitioner's PTSD issues. He attached copies of the doctors letters. According to petitioner it was around this time that his workers compensation benefits were terminated.

Since the respondent no longer paid for benefits, the petitioner continued to seek treatment for his right knee and his psychological therapy from the Veterans Administration Hospital. Petitioner testified that the VA therapy sessions were not as helpful as the ones at Hope Enrichment Center.

At the request of Petitioner's attorney, he was examined by a psychologist, Dr. Colin Brieztke, Psy.D. on September 12, 2014. The doctor made a diagnosis of post-traumatic stress disorder and personality change due to head trauma. He opined that these conditions were causally related to the work accident. He further opined that Petitioner had not achieved MMI and recommend individual psychotherapy and pharmacotherapy to maximize his "ultimate level of recovery." Dr. Brietzke disagreed with Dr. Hanlon's opinion that Petitioner exhibited signs of a somatoform disorder. Petitioner was not allowed to return to work for "at least another 6 months pending therapy outcomes."

Petitioner testified that currently he still has anxiety and panic attacks, he "does not do trucks," he does not even get close to them. He claims he is working on getting better at it, because it was his life. His right knee and hip are in constant pain. He has a cane because he has a fear of falling because his knee and hip might give out. He also has chronic knee and low back pain. He has a stimulator unit for the knee and low back. His neck occasionally has spasms wherein he cannot move his head freely. He has headaches daily that come from the spasms, he feels them go up his neck to the top of his head. He stated that he never had headaches before the accident.

The petitioner enrolled in school on or about August 4, 2014 and completed a two-year program, resulting in his bachelor's degree in psychology. Petitioner received his degree on April 28, 2016. The petitioner testified that he is currently looking for employment.

The petitioner's wife, Ariajo Cobb-Tate, testified she and the petitioner have been married for twenty-seven years. They lived together before the accident and after the accident. She stated that she observed the petitioner being very agitated whenever he was a passenger in a vehicle or when their car came close to any trucks. She said that before the accident, the petitioner was the primary driver for the family, but after the accident, she or their children did the driving for about a year and a half. She stated that petitioner gets very emotional when in the car, especially when he sees trucks changing lanes.

Petitioner's Prior Medical History:

On August 5, 2011, Petitioner underwent a PTSD evaluation at the VA Hospital. He complained of nightmares and avoided situations which reminded him of his time in the military. He was constantly watchful and startled. He was referred to the Psychology Department for further evaluation.

Petitioner was interviewed by Pamela Lawson, LCSW, on August 19, 2011 for evaluation of his anger and panic attacks. He reported significant PTSD, depressive symptoms, anxiety, panic attacks and violent behavior. He would drink alcohol to self-medicate but indicated he was sober since 2007. Petitioner stated he was overwhelmed and wanted help. "I need to get help with my anger and understand why I am having so many problems." Petitioner and his wife were concerned that he would get into serious problems at work due to his anger issues. Petitioner described feeling on edge most of the time. He admitted to a depressed mood. He felt depressed 5-7 days per week. He was frustrated with his boss. He had racing and fleeting thoughts. He stated that he was not bipolar. His energy level was fair. He indicated that he isolated himself from people when he was very depressed. When asked whether he had repeated disturbing memories, thoughts or images of the stressful experiences from the past, Petitioner reported "quite a bit." When asked whether he had repeated disturbing dreams of experiences from the past, he said "extremely." He reported trouble sleeping, feeling irritable and angry outbursts. He described cold sweats from flashbacks/nightmares. Sometimes he was unable to sleep for 1-2 days. The less sleep he had, the worse he became. He had a little difficulty concentrating. He raised his voice throughout the evaluation. Current medical problems were: swelling testicles, headaches, panic attacks, neck tension and heart palpitations. He reported headaches 2 days per week due to anger. He had a panic attack the week prior. The panic attacks were characterized by strong heart palpitations, sweating and extreme anxiety. (PX 15)

In speaking about his past, Petitioner reported that his parents divorced when he was 8 years old. He witnessed his father physically abusing his mother. He was unable to show his mother affection. He was sent to the South at age six to leave with an aunt because he was misbehaving. His father and paternal uncle drank heavily. Petitioner stated that he had a run in with a security guard the day he entered the military at age seventeen. The security guard "pulled a gun on him. "I still remember when that security guard pulled a gun on me; I can't get it out of my head." He experienced many racially motivated incidents on the military base and while in the military. "Despite the fact that he sought help with these incidences, he received no help." He was declared AWOL once for being off the job due to an illness. He claimed that he was never allowed time off even when he was sick. On another occasion, he claimed marijuana was placed among his belongings in an attempt to frame him for drug possession. He was chased by Caucasians at a local Mississippi shop that sported a Confederate flag. He stated that the racism escalated and fueled his anger over time because he had not received the closure he needed. He

was transferred from Mississippi to Japan. Petitioner thought this new location would offer him a fresh start. While in Japan, he saw his friend killed. He witnessed a Japanese man set himself on fire at a demonstration protest. He saw a Japanese woman hanging from the rafters because an American solider would not marry her. Petitioner described his job in the military as "picking up bodies." He could not forget the horror associated with this. In the Philippines, he witnessed a fellow soldier with his throat cut. He wanted to make the military his career but he was forced out of the military prematurely and could not find a job. In 2010 in Utah, he had a severe panic attack and was rushed to the emergency room. Although he had frequent panic attacks prior to the incident in 2010, this was the first time he was diagnosed with panic disorder. He had bad experiences at other VA Hospitals where they did not care. He admitted that his problems were causing hardships for his family. (PX 15)

Petitioner's wife detailed his frequent anger outbursts. For example, Petitioner would throw objects in grocery stores and pushed police officers when he became angry. (PX 15)

The diagnosis was adjustment disorder, mixed anxiety/depression; post-traumatic stress disorder; major depressive disorder, recurrent, moderate; and alcohol abuse. He was referred to Dr. Eisenberg for psychotherapy due to anxiety, trauma, personality disorder and affective disorder. (PX 15)

Petitioner was evaluated by Dr. Eisenberg on August 19, 2011. It was noted that he was a veteran with significant anger problems starting during his service and continuing throughout his life. The anger issues were affecting his job and relationship with his family. The doctor recommended psychotherapy for anger management and PTSD. (PX 15)

On October 18, 2011, Petitioner underwent a psychotherapy session with Dr. Eisenberg at the VA Hospital. Petitioner was angry and blamed it on being discharged from and mistreated by the military. The police accused him of being drunk but he claimed that was not the case. Before that, in England, he was drunk on the street but did not do anything wrong; he was just waiting for a taxi. He dealt with dead bodies in the service. He admitted that he was not flexible and preferred to be alone. He would avoid conflict if he could but sometimes he got very "explosive." Dr. Eisenberg made a diagnosis of post-traumatic stress disorder as manifested by a strong sense of having been mistreated; recurrent and intrusive distressing recollections/dreams of the traumatic events; irritability; and anger outbursts. (PX 15)

During his session with Dr. Eisenberg on November 17, 2011, Petitioner talked about some of his frustration as an over-the-road trucker including the stupidity of other drivers on the road and the company for which he worked. He associated motor vehicle accidents to the burning of flesh in Japan during demonstrations. He had to call his wife frequently to calm down when things on the road got frustrating. He indicated that he had a BA in Industrial Technology and was an aircraft mechanic in the eservice for many years but could not get a job at O'Hare. He was interested in biofeedback as a way to relax. The diagnosis was PTSD. (PX 15)

Petitioner attended a psychotherapy session with Dr. Eisenberg on December 14, 2011. Petitioner reported that his trucking company was "playing games with him." He complained that they called his cell phone which he turns off when he is at home. He stated they "won't admit they made a mistake and he is insisting they pay him." Apparently, the company sent his partner on the road with someone else because he did not answer his phone. *(Petitioner denied making this statement when he was questioned about it on cross examination at the hearing on June 10, 2016)* He claimed that his aunt stole money from his father's estate. Lately, the aunt felt guilty and sent him information about a very small policy over which his brother was causing problems. Petitioner reported much frustration and stated that it reminded him of his time in the military. The diagnosis was PTSD. (PX 15)

During his psychotherapy session with Dr. Eisenberg on January 31, 2012, Petitioner discussed his frustration with his company policies. He felt that there was racism involved. He stated that the company made it hard for him to "do the work and get his money." He claimed that everything was difficult and he became irritable. He was not sleeping well. The diagnosis was PTSD. (PX 15)

On February 14, 2012, Petitioner's wife told Dr. Eisenberg that her husband was not sleeping well and he was irritable. He talked about his job, doctors and the world as though everyone were against him. He stated, "no one cares." He had groin pain for 25 years but no one took it seriously. He did not trust the doctors that they knew what they were doing or could do it right. He felt everyone on the job was harassing him. He stated "it is just like the military." He reported that the company did "stupid things". He felt that new illegal immigrants were treated better than him and he served his county. He was interested in attending biofeedback sessions. (PX 15)

During his session with Dr. Eisenberg on February 23, 2012, Petitioner reported a negative attitude toward misused authority and stated that he would speak negatively to police or anyone else if they said or did anything offensive. Just like the military, he stated, "they think they own you." He had big problems with his trucking company. He stated they try to "steal my money" and do all kinds of irrational and dangerous things. His wife wanted him to communicate with her and the kids more when he came home from a truck driving trip. Petitioner stated that he liked to unwind by himself. He reported that his son was in Iraq and he may have some difficulties from his time in the military. He was trying to find another job closer to home. (PX 15)

Petitioner attended a psychotherapy session with Dr. Eisenberg on March 6, 2012. He talked about the company he worked for and how "idiotic they were." He stated that no one knew what they were doing and he was constantly given the "run around". He was having nightmares about his military service and his "bad conduct" discharge. He stated that he wished he had his gun in 1984 when he was discharged and he could "find them all now." He felt the military did not deal with him honestly or fairly. Authority was not always a big a problem for

him as it was now. He stated he was looking for another job. He was angry and upset. He was in pain but would not let them do surgery as they have suggested for his back. (PX 15)

On April 12, 2012, Petitioner told Psychologist Payvar that he slept 3 hours at most. He complained of hip arthralgia and groin pain. He wanted help to manage his anger and pain. Some days he experienced "flashbacks of incidents while in the service." He reported unresolved and long-standing anger. Of concern was that his anger episodes were getting more regular, which tended to be every other day. Petitioner stated that "I don't want to get to the point where I hurt someone." (PX 15)

During his session with Dr. Eisenberg on May 1, 2012, Petitioner stated that he was upset with the military and they "destroyed" his records. He thought the doctors were stupid for wanting to cut the nerves around his testicle and he had not been compensated for the pain he experienced for 25 years. He described many situations in the military in which he could not function as they requested. He said he would not endanger himself for something "stupid" and it was the officers who were getting paid to take risks, not him. He experienced injustice and lack of fairness in the military. (PX 15)

Medical History Post Work Accident:

Petitioner was taken by ambulance to the University of Iowa Hospital & Clinic. According to his history, he was in a semi-cab when the driver lost control and the semi weaved back and forth. Petitioner was ambulatory at the scene and had no major discomfort. There was no loss of consciousness. He was not restrained because he was in the bed of the cab. "On arrival, [Petitioner was] speaking clearly and joking with staff." There was "no acute distress … seen lying in hospital bed, exam revealed a well-developed male." His prior medical history was significant for a cervical fusion at C4-C5. A CT of the cervical spine revealed anterior cervical fusion surgical changes from C5 through C7. The C5 and C6 vertebral bodies did not show any bony fusion. There were multi-level degenerative changes with areas of severe neuroforaminal stenosis. X-rays of the thoracic/ lumbar spine and right elbow were negative. The diagnosis was neck pain status-post motor vehicle accident. He was discharged with pain medications. (PX 10)

On August 15, 2012, Petitioner was evaluated at the emergency room at the University of Chicago. He complained of neck, knee and hip pain following a motor vehicle accident. The diagnosis was knee and hip pain. (PX 18)

X-rays of the right knee and right hip performed on August 16, 2012 revealed osteoarthritis without evidence of fracture. (PX 18)

Petitioner began treating with Dr. Gupta at Weiss Hospital on August 31, 2012. He gave a history of back, leg, neck and arm pain which started after a motor vehicle accident. He reported

that the neck pain was sharp, especially with movement. Dr. Gupta interpreted x-rays of the cervical spine as revealing evidence of a prior fusion at C5-C6 and C6-C7 which appeared to be solid. He had degeneration above and below these levels. He also had evidence of congenital stenosis. Lumbar radiographs demonstrated no fractures or subluxations. Likewise, thoracic spine x-rays were negative. The assessment was cervical, thoracic and lumbar whiplash syndrome which was work-related. He recommended physical therapy for his cervical, lumbar and thoracic spine and Petitioner was taken off of work through October 12, 2012. (PX 16)

Petitioner began physical therapy at the University of Chicago on September 7, 2012. It was noted that he presented with complaints of low back, cervical and right knee pain. (PX 18)

On September 10, 2012, Petitioner was evaluated by Dr. Westin at the Illinois Bone & Joint Institute at the request of Dr. Rose. At the time of the exam, he complained of pain over the greater trochanter area of the right hip. He stated that his right knee was sore anteriorally and medially. He complained of right elbow soreness laterally, especially in full extension. He admitted to a prior left knee arthroscopy in 2005. He had several procedures on his left upper extremity due to another accident and had a subsequent ulnar shortening and surgeries for his left ulnar nerve. Dr. Westin interpreted a repeat x-ray of the right knee as showing medial bone-to-bone arthrosis. The left knee x-rays revealed lateral patellofemoral bone-to-bone arthrosis. The medial joint space on the left knee was a little bit narrow but much better than the right. He received right hip and right knee injections. Dr. Westin concluded that he hoped to have Petitioner functional again without the need for a knee replacement. He was referred for physical therapy and restricted from driving. (PX. 11)

On September 25, 2012, Dr. Eisenberg made a diagnosis of post-traumatic stress disorder, subacute, as manifested by a strong sense of having been mistreated in the military. (PX 15)

Petitioner returned to Dr. Eisenberg on October 11, 2012 and gave a history of being in a work accident. He stated that he was sleeping in the back of the cab when his partner was cut off by another truck driver. His partner swerved into a construction zone and was able to get into an area in which there was no traffic. Petitioner stated that he would not drive a car and stated that he was receiving workers' compensation. He had been doing better in terms of his anger and family adjustment. He stated that things were back to where they were previously. He was not sleeping well. He related the way his company treated him to the way he was treated poorly in the service. (PX 15)

During Petitioner's psychotherapy session with Dr. Eisenberg on October 18, 2012, he reported that he was very angry about his trucking company and compared them to the military. He stated everyone is "full of shit" and out to hurt him. He complained the doctors have not been able to fix the pain in his groin and he was unable to have sex. He was not driving and indicated that he was not ready to drive a truck. He was trying to find a job driving in the city or another trucking alternative. He was very bitter. He felt that only if he inflicted pain on others would they understand his situation. The diagnosis remained PTSD. (PX 15)

On October 12, 2012, Dr. Gupta recommended a psychiatric evaluation. (PX 16)

A MRI of the cervical spine performed on October 20, 2012 revealed new trace retrolisthesis of C3 on C4 when compared to the prior MRI of March 15, 2010. There were stable post-surgical changes from the anterior cervical spine fusion between C5 to C7. There was complete osseous fusion across C6-C7 and partial osseous fusion ventrally at C5-C6. There was multi-level degenerative discogenic disease and facet arthrosis throughout the cervical spine resulting in varying degrees of central canal and bilateral foraminal stenosis which was stable. A MRI of the lumbar spine revealed partial sacralization of the left half of the L5 vertebral body. There were degenerative changes resulting in moderate central canal stenosis with moderate right foraminal stenosis at L4-L5 and mild central canal stenosis with mild left and mild/moderate right foraminal stenosis at L3-L4. There was mild subcutaneous edema within the posterior soft tissues of the lower back and upper buttock region. (PX 16)

Petitioner returned to Dr. Westin on October 22, 2012. He reported a couple of episodes in which his right lower extremity gave way. He stated that his knee and hip felt the same. The diagnosis was right knee medial compartment osteoarthritis. The doctor opined that he had not gained enough strength yet in the right knee. He believed the giving way was from the right knee bone-to-bone contact. The right hip x-rays looked good; however, there was bursitis. Dr. Westin recommended an unloader brace to reduce the giving away and some of the medial pain. (PX 11)

During his biofeedback session with Dr. Payvar on October 25, 2012, Petitioner reported that his main concern was the issue of anger management and fears arising from the recent motor vehicle accident in which he was a passenger. According to his wife, Petitioner was now fearful of being in the car as well as experiencing continued hypervigilance. (PX 15)

On November 8, 2012, Petitioner told Dr. Eisenberg that he experienced a lot of racial discrimination in the military. He felt that he was unfairly denied access to specialized jobs. He was not sleeping well and awoke sweating profusely. He did not remember his dreams most of the time. Sometimes he would run in his dreams. He admitted to threatening people who were violating him and stated that he "won't back down". He was encouraged to talk about the motor vehicle accident and about the military situations which he was treated unfairly. (PX 15)

As of November 8, 2012, Petitioner continued to complain of back and knee pain. Dr. Gupta interpreted the MRI of the cervical spine as revealing C4-5 stenosis with some cord changes particularly on the right side which was adjacent to his prior fusion. He interpreted the lumbar spine MRI as revealing no disc herniation but some multilevel spinal stenosis at L3-4, L2-3, which was very mild, and possibly at L4-5. Dr. Gupta opined that Petitioner had stenosis with a disc herniation at C4-5 along his prior fusion. With regard to his lumbar spine, he had some generalized stenosis but no other findings. The doctor recommended evaluation by a pain management specialist for his whiplash syndrome and additional physical therapy. He also recommended consultation with psychiatry. He was authorized off work for six (6) weeks. (PX 16)

Petitioner was reevaluated by Dr. Gupta on November 12, 2012. He had undergone four (4) weeks of physical therapy since his last visit. He complained of occasional knee pain. He reported neck pain which was aching and 10/10 in terms of intensity. It was worse with all upper extremity activity movements. He denied any arm symptoms, but noted ataxia which was significant. He had been unable to drive or sleep since the accident. On exam, he had a normal gait with good strength and balance with heel and toe walking. For bending, he was unable to reach past his knees. The doctor opined the Petitioner had persistent whiplash syndrome. He recommended additional physical therapy and a cervical MRI. He believed that the back pain with radicular pain into the knee could be caused by an L3-L4 disc herniation and recommended a lumbar MRI. Finally, Dr. Gupta recommended a psychiatric evaluation because it appeared that Petitioner had some elements of post-traumatic stress disorder. (PX 16)

Petitioner was evaluated by Dr. Daniel Troy, at the Respondent's request, on November 13, 2012. He gave a history of being asleep in the cab of a truck when the truck was forced off the road. He reported that he was tossed around; however, netting protected him from falling out of the bunk. At the time of the exam, he complained of neck pain, right significantly worse than left. He stated that his back continued to be symptomatic but was improving. His past surgical history was significant for a left knee arthroscopy in 2005; anterior cervical discectomy and fusion from C5 to C7; and surgeries for his right wrist and left upper extremity. X-rays of the pelvis revealed mild bilateral degenerative joint disease. X-rays of the lumbosacral spine revealed age-appropriate degenerative changes with well-maintained lordosis and disc spaces with no instability on flexion or extension. X-rays of the cervical spine were interpreted as revealing the presence of a C5 to C7 anterior cervical discectomy and fusion with significantly advanced degenerative changes at the C3-4, C4-5 and C7-T1 levels. No instability was noted with flexion and extension. X-rays of the right knee demonstrated bone-on-bone changes in the medial aspect with a secondary genu varum deformity. X-rays of the left knee revealed moderately advanced degenerative changes greatest along the medial tibiofemoral and patellofemoral compartments. The doctor interpreted the MRI of the lumbar spine taken on October 20, 2012 as revealing mild degenerative disc disease at L2-3 and L3-4. He interpreted the MRI of the cervical spine as revealing multiple pre-existing degenerative changes greatest at the C3-4, C4-5 and C7-T1 levels. The doctor opined that all findings were pre-existing with no traumatic pathology present. Dr. Troy further opined that, at most, Petitioner suffered a slight exacerbation of the pre-existing degenerative changes of the cervical spine. He recommended an additional six (6) weeks of physical therapy. With regard to the lumbosacral spine, Dr. Troy opined that Petitioner was most likely suffering from a lumbosacral strain which he believed would respond to therapy over the next four to six (4-6) weeks. Petitioner had no complaints regarding either shoulder. His symptoms were isolated to the trapezial and cervical areas. Dr. Troy opined that Petitioner's knee pain and symptoms were pre-existing. He had significantly advanced degenerative changes in the right knee greater than the left which was consistent with his complaints. Dr. Troy noted that Petitioner had no complaints of knee pain during his evaluation at the emergency room at University of Iowa Hospital. With regard to the right hip, Dr. Troy indicated that Petitioner developed a greater trochanteric bursitis which one

could argue was traumatically induced by the accident; however, it had resolved. With regard to Petitioner's claim of substantial vision loss, nothing on clinical examination suggested visual impairment. Dr. Troy observed Petitioner walking in his office and saw nothing to suggest problems with his vision. Likewise, petitioner did not make any comments regarding problems with his vision during the evaluation. Dr. Troy opined that petitioner could return to full-duty work following the completion of an additional six (6) weeks of physical therapy for his cervical and lumbar spine. Following additional physical therapy, he would achieve maximum medical improvement. If he was unable to return to full-duty work following additional physical therapy, the doctor suggested a FCE. In the interim, he was released to sedentary-light duty work with limited walking and standing. The doctor concluded that petitioner would continue to have intermittent neck pain secondary to the advanced degenerative arthritic changes in his cervical spine and would continue to have bilateral knee pain related to the pre-existing degenerative changes. (RX 1)

During his psychotherapy session on November 14, 2012, petitioner reported nightmares related to his time in the service. He was upset that he was arrested in Britain for nothing. He was told he did not have an ID and was drunk. He did not understand why "Bobbie's called his base. They should have just let me go." He was upset that he was not treated for alcoholism but they put it on his DD214. He no longer drank because he could talk to his wife. He was upset that he was discharged from the military after 11 years. They said he used "drugs" but the test was inconclusive. The doctor concluded that he was angry and upset about how he was treated in the military. He was not driving. The diagnosis remained PTSD. (PX 15)

In a physical therapy progress note dated December 17, 2012, petitioner reported no change in his pain. The therapist noted that he had not shown any significant improvement either objectively or subjectively despite consistent physical therapy for six (6) weeks. Therefore, it was recommended that Petitioner return to his doctor for consideration of a FCE. (PX 12)

During his therapy session with Dr. Eisenberg on December 12, 2012, petitioner stated that he was not sleeping. He had many memories of death and negative events since the work accident. While he was overseas in Okinawa, he reported seeing many negative events like people blowing up on base frequently. He stated that it was dangerous but that no one cared. (PX 15)

Petitioner was initially evaluated at Hope Enrichment Center by Carrie Cherap, a licensed clinical professional counselor, on December 19, 2012. He stated that he was a truck driver for over twenty (20) years. He stated that two (2) of his friends were killed two (2) months prior to his motor vehicle accident. With regards to the work accident, he stated that he was sleeping in the cab of the truck. At the time of the accident, he was tossed in the bunk. The therapist indicated that petitioner's mood was anxious and slightly depressed. He was having difficulty with his self-image due to not working. He reported an increased history of anger and outbursts. The diagnosis was chronic post-traumatic stress disorder. (PX 17)

On December 20, 2012, petitioner returned to Dr. Gupta and complained of back, neck and arm pain. He also complained of bilateral knee pain with a shooting pain into his legs. X-rays of the lumbar spine revealed degenerative scoliosis with apex to the left at L4-5. Very minimal slippage was noted at L4-5 with disc degeneration at L4-5 and L5-S1. Cervical spine x-rays revealed significant facet arthropathy. Cervical disc degeneration was noted particularly at C3-4 with complete loss of disc height. Dr. Gupta recommended additional pain management and a neurology consultation due to petitioner's complaints of ongoing headaches and neck pain. (PX 16)

During his therapy session with Dr. Eisenberg on December 21, 2012, petitioner reported that he was applying for service-related disability benefits. He admitted to a recent incident in which he drank to excess and was laid out in the backyard of his niece's house. His wife was trying to understand more about PTSD so she could help her husband and help the children understand why their father was so isolated all of these years. Although he had attended college, petitioner wanted to drive a truck to minimize the number of people with whom he would have to interact. His anger went to extremes out of nowhere. He did not care who he had to confront. Petitioner understood that he was using alcohol to help to avoid his thoughts and feelings. Lately, he had been talking more to his wife about the military but there was still a lot she did not understand. He was overcome with emotion when discussing people who disappeared, "came up missing" or were killed. He cried and stated that his tears were for good friends who had been killed. At the end of the session, he recalled a situation in the military in which there were not enough parachutes for everyone on a plane and they thought the plane was going down. Petitioner stated that he was "crew chief" and was not going down with the plane no matter what. (PX 15)

In a report dated January 3, 2013, Therapist Cherap indicated that she interviewed petitioner on December 19, 2012 and December 28, 2012. According to the report, petitioner presented for treatment of phobic responses to driving semi-trucks and dramatic changes in mood and demeanor. He reported that this began shortly after an accident at work. During his first interview on December 19, 2012, petitioner appeared slightly apprehensive and anxious. He had some difficulty providing details about the accident. His speech was slow and deliberate but on topic. He was able to provide long-term memory information and was oriented to person, place and time. His concentration was normal during the interview. He had not worked since the accident. Over the next weeks and months following the accident, petitioner reported that he had become increasingly anxious driving a car, especially if he was near large semi-trucks. He also indicated that he was phobic regarding driving a semi-truck, a job that he had done without incident for twenty-four (24) years. He was not taking any over-the-counter or prescription medications. According to the clinician, petitioner's answers on the PTSD symptoms status questionnaire suggested that he was experiencing multiple symptoms of PTSD more than once per day. The diagnosis was chronic post-traumatic stress disorder. It was recommended that petitioner obtain individual outpatient mental health services to alleviate his symptoms. The

therapist suggested that he be evaluated one to two (1-2) times per week for the first eight (8) weeks. At that time, he could be reassessed to determine the appropriate frequency to enable him to overcome his symptoms. The therapist recommended that he remain off work for the following thirty (30) days because exposure to semi-trucks or the trucking industry could negatively impact his phobic and anxiety symptoms. (PX 17)

Petitioner underwent an individual therapy session on January 4, 2013. It was noted that his mood was depressed and he appeared lethargic. (PX 17)

Petitioner underwent a second individual therapy session on January 9, 2013. The goals of therapy were to reduce phobic responses to driving in semi-trucks; improve stress management skills; improve self- worth; decrease physical symptoms associated with anxiety; improve competence in impacting the environment and others in a positive manner; and to decrease symptoms of PTSD. (PX 17)

During his session with Dr. Eisenberg on January 15, 2013, petitioner reported that his house was broken into. His wife and daughter chased down the robbers. He recalled in a dream feeling helpless in the Philippines when he and a friend found themselves in the middle of a shootout. (PX 15)

During his individual therapy session on January 18, 2013, petitioner reported physical pain and discomfort. His mood was depressed and he appeared lethargic. (PX 17)

On January 24, 2013, petitioner gave an account of the motor vehicle accident to Dr. Eisenberg. He talked about being in the dark and not knowing what was happening as he bounced around in the backseat of the truck asleep. He tried to free himself form the "net" to see what was going on. After 28 years, he was granted 10% disability by the VA for his groin injury. He reported the military had lost his medical records for many years and were not helpful in 1984 when he was "being put out of the service." (PX 15)

On January 25, 2013, petitioner attended an individual therapy session. He reported being anxious while riding in a car. He presented with feelings of anxiousness and depression. (PX 17)

Petitioner was re-evaluated by Dr. Gupta on January 31, 2013. He complained of headaches, neck pain, ataxia, tremors and ongoing back, neck and leg pain. He stated that he was treating with a therapist for his depression and PTSD. The diagnosis was significant thoracolumbar strain, concussion, PTSD, depression, ataxia and headaches. The doctor continued to authorize him off work and recommended pain management. (PX 16)

During his individual therapy session on February 4, 2013, petitioner reported continued feelings of anxiety while driving trucks. He was anxious and lethargic. (PX 17)

During his psychotherapy session with Dr. Eisenberg on February 7, 2013, petitioner talked much about racism in the military and society generally. He had a friend in England who murdered someone but petitioner felt that his friend was not treated properly. He visited his friend in jail but then returned to the U.S. He was upset and got into trouble with the military police. Petitioner was quick to fight and stand his ground especially when treated unfairly. He related growing up in Chicago to the reality in the military in 1980s and Texas at that time. (PX 15)

Dr. Troy authored a supplemental report on February 11, 2013. The doctor reviewed the physical therapy records and once again recommended a FCE based upon petitioner's lack of progress in therapy. The doctor noted that one of the reasons for the FCE was to fully evaluate the validity of petitioner's complaints, to determine his functioning baseline and if he would benefit from additional treatment. Dr. Troy disagreed with the referral to a pain specialist and spine specialist. He noted that the MRI of the lumbar spine taken on October 20, 2012 demonstrated only mild degenerative disc disease at the L2-3 and L3-4 levels. With regard to the MRI of the cervical spine dated October 1, 2012, Dr. Troy opined that this demonstrated pre-existing degenerative changes with the greatest degeneration at C3-4, C4-5 as well as the C7-T1 levels above and below his prior fusion. Dr. Troy reported that based upon those findings, Petitioner should have responded appropriately to physical therapy but did not. The doctor opined that all the degenerative changes existed prior to the work accident. Dr. Troy concluded that Petitioner had achieved maximum medical improvement and should have returned to full-duty work following his six (6) week course of physical therapy. (RX 2)

On February 14, 2013, petitioner reported a recent family death. He also reported increased physical pain and problems coping. His mood was conflicted. (PX 17)

Petitioner described being upset by Jesse Jackson misusing campaign funds during his session with Dr. Eisenberg on February 21, 2013. He was upset that no one in the military helped him when he was sick and that Agent Orange is connected to Parkinson's disease because his brother died from Parkinson's. He stated that he did not talk to his sister-in-law because he never liked her and she sent a truant officer to his house because his wife home-schooled their children. (PX 15)

Petitioner was evaluated by Dr. Cummings at the VA on February 20, 2013. He complained of a 10 year history of numbness and tingling in his entire left arm with shooting pains down the outer aspect of his right leg and numbness on the inner aspect. He had minimal symptoms in his neck and back. He complained of headaches for 10 years which occurred 3 times per week with no trigger. He had tremors in his hands, more prominent on the left. The diagnosis was cervical and lumbar radiculopathy; chronic tension headache; and tremor at rest with no other signs of Parkinson's. (PX 15)

On February 26, 2013, petitioner underwent a neuropsychological evaluation with Dr. Hanlon Ph.D., ABPP, at Northwestern Feinberg School of Medicine. Dr. Hanlon opined that on objective neuropsychological assessment, petitioner revealed no evidence of neurocognitive dysfunction attributable to a concussion. All his neurocognitive functions including attentional capacity, memory functions, language abilities, visuoperceptual processes, constructional abilities, executive functions, verbal reasoning and perceptual reasoning were intact. Assessment of his personality and psychopathology revealed mild anxious depression characterized by irritability and poor frustration tolerance, combined with a tendency for somatization involving the development of physical symptoms in response to psychological stress and the conversion of stress into physical problems. The doctor opined that it was very likely that petitioner's depressed mood was manifested, in part, as physical pain and discomfort. His personality profile also reflected narcissistic personality traits, obsessive-compulsive personality traits and negativistic (passive-aggressive) personality features. (RX 3)

In addressing the alleged PTSD, Dr. Hanlon opined that petitioner did not meet the diagnostic criteria. Based upon petitioner's self-report, he initially stated that he did not know how he was injured and subsequently stated that he was asleep at the time of the accident. Following the accident other than physical pain, he stated "I guess I felt normal." Also, the emergency room records from University of Iowa documented that he was "joking with the staff." As such, Dr. Hanlon reported that petitioner clearly did not experience intense fear, helplessness or horror at the time of the motor vehicle accident or following the accident. Likewise, assessment of personality and psychopathology during Dr. Hanlon's evaluation was not suggestive of PTSD. Dr. Hanlon's diagnosis was mild depression, which was likely long-standing and unrelated to the work accident, and somatoform disorder. From a neuropsychological perspective, Dr. Hanlon opined that petitioner was capable of returning to his job as a truck driver. He revealed no evidence of cognitive dysfunction and it was unlikely that he suffered a concussion at all in the accident. Petitioner reported no acute post-concussive symptoms and he did not even undergo a head CT scan in the emergency room. The doctor concluded that it was unlikely that petitioner sustained a concussion and there was no evidence of cognitive dysfunction. (RX 3)

During his therapy session on March 1, 2013, petitioner reported increased agitation, anxiousness and depression since his recent neuropsychological evaluation. His mood was angry and conflicted. (PX 17)

On March 14, 2013, petitioner returned to Dr. Gupta and complained of ongoing neck and back pain. He denied any radicular symptoms. The diagnosis was post-concussive syndrome; post-traumatic stress disorder; and cervical, lumbar and thoracic whiplash syndrome. Dr. Gupta recommended evaluation by a neurologist, counseling, psychiatric care, long-term pain management and additional physical therapy. Dr. Gupta continued to authorize him off work. (PX 16)

On March 20, 2013, a certified letter was sent to Petitioner requesting that he report to work on March 25, 2013. (RX 4)

In a letter dated March 25, 2013 to Petitioner's attorney, Ms. Cherep noted that she was a licensed clinical professional counselor. Per her observation, petitioner continued to struggle with symptoms of post-traumatic stress disorder and severe anxiety which was a chronic and episodic condition. When active, these conditions substantially limited several of petitioner's major life activities including concentrating, adequate problem solving, appropriately interacting with others and self-care behaviors. As a result, he was unable to work. Cherep opined that he needed a leave of absence for treatment and recovery. She anticipated that he would be able to return to work on May 25, 2013. (PX 17)

During his session with Dr. Eisenberg on April 4, 2013, Petitioner described being stressed by financial issues caused by stolen checks from many years ago. The bank wanted money from him that represented an overpayment but he never received the money. He stated a lawyer would handle the situation. It reminded him of the military in which he had to prove he was right. (PX 15)

Petitioner returned to Dr. Eisenberg on April 18, 2013. He received his medical records and he was trying to digest what they said. He saw inaccuracies and things he did not want to remember. He drank a lot of alcohol in the service. He was too angry to practice his biofeedback exercises. Many years had gone by and petitioner admitted that he did not get help when he was first out of the service. The diagnosis remained PTSD. (PX 15)

Petitioner attended a psychotherapy session with Dr. Eisenberg on May 7, 2013. He was aggravated with bureaucracy of a company who made a brace for his knee that he had been trying to return. He returned it to the guy who fitted it and the company wanted him to mail it to Utah. (PX 15)

During this psychotherapy session with Dr. Eisenberg on May 9, 2013, Petitioner stated that his anger had been triggered by police and movies. His adult children were beginning to see his issues with trauma and stress and they did not understand how their mother dealt with him. According to the doctor, he actually seemed calmer. He complained about the competency of people with whom he interacted to get things done. (PX 15)

In a biofeedback session on May 9, 2013, Dr. Payvar reported that petitioner's own efforts were leading to improved outcomes. (PX 15)

Petitioner was evaluated by Dr. Rogers on June 3, 2013. He stated that he had problems with poor sleep since he was in active duty in the Army. He also reported problems with nightmares and sweats. (PX 15)

On June 6, 2013, Dr. Gupta recommended an additional eight (8) weeks of physical therapy for the cervical and lumbar spine and a neurological consultation. The doctor continued to authorize him off work. (PX 16)

In a letter dated July 1, 2013 from Social Worker Cherep to opposing counsel, she noted that petitioner continued to struggle with symptoms of post-traumatic stress disorder and severe anxiety which she noted was a chronic and episodic condition. When active, these conditions substantially limited several of petitioner's major life activities. She recommended a leave of absence for treatment, recovery and work readiness. Petitioner would be reassessed in 90 days. (PX 17)

During his psychotherapy session with Dr. Eisenberg on July 25, 2013, petitioner reported that he had terrible intermittent groin pain. He stated it was "incapacitating." Pain killers did not work. He was making progress with Dr. Payvar and reported that the medication was helpful. He was still upset that the military still "threw me away rather than recognize that he had a problem and needed help." (PX 15)

During a biofeedback session on August 1, 2013, the doctor noted that this was the first follow-up visit since his visit in April 2013. Petitioner and his wife reported positive changes and continuing improvement in petitioner's PTSD symptoms. (PX 15)

Petitioner returned to Dr. Gupta on August 1, 2013. He had not undergone any additional treatment. He stated that his symptoms were the same. He had some knee pain which the doctor believed was related to existing knee disease. His neck pain continued. He described it as a twisting, locking pain. He had elbow pain which the doctor believed was an isolated non-radicular pain. The doctor noted that he was concerned about petitioner's significant symptoms. He recommended cervical and lumbar pain management possibly with trigger point injections. He also believed that he should proceed with additional physical therapy and psychiatric treatment for his post-traumatic stress disorder. He continued to authorize him off work. (PX 16)

Petitioner returned to Dr. Gupta on August 3, 2013. He stated that his neck and back pain were sharp. He described it as 9/10 in terms of intensity. He was seeing a psychologist. There was some concern that he needed a brain scan. On exam, he had a normal gait with good strength and balance with heel and toe walking. He continued to make a diagnosis of whiplash syndrome and post-traumatic stress disorder. Dr. Gupta opined that he did not need surgical treatment. He recommended treatment with Dr. Clement Rose, his internist, or a physiatrist. He gave him an off-work note as he looked to obtain a consultation with a primary care type specialist with a specialty for his lumbar and cervical spine. (PX 16)

During his session with Dr. Eisenberg on August 8, 2013, Petitioner described a conflict with the father of his grandson who tried to accuse Petitioner's daughter of child abuse because he did not want to pay child support. He was also in conflict with his son who disrespected his

wife. It was noted that his son had PTSD, too but would not acknowledged it. Petitioner planned to file a claim for PTSD with the Regional VA office. (PX 15)

In a report dated August 29, 2013, Dr. Paver indicated that she remained pleased with the progress Petitioner had made in coping with his PTSD and anger. He claimed to make educational goals for new possible career. (PX 15)

Petitioner returned to Dr. Eisenberg on August 29, 2013. He talked about the problems the military caused itself "giving arms to the wrong people, intentionally having one group kill those belonging to another group." Petitioner was very untrusting of the motives of the military and felt unprotected by the military. He was upset when a trucker with a history of speeding plowed into a car and killed six people. "They didn't take him off the road." (PX 15)

The Petitioner attended a biofeedback session with Dr. Paver on September 12, 2013. He reported an incident where he felt angry but was able to quickly deescalate from that state.

During his psychotherapy session with Dr. Eisenberg on September 12, 2013, petitioner reported that he had a very frustrating day and by the evening he got angry but came out of it quickly. His wife reported he was making progress with his anger. He had an EMG which he believed damaged his nerves. He had constant headaches but doctors had no explanation except to indicate that it was in his mind. (PX 15)

Petitioner was evaluated by Dr. Rogers at the VA on October 17, 2013 and reported left knee pain since he dislocated his knee while on active duty in the military. X-rays were compared to those taken on October 17, 2013 and revealed worsening of the previously noted osteoarthritis with severe degenerative changes manifested by sclerosis of the articular surfaces, subchondral cyst/osteophyte formation and narrowing of the medial ad patellofemoral compartments. There was no acute fracture dislocation or significant joint effusion. On the knee exam, there was a small effusion but no laxity or structural problems. He was referred to physical therapy. (PX 15)

Petitioner attended a psychology appointment with Dr. Eiseberg on October 17, 2013. Many things had caused some regression in petitioner's attitude. He was stressed by government shut down. His sense of deprivation and discrimination had been exacerbated. He could identity with people who acted out on their anger because part of him would like to do the same even though he knew it was not the best course of action. He said that the doctors could not "cure me." (PX 15)

During his biofeedback session on October 17, 2013, Petitioner reported increased stressors in the last few weeks since his last visit. National events affecting veterans had become bothersome. He continued to show improved coping skills compared to the past. (PX 15)

During his therapy session on November 7, 2013 with Dr. Eisenberg, petitioner reported that he was frustrated with the bureaucratic process involved in trying to gain admission to a psychology/energy program at Chicago State. He needed an extension of time to get everything organized. His frustration with the process felt like the hassles he encountered in the Army. (PX 15)

On December 5, 2013, petitioner told Dr. Eisenberg that he was registered for school and would have an undergraduate psychology degree in two years. The couple talked about their children and grandchildren who used them for support despite them being elderly. According to his wife, petitioner could still become volatile but calmed down much more quickly. (PX 15)

During petitioner's biofeedback clinic with Dr. Pavar, on December 5, 2013, Petitioner stated he did not anticipate much stress from transitioning into full-time school work. He still would get angry but found his feelings did not linger as long as they had in the past. Overall, he continued to show improvement. (PX 15)

On January 9, 2014, Petitioner told Dr. Eisenberg gave a detailed history of a recent stop pby the police for "no good reason." He challenged the police about why they stopped him and gave them a "tongue-lashing." He also talked about the nieces he and his wife had raised who were not fulfilling their expectations. (PX 15)

During his therapy session on January 30, 2014 with Dr. Eisenberg, petitioner focused on the stress of transitioning back to school and the demands he faced with the changes. Petitioner talked about a 46 vehicle pileup near Michigan City in which three were killed. Another truck ran through a toll booth and a squad car caught on fire. He claimed that this triggered his memories of the military and his work-related motor vehicle accident. (PX 15)

In a letter dated February 7, 2014, respondent requested petitioner to return to work or provide documentation why he was unable to do so. (PX 6) Petitioner did not return to work.

On February 13, 2014, petitioner met with Psychologist, Dr. Eisenberg, and stated that was very frustrated with computer issues and his college classes. He was close to being overwhelmed with computer difficulties such that he was unable to get the content of courses and navigate the computer quizzes and tests. (PX 15)

In a narrative report directed to opposing counsel dated March 4, 2014, Dr. Gupta made a diagnosis of cervical, lumbar and thoracic whiplash syndrome; disc herniation at C4-5; post-traumatic stress disorder; ataxia; and headaches all which he related to the work accident. He recommended additional treatment consisting of chronic pain management, consultation with a neurologist and a psychiatric evaluation. He concluded that petitioner had not achieved maximum medical improvement and could not return to work driving a commercial vehicle. (PX 21)

In his therapy session on March 13, 2014, petitioner talked extensively about a friend whose wife absconded with money and household goods. Petitioner tried to convince the husband to press charges which he ultimately did. He was taken aback by the extent this friend wanted to "punish himself." Petitioner stated he would not tolerate such behavior. He stated that he sets boundaries including a relationship with his mother- in-law. She never liked him so he only did the minimum for her or whatever his wife "demanded." He appreciated that his wife was so helpful with him in his struggle with PTSD. (PX 15)

Petitioner underwent a review of his medications with Psychiatrist Polsby on April 17, 2014. It was noted that petitioner had PTSD from military service. He was in rescue and picked up dead bodies. He saw a young man set himself on fire after putting gasoline on himself. He was having trouble with nightmares and snapping at people. They discussed the risk and benefits of Serquel at bedtime for sleep, anxiety and flashbacks. The recommendation was to continue therapy with Dr. Eisenberg. (PX 15)

Petitioner attended a psychology session with Dr. Eisenberg on April 17, 2014. There was no mention of the work related motor vehicle accident. Petitioner was very frustrated due to computer-related problems. All school assignments needed to be turned in via the computer. It was too difficult for him given his computer knowledge and it exacerbated his stress syndrome. He was required to do in class essays on the computer which were impossible to complete in a timely fashion. He did not believe his counselor or anyone else at the school would be sympathetic to his situation. He drew parallels between school and the military in terms of being set up to fail and not receiving the appropriate help. (PX 15)

In a psychology note dated April 24, 2014, Petitioner stated that the prior two weeks had been difficult due to the stress of his schoolwork mounting. He requested a letter to see whether he could have more time on an upcoming test. The doctor noted that the stress of academic work has worsened his PTSD symptoms and insomnia.

On May 8, 2014, Petitioner attended therapy with Dr. Eisenberg at the VA. Petitioner described stressors and frustrations he had at school. He was still trying to learn the computer systems. He had trouble with one particular teacher who seemed to be transitioning from a woman to a man. He was frustrated with tutors who "don't do their job." He was meeting with other vets and non-vets with anger problems. The diagnosis was PTSD. (PX 15)

Petitioner attended a psychology session on May 22, 2014 at the VA Hospital. The focus was on coping with his recent stressors including a poor grade he received in one of his courses. He was planning to meet with the school administrators. He was very upset with his teacher, his school and with the Veterans Administration. He claimed that his teacher told him that he would help him and he turned in all of his work; however, she gave him an "F". The teacher had not answered any of his emails. He could never finish his assignments in class due to lack of computer skills. The teacher said she would help him but she never did. Also, the school

did not help him. The school charged him for a bus pass that he did not need. They charged him for health insurance but he noted that he was a VA vet and the school knew that. The VA did not pay for his books and the school was asking him for the money. All of these things were reminding him of service bureaucracy and lack of help. He also pointed to VA scandals as proof that "VA ain't shit." For years the VA doctors told him his groin pain was "in his head." It was noted he was taking at least one anti-psychotic medication. He cried heavily when speaking of a church member, a veteran, who had recently committed suicide. He felt depressed at times. His sleep varied. He experienced nightmares, flashbacks, anxiety, avoidance and increased vigilance. The diagnosis was PTSD and depressive disorder. (PX 15)

Petitioner was evaluated by Dr. Eisenberg on June 25, 2014 and complained of a lot of stress. His wife had to subdue him at one point. He focused on racism in the military, and outside of it, and abuse of authority, something which really excited his anger. He had to drop one summer school class. Petitioner was upset with having difficulty getting a job post-military. He described what he did as "killing people." The diagnosis was post-traumatic stress disorder.

In his psychology session with Dr. Eisenberg on July 15, 2014, Petitioner stated that he felt the VA should pay him back to 1984 when they first said they could not find any issue in his medical records. Later they found the records and awarded him 10% but did not pay him back to when they made the mistake. He talked at length about his grandson and grandson's mother who did not have time for her son. He was quite irritable. (PX 15)

On August 21, 2014, Petitioner's wife indicated that her husband was yelling downstairs in the hospital earlier that day. He had more good days than before, but somedays were still bad. He received good grades in his college courses. He complained about difficulty getting his "ID card". He thought that excessive force was used in the Ferguson case. "Why didn't they shoot him in the leg?" He said that his VA disability claim was sent to South Dakota; however, he had not heard anything. (PX 15)

Petitioner was evaluated by Dr. Brietzke, Psy.d on September 12, 2014. The doctor made a diagnosis of post-traumatic stress disorder and personality change due to head trauma. He opined that these conditions were causally related to the work accident. He further opined that Petitioner had not achieved MMI and recommend individual psychotherapy and pharmacotherapy to maximize his "ultimate level of recovery." Dr. Brietzke disagreed with Dr. Hanlon's opinion that Petitioner exhibited signs of a somatoform disorder. Petitioner was not allowed to return to work for "at least another 6 months pending therapy outcomes." (PX 20)

During a biofeedback session on September 19, 2014 with Dr. Pavar, Petitioner discussed current stressors with taking a number of college courses and managing his time effectively.

Petitioner was evaluated by Dr. Eisenberg on October 19, 2014. He had angry outbursts related to a sense of being mistreated in the military and being discharged unfairly after 13 years. He could act in very unacceptable ways in public such as throwing products to the floor in a

supermarket when upset. His wife was concerned he would get into trouble with his anger. The doctor noted that he seemed to have PTSD, subacute, at the least. (PX 15)

In a psychotherapy session with Dr. Eisenberg on October 29, 2014, Petitioner reported that while in the military he was almost left on a plane when others were going to parachute. He saw a person on fire. He became irritable and angry on a regular basis. He endured much racism and was angry about that as well.

During his biofeedback session with Dr. Pavar on November 12, 2014, Petitioner focused on his stress regarding school.

Petitioner returned to Dr. Eisenberg on November 26, 2014. He was angry about what happened in the Ferguson case in terms of the police shooting someone and not being held accountable. He thought the police officer should have shot to wound if he felt threatened. He was angry at the system and the politicians. He felt the middle class was being demolished. He felt there would be a "revolution and it would not be pretty." He was angry at the VA and military for losing his records and for establishing ridiculous procedures that only frustrate deserving veterans. He felt the dollar was going down and all the little people were losing ground. He expressed contempt for an alderman who used to be a policeman. He also talked about his son who was in the Army who served overseas and who distanced himself from the family due to the PTSD. (PX 15)

X-rays of the right knee performed on December 1, 2014 revealed severe degenerative changes manifested by sclerosis of the articular surfaces, subchondral cyst/osteophyte formation and narrowing of the medial compartment. Multiple osteochondral bodies were noted along the posterior aspect of the knee which was consistent with synovial osteochondromalosis. X-rays of the left knee revealed severe degenerative changes manifested by sclerosis of the articular surfaces, subchondral cyst/osteophyte formation and narrowing of the medial and patellofemoral compartments.

During his psychotherapy session with Dr. Eisenberg on December 18, 2014, Petitioner talked at length about the grandson who spent much time with them until several months prior when his mother moved him to Joliet. Petitioner felt that the grandson would do better with them. (PX 15)

Petitioner was evaluated by Dr. Eisenberg on February 5, 2015. He reported doing better. He even talked down one veteran at school who was having a PTSD episode.

During his session with Dr. Eisenberg on March 10, 2015, Petitioner became upset when discussing the pilot who almost killed him in the military.

In his disability benefits questionnaire dated March 10, 2015, Dr. Coulson reported that Petitioner's depression was less likely than not due to his marital difficulties. Petitioner's other

stressors included a pilot who armed his plane with a weapon and experiencing a man setting himself on fire. (PX 15)

In a supplemental report dated March 11, 2015, Dr. Hanlon reviewed Dr. Brietzki's report and test results. Dr. Hanlon highlighted what he opined were inconsistencies and unfounded conclusions:

-in his report Dr. Brietzki indicated that "on test measuring effort and feigned symptoms, Mr. Tate's performance was well within normal limits suggesting that he approached testing in a honest manner and did not make efforts to alter his performance for secondary gain or otherwise." Dr. Brietzki administered the validity indicator profile, contrary to Dr. Brietzki's description, Petitioner's response style resulted in an "invalid/inconsistent" profile on the non-verbal subtest of the validity indicator profile. Despite demonstrating insufficient test taking effort on the validity indicator profile, Dr. Brietzki concluded that Petitioner consistently put forth sufficient test taking effort. As such, Dr. Hanlon reported that the interpretation of Petitioner's effort by Dr. Brietzki was inaccurate and unfounded.

-on page 2 of his report, Dr. Brietzki documented "on tests of non-psychological functioning, Mr. Tate performed within the average or greater ranges of tests of visual perception, all aspects of language functioning, processing speed, visual scanning and divided visual attention and all aspects of all visual memory which was a particular strength. Performance in the mild to moderately impaired range were found on the test of storing memory, short and long delayed word list memory and executive functioning. Impaired functioning was seen on no test". Later on page 9 of his report, Dr. Brietzki documented "memory performance was an area of weakness for Mr. Tate, particularly within the area of verbal memory. More specifically, on a word list learning task, Mr. Tate's learning curve was somewhat depressed in both his immediate and delayed recall of this information dealt within the borderline range. Recognition similarly fell within the borderline range." According to Dr. Hanlon, Dr. Brietzki initially documented that Petitioner's verbal memory functions were in the mild-moderately impaired range. Later, he concluded that Petitioner's verbal memory functions were in the borderline range. However, when the California Verbal Learning Test II was administered to Petitioner and rescored, Petitioner actually performed in the average to high average range consistently. Therefore, Dr. Hanlon concluded that the interpretation by Dr. Brietzki was inaccurate. To objectively assess personality and psychopathology, Dr. Brietzki administered the personality assessment inventory ("PAI"). However, Petitioner's PAI profile was invalid due to his failure to appropriately consider item content. As a result, Dr. Hanlon opined that no valid assessment of personality, mood, anxiety or other psychopathology was achieved during the evaluation of Petitioner by Dr. Brietzki. As such, the conclusion by Dr. Brietzki that Petitioner manifested post-traumatic stress disorder was apparently based exclusively on subjective information provided by Petitioner and his wife in the

selective records with which he was provided. Specifically, Dr. Hanlon referred to page 1 of Dr. Brietzki's report in which he documented that "all information in this evaluation is based on an interview with Mr. Tate, his wife, Joanne Tate and a review of medical records provided by Mr. Tate's attorney." Dr. Brietzki documented "Mr. Tate is educated through a high school diploma he earned in 1972." However, during a previous neuropsychological evaluation on February 26, 2013, Petitioner reported that he holds a B.S. in Industrial Technology from Chicago State University. According to Dr. Hanlon, Dr. Brietzki provided no foundation for the diagnosis of personality change due to head trauma. Technically, the diagnosis Dr. Brietzki seemed to be applying was personality change due to another medical condition. However, no medical condition was cited as the basis for the diagnosis. Dr. Hanlin concluded that Dr. Brietzki did not diagnose Petitioner with a traumatic brain injury, post-concussion syndrome, a neurocognitive disorder or a pain disorder. As such, the clinical basis of the diagnosis of personality change due to head trauma was unspecified and the diagnosis was unfounded. (RX 5)

During his biofeedback session with Dr. Payvar on April 7, 2015, Petitioner focused mostly on his recent frustration with his compensation/pension exam and rejection of his disability application. Petitioner's wife said that his mood was mostly depressed and he had been communicating less with his family. He reported feeling increased anxiety about upcoming finals.

Petitioner attended a psychotherapy session with Dr. Eisenberg on April 21, 2015. He reported panic attacks and a lot of anxiety. He stated that he blanked out on a test that day despite knowing the material. His wife stated that he got angry and upset a lot.

On April 21, 2015, Petitioner attended a biofeedback session with Dr. Payvar. He focused mostly on anxiety about upcoming school finals.

Petitioner was evaluated by Dr. Eisenberg on June 5, 2015. He stated that Memorial Day was not a good day for me. Petitioner admitted to drinking. He tried to avoid his wife who followed up him upstairs and comforted him. He drank again two days later. Petitioner was irritable with Memorial Day and not really feeling that anyone cared about the sacrifices by those he served.

During his therapy session with Dr. Eisenberg on June 26, 2015, Petitioner stated that he disliked a woman in the disability office who was supposed to help him but did not. He stated "no one likes her." Instead of acting out, he indicated that he would talk to her boss and organize the other veterans to come with him to make statements. He was waiting to be approved for marijuana from the pain clinic. Petitioner did not get help he needed in the service and resents the help offered now. The diagnosis was PTSD.

In a note dated July 20, 2015, Petitioner told Dr. Howrey that he had pain located primarily in his left knee, both hips and in his groin. Petitioner admitted that both his hip and knee pain started in the military. (PX 15)

During his therapy session on September 4, 2015, Petitioner reported being upset and frustrated with the administration at his school. He was experiencing issues with English class and writing papers under time pressure.

On October 2, 2015, Dr. Eisenberg reported that Petitioner became angry and irritable on a regular basis. They discussed an incident in the military when Petitioner was almost left on a plane because there were not enough parachutes. He claimed that he experienced a lot of racism and he was angry about that as well.

On October 16, 2015, Petitioner and Dr. Payvar discussed difficulty he was having with one of his classes and the instructor.

A MRI of the hips performed on October 27, 2015 revealed mild degenerative joint disease in both hip joints.

Petitioner's biofeedback session on November 9, 2015 was spent discussing Petitioner's reaction to the recent death of his neighbor who he had known for many years. The manner of his neighbor's death triggered PTSD and anxiety symptoms.

During this therapy session on February 19, 2016, Petitioner complained of a lot of pain in his back, knees and neck. He stated that he was not sleeping. He was working part-time on work-study at VBA. He wanted to attend additional schooling for his M.A. Dr. Eisenberg reported that he seemed depressed but began to perk up when they began talking about work and school.

X-rays of the left hip performed on February 26, 2016 revealed no acute abnormality involving the femoral head and adjacent acetabulum. A MRI of the cervical spine revealed post-operative changes with fixation by plate and screws at C5 through C7. There were moderate degenerative changes and neural formina narrowing. (PX 15)

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v.*

Industrial Commission, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

It is well established that a claimant carries the burden of proof with respect to each element of his claim by the preponderance of credible evidence. *Parro v. Indus. Comm'n*, 260 Ill.App.3d 551, 554-55 (1st Dist. 1993). The claimant may present witnesses to prove his case. It is the function of the Arbitrator to determine the credibility of those witnesses, draw reasonable inferences based on the testimony, and determine the weight to be assigned the testimony. *Parro*, 260 Ill.App.3d at 554. The Arbitrator need not find for a claimant merely because there is some testimony that standing alone would justify a favorable outcome. *Burrgess v. Industrial Comm'n*, 169 Ill.App.3d 670, 676 (1st Dist. 1988). Rather, the Arbitrator should consider both direct and circumstantial evidence and draw reasonable inferences there from, even if it is contrary to the testimony. (*Id.*) It is the Commission's function to evaluate the evidence and resolve the conflicts that arise. *Beattie v. Industrial Comm'n*, 276 Ill.App.3d 446, 449 (1995).

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

It is well established that a claimant carries the burden of proof with respect to each element of his claim by the preponderance of credible evidence. *Parro v. Indus. Comm'n*, 260 Ill.App.3d 551, 554-55 (1st Dist. 1993). The claimant may present witnesses to prove his case. It is the function of the Arbitrator to determine the credibility of those witnesses, draw reasonable inferences based on the testimony, and determine the weight to be assigned the testimony. *Parro*, 260 Ill.App.3d at 554. The Arbitrator need not find for a claimant merely because there is some testimony that standing alone would justify a favorable outcome. *Burrgess v. Industrial Comm'n*, 169 Ill.App.3d 670, 676 (1st Dist. 1988). Rather, the Arbitrator should consider both direct and circumstantial evidence and draw reasonable inferences there from, even if it is contrary to the testimony. (*Id.*) It is the Commission's function to evaluate the

evidence and resolve the conflicts that arise. *Beattie v. Industrial Comm'n*, 276 Ill.App.3d 446, 449 (1995).

Psychological/PTSD issues:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein. The Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that the accident caused the alleged diagnosis of PTSD or that it aggravated a previously existing condition.

The Arbitrator finds the opinion of Dr. Hanlon more credible that that of Dr. Brietzke. Dr. Hanlon is a board certified clinical neuropsychologist, licensed clinical psychologist and Associate Professor of Psychiatry and Neurology at Northwestern University Feinberg School of Medicine. Dr. Hanlon reviewed Petitioner's complete medical records, conducted twelve (12) tests and interviewed Petitioner at length. Dr. Hanlon's diagnosis was mild depression, which was likely long-standing and unrelated to the work accident, and somatoform disorder. From a neuropsychological perspective, Dr. Hanlon opined that Petitioner was capable of returning to his job as a truck driver. He revealed no evidence of cognitive dysfunction and it was unlikely that he suffered a concussion at all in the accident. Petitioner reported no acute post-concussive symptoms and he did not even undergo a head CT scan in the emergency room. The doctor concluded that it was unlikely that Petitioner sustained a concussion and there was no evidence of cognitive dysfunction. With regard to the alleged diagnosis of PTSD, Dr. Hanlon opined that opined that Petitioner did not meet the diagnostic criteria.

The Arbitrator finds that Dr. Brietzke's diagnosis of post-traumatic stress disorder and personality change due to head trauma was unfounded. Dr. Brietzki provided no foundation for the diagnosis. Technically, the diagnosis Dr. Brietzki seemed to be applying was personality change due to another medical condition. However, no medical condition was cited as the basis for the diagnosis. According to Dr. Hanlon, Dr. Brietzki did not diagnose Petitioner with a traumatic brain injury, post-concussion syndrome, a neurocognitive disorder or a pain disorder. As such, the clinical basis of the diagnosis of personality change due to head trauma was unspecified and the diagnosis was unfounded.

Assuming, arguendo, that Petitioner does have PTSD, it is long-standing and was not aggravated by the work-related motor vehicle accident. Petitioner was initially diagnosed with PTSD by the VA Hospital in August 2011, a year prior to the work accident. Following the work accident, he continued to the treat with the VA's Mental Health Department and mentioned the work accident during only 2-3 times during his numerous psychotherapy/biofeedback sessions. On September 25, 2012, Dr. Eisenberg made a diagnosis of post-traumatic stress disorder, subacute, as manifested by a strong sense of having been mistreated in the military.

Additionally during most of his psychotherapy the Petitioner listed issues with his treatment by and service in the military, his treatment and issues with his employer and family issues. The accident and its after effects was a minor issue as noted in the medical records.

A. Physical Injuries

Based upon the initial medical records and the opinions of Dr. Troy, the Arbitrator finds that Petitioner sustained a temporary exacerbation of his pre-existing degenerative changes in his cervical spine and a lumbar strain. At the time of Dr. Troy's examination, Petitioner had no complaints regarding either shoulder. His symptoms were isolated to the trapezial and cervical areas.

The Arbitrator finds that Petitioner's knee pain and symptoms were pre-existing. He had significantly advanced degenerative changes in the right knee greater than the left which was consistent with his complaints. Petitioner had no complaints of knee pain during his evaluation at the emergency room at University of Iowa Hospital. With regard to the right hip, Dr. Troy indicated that Petitioner developed a greater trochanteric bursitis which one could argue was traumatically induced by the accident; however, it had resolved.

Were all the medical services that were provided to the Petitioner reasonable and necessary and has the Respondent paid the appropriate costs for the reasonable and necessary medical services that were provided to the Petitioner?

The Arbitrator finds that the medical treatment, with respect to Petitioner's injuries to his hip, cervical spine and lumbar spine, were reasonable and necessary. The Arbitrator finds that Petitioner achieved maximum medical improvement for his work-related accident as of December 24, 2012 based upon the opinion of Dr. Troy. Any medical treatment after December 24, 2012 is not reasonable or necessary.

The psychological issues were not causally connected to the accident and as such the Respondent is not liable for the costs of said treatment.

Is the Petitioner entitled to TTD from August 14, 2012 through August 3, 2014 and maintenance from August 4, 2014 through April 28, 2016

Based upon Petitioner's refusal to accept light-duty work, the Arbitrator finds that Petitioner is entitled to TTD benefits from August 13, 2012 through December 6, 2012 or 16 3/7weeks (16.429 x $901.93 = $14,817.81). Respondent has a credit of $14,559.72 for TTD payments.

What is the nature and extent of the injury?

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: Neither Petitioner nor Respondent presented an AMA Impairment Rating. Based on the failure to submit an AMA Impairment Rating the Arbitrator gives no weight to this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a truck driver. The Petitioner's testimony was that he cannot return to work as a truck driver because of his emotional instability when riding in a car near trucks. The Petitioner described right leg and hip pain, with his leg giving out on him. The full use of the right leg is essential for the Petitioner to climb into and out of the truck and to safely operate the vehicle on the highways. He was determined to be at MMI in December of 2012 with respect to the physical aspects of his injury. Petitioner was offered light duty work, but refused to try it so there is no basis to determine if he could have in fact returned to some form of employment. The mental health issues were found to be not related to the accident. The Arbitrator gives some weight to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 58 at the time of his accident. There is no evidence that Petitioner's age impacted his injury or created any permanent disability. No weight is given to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that he is unable to work due to his mental instability. Petitioner did not provide any evidence that he is unable to do any job due to his physical condition. Petitioner testified that he has returned to school and is working on a degree in psychology and intends to seek employment in that area. No evidence was presented as to how much Petitioner could earn if employed in this field or how that would compare to Petitioners earnings with respect to the Respondent. The Arbitrator is unable to make any determination with respect to this issue because no evidence was presented on it. The Arbitrator gives little weight to this factor.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained an injury to his hip which has been resolved and an aggravation of his previously existing cervical spine and lumbar spine conditions. The mental health issues are not causally connected to the injuries sustained as result of the accident. Significant weight is given to this factor.

Given the nature of the injury the Petitioner suffered to his right leg and to his person as a whole following the August 12, 2012, accident, he is entitled to have and receive from the Respondent compensation for 3% loss of use of the person as a whole, or 15 weeks at a weekly PPD rate of $712.55 / per week and 15% loss of the use of his right leg or 32.25 weeks at a PPD rate of $712.55.

Is the Petitioner entitled to attorneys' fees and penalties?

The termination of TTD benefits by Respondent on December 4, 2012 was reasonable and was not vexatious. Respondent had offered Petitioner light duty work, which Petitioner declined to even attempt to see whether or not he was capable of returning to some form of work and had a medical opinion from Dr. Troy that Petitioner had reached MMI. Petitioner was claiming PTSD issues that prevented him from returning to work but based upon the voluminous medical records and documentation the Arbitrator has determined that the Petitioners mental issues were not causally connected to the accident that occurred on August 13, 2012.

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's current condition of ill being subsequent to August 13, 2012 arose out of his employment as alleged. Respondent required Petitioner to submit to Section 12 examinations throughout Petitioner's treatment and offered light duty work to Petitioner which he declined to even attempt. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d) 2 and 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 47.25 weeks, because the injuries sustained caused the 15% loss of the right leg and the 3% loss of the person as a whole, as provided in Sections 8(d)2 and 8(e) of the Act.

Respondent shall pay the Petitioner 16 3/7 weeks TTD, from August 14, 2012 through December 11, 2012, at the rate of $901.93 per week. Respondent will be given credit for any amounts previously paid.

Respondent shall pay for the medical treatment from August 13, 2012 through December 24, 2012, as it has been determined to be reasonably related and necessary medical treatment. The Respondent is not liable for costs associated with Petitioner's mental health treatment.

Deborah L. Simpson

Signature of Arbitrator

February 22, 2017
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Katrina Bruce,
Petitioner,

vs. No. 12 WC 22516

State of Illinois,
Dept. of Human Resources,
Respondent.

18IWCC0482

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability and permanent partial disability and being advised of the facts and law, supplements 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, with the following supplemental findings.

Petitioner, a 53-year-old caseworker, testified she spent most of her day typing on a keyboard. On April 10, 2012, she was diagnosed with trigger finger and reported that diagnosis to her employer. Petitioner claims her repetitive work duties caused her condition. The Arbitrator denied Petitioner's claim, finding she did not prove accident. The Arbitrator found that Petitioner only presented the diagnosis of her condition to her employer. The Arbitrator found all other issues moot.

The Commission affirms and adopts the Arbitrator's finding that Petitioner did not prove accident. However, the Commission further finds that Petitioner failed to prove that her trigger finger condition was causally related to her work activities. Respondent's Section 12 expert, Dr. Vender, opined that trigger finger cannot be caused by repetitive keyboarding; rather, it requires repetitive injury or trauma to the palm of one's hand. He opined that Petitioner's job activities did not sufficiently stress the palm of Petitioner's hand to cause her trigger finger condition.

The Commission finds Dr. Vender had a sufficient understanding of Petitioner's job duties, and because of his expertise as a hand surgeon, the Commission finds his opinions more persuasive than those of Petitioner's family physician, Dr. Tranmer. Petitioner's Section 12 expert, Dr. Marder, failed to give a causation opinion.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 27, 2017, is hereby affirmed and adopted, with the supplemental findings stated herein.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: AUG 6, 2018

o-06/27/18
jdl/mcp
68

AUG 6 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRUCE, KATRINA
Employee/Petitioner

Case# **12WC022516**

STATE OF ILLINOIS
Employer/Respondent

18IWCC0482

On 3/27/2017, 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 0.89% 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:

0139 CORNFIELD & FELDMAN
JIM M VAINIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

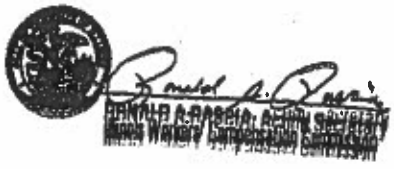
4980 ASST ATTY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

MAR 27 2017



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

Katrina Bruce
Employee/Petitioner
v.
State of Illinois
Employer/Respondent

Case # **12 WC 22516**

18IWCC0482

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **November 21, 2016, December 14, 2016, December 21, 2016, and January 21, 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 **April 12, 2012,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$64,528.32**; the average weekly wage was **$1,240.93**

On the date of accident, Petitioner was **53** years of age, **single** 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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of 0

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

ORDER

Because Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment, benefits are denied

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

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

Fulton Black

Signature of Arbitrator

March 24, 2017
Date

MAR 27 2017

FACTS

Petitioner assesses clients for approval for public assistance, and she conducts interviews and completes reports. Petitioner claims that her job requires a lot of use of computer keyboards to document her work.

Petitioner works a normal 8 hour day with two 15-minute breaks and one half-hour lunch. While she does not transcribe conversations, she does input data into forms and notate information for processing applications.

Petitioner was originally diagnosed with trigger finger on April 10, 2012 by Dr. Patrick Tranmer. (RX1) Petitioner filed a notice of injury on April 24, 2012. The report does not describe a specific accident date or occurrence but states "diagnosed with trigger finger 4/10/12." (RX1) Petitioner filed for an accommodation with the Bureau of Accessibility and Job Accommodations ("BAJA") on April 17, 2012. (RX6 at 11) Petitioner explained that she was familiar with this procedure because she previously had filed for a reasonable accommodation with BAJA for a lower back issue. Petitioner testified that she never heard any response to her request for her accommodation for her back issues until after she filed the request for the trigger finger.

She reported her diagnosis to her supervisor Ozzy Wright on April 24, 2012. Mr. Wright issued a report stating "Said employee informed me that her doctor advised her that she had a condition known as trigger finger. She also stated she could not continue to enter her work because of the repetitive motion." (RX4)

On April 10, 2012 Petitioner was referred to Occupational Therapy by Dr. Tranmer with a history of hand and finger pain. (PX1 at 32)

On April 19, 2012 Petitioner presented to Dr. Tranmer. He noted that she was having problems with hand at work, does data entry, sits at the computer all day, right middle finger locks, and her work needs documentation that she needs a hand rest. (PX1 at 29) Dr. Tranmer limited her from data entry until May 29, 2012. (PX1 at 30)

On May 11, 2012 Petitioner presented to occupational therapy. Notes from that date indicated that Petitioner was kept from work as they were not able to meet the restrictions placed by her physician and that that the patient was happy with that decision. Petitioner described less pain and less frequent triggering. Therapists fabricated a trigger splint, and Petitioner was instructed not to engage in any typing. (PX1 at 36)

On May 24, 2012 Dr. Tranmer noted that Petitioner had been seeing occupational therapists for the last 6 weeks, was resting hands, and was off work. She was supposed to return to work on May 29, 2012. (PX1 at 27)

On June 02, 2012 Dr. Tranmer noted that Petitioner had indicated her employer was not allowing her to return to her regular job because Dr. Tranmer had asked that she not do escalated type of typing. He further noted that "They told her to file for disability because she is not able to do her former job at 100%." (PX1 at 25)

On June 27, 2012 Petitioner presented to Dr. David Marder for her own independent medical evaluation. Petitioner stated that her condition had improved but that she still felt some stiffness, like arthritis, in her fingers and occasionally feels a clicking in her right third finger. (PX4 at 116) Dr. Marder did not render any causation opinion in his report. (PX4)

On June 28, 2012 Petitioner returned to Dr. Tranmer. An X-ray of the hands taken on that date was unremarkable and showed no acute fractures or dislocations. (PX1 at 42)

On July 17, 2012 Petitioner visited Dr. Alfonso Mejia. Notes from that visit indicate that Petitioner was to return to work with her ergonomic recommendation as per her primary care physician. (PX1 at 40) On July 17, 2012, Petitioner also saw Dr. Tranmer for a "form correction / completion" Notes from that visit show that Occupational Medicine recommended that Petitioner get an ergonomic work site evaluation. Dr. Tranmer stated in the records that he completed forms noting that Petitioner no longer had a disability. (PX1 at 20)

On August 3, 2012 Petitioner presented to Dr. Michael Vender for an independent medical examination that was requested by Respondent. At a deposition, Dr. Vender opined that Petitioner's job duties neither caused nor contributed to her condition, because Petitioner's job does not require forceful gripping. (PX5 at 20-23)

On March 13, 2013 the University of Illinois at Chicago Assistive Technology Unit provided a Worksite Modification evaluation which recommended a new office chair, a wrist rest, a copy stand, a phone headset, and a countdown timer for pacing typing. (PX2 at 89)

On June 5, 13 and on July 31, 2013 Joycelyn Dyson of BAJA issued Reasonable Accommodation Request responses. (PX6 at 14, 17) Petitioner testified that she maintained contact with Joycelyn Dyson about the status of her accommodations and her return to work. Petitioner testified that she was contacted by phone about returning to work on February 20, 2014 as the department finally had procured all of the materials for

Petitioner's accommodation. Petitioner testified that she used the full remainder of her personal time while she was off. After her personal benefit time expired, she collected non-occupational disability benefits from State Retirement Systems until her ultimate return to work on February 20, 2014.

Petitioner states that she has returned to work full time in the same position. She has not had any further medical treatment and takes no over the counter or prescription medications for the finger. Petitioner reported that her finger has not locked up but that she still feels some soreness in her middle finger that is worse in the mornings.

ACCIDENT

Petitioner was originally diagnosed with trigger finger on April 10, 2012 by Dr. Tranmer. When Petitioner filed a notice of injury on April 24, 2012, she did not describe a specific accident or occurrence. The report states "diagnosed with trigger finger 4/10/12." Petitioner reported a diagnosis, not an accident, to her supervisor, Ozzy Wright, on April 24, 2012. As a result, Mr. Wright then issued a witness report stating that an employee had informed him said employee's doctor advised her that she had a condition known as trigger finger. Petitioner's testimony did not establish that there was an accident.

Based upon the foregoing, the Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of employment.

The remaining issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brendon Gibson,
Petitioner,

vs. No: 17 WC 01547

18IWCC0483

State of Illinois,
Illinois Youth Center-Harrisburg,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 15, 2018, is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: AUG 6 - 2018

o-08/01/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIBSON, BRENDON
Employee/Petitioner

Case# **17WC001547**

STATE OF ILLINOIS/IYC HARRISBURG
Employer/Respondent

18IWCC0483

On 2/15/2018, 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 1.78% 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
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0502 STATE EMPLOYEES RETIREMENT
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0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
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CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

FEB 15 2018

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

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
NATURE AND EXTENT ONLY

BRENDON GIBSON
Employee/Petitioner

v.

STATE OF ILLINOIS/IYC HARRISBURG
Employer/Respondent

Case # **17** WC **01547**

Consolidated cases: _____

18IWCC0483

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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 16, 2017**. By stipulation, the parties agree:

On the date of accident, **November 4, 2016**, 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 **$86,604.00**, and the average weekly wage was **$1,665.46**.

At the time of injury, Petitioner was **47** years of age, ***single*** with **1** dependent children.

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

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

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 receive credit pursuant to Section 8(e)17 of the Act for the prior award of 7.5% loss of use of the left leg and the prior settlement of 1% loss of use of the left leg, for a total of 8.5% loss of use of the left leg.

Respondent shall pay Petitioner the sum of **$775.18**/week for a further period of **0** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **an additional 0% loss of use of the left leg.**

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

February 12, 2018
Date

ICArbDecN&E p.2

FEB 15 2018

STATE OF ILLINOIS)
) ss
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

BRENDON GIBSON
Employee/Petitioner

18IWCC0483

v.

Case #: 17 WC 01547

STATE OF ILLINOIS/IYC HARRISBURG
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on November 4, 2016, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 47 years old, single, and had one dependent child. He was employed as a Juvenile Justice Supervisor. On November 4, 2016, he responded to a fight between two youth in a classroom. During the altercation, he suffered an injury to his left knee. Respondent's Exhibit 5 is security video from inside the classroom and outside in the hallway. The video shows the altercation, with several officers responding, and shows Petitioner eventually ending up on the ground with one of the youth. After both youth are handcuffed, Petitioner is shown limping as he walked out of the room. The second video shows Petitioner limping down the hallway after the incident. RX5.

Petitioner testified that he had a previous left knee injury on August 13, 2015, for which he received an arbitration award of 7.5% loss of use of the left leg on January 26, 2016. RX3. He also had a left knee injury on May 16, 2016, which he settled for 1% loss of use of the left leg on March 27, 2017. RX4. Petitioner testified that his left knee was "getting back to normal" prior to the current accident of November 4, 2016, and that he was working full duty without active medical care or medication.

On November 7, 2016, Petitioner presented to Dr. Nathan Mall, who treated him for his previous injury. He reported swelling and popping and complained of pain laterally and posteriorly. He stated he had some radiating pain down the lateral aspect of his leg to his ankle. He also reported some mild low back pain. On examination, there was mild effusion in the left knee and pain along the lateral joint line, especially very far posterior in the area of the lateral

gastric and lateral hamstring. Stability, sensation, and motor function were intact. There was some discomfort over the peroneal nerve, which caused some mild symptoms down into his ankle. He had some pain in his left leg with forward flexion of his lumbar spine and some discomfort to palpation on the left and along midline of the lumbar spine. Assessment was lumbar strain and possible left knee lateral meniscal tear. Dr. Mall recommended an MRI of the knee, physical therapy for the knee and the lumbar spine, and anti-inflammatory medication. He was allowed to return to work full duty and was to follow up in about three weeks. PX3. Petitioner testified that did not return to Dr. Mall following this examination.

On November 8, 2016, Petitioner underwent a left knee MRI. It revealed (1) intact menisci and cruciates; (2) small medial trochlear osteochondral defect, noted as ***"present on previous study from May and is essentially unchanged"***; (3) patellar tendinopathy; (4) minimal joint effusion; and (5) mild thickening of the iliotibial band and adjacent edema, noted as ***"present previously without significant change"***. PX5.

On November 9, 2016, Petitioner presented to NovaCare Rehabilitation for a physical therapy initial evaluation. He reported constant ache in the lateral and anterior knee with occasional shooting pain with weight-bearing activities. The Arbitrator notes that Petitioner's complaint to Dr. Mall was pain laterally and *posteriorly*, rather than anteriorly. According to the submitted bills, Petitioner underwent therapy on November 9, 11, 14, 17, 23, 25, 30, and December 2 and 5, 2016, for a total of nine therapy sessions. The discharge summary of January 11, 2017, notes his prognosis was excellent. PX4.

Petitioner testified that physical therapy helped somewhat but did not get him where he felt he needed to be. He testified that his left knee is worse now that it was before his most recent accident and that he has limited mobility that inhibits his ability to move quickly. He stated his range of motion comes and goes. He takes Aleve twice a day to help with his pain and improve his mobility. He testified that his knee is not as stable as it used to be and he now wears a brace to help with stability. He sometimes wears a compression sock to add warmth and comfort to his knee. He testified that the severity of his symptoms varies with his level of activity. He had no complaints with regard to his low back.

On cross-examination, Petitioner admitted he had treated only one time with Dr. Mall and that he had not had any treatment since his release from therapy.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although Petitioner's date of accident was after the effective date of Section 8.1b of the Act, neither

party offered into evidence a reported level of impairment pursuant to Subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Juvenile Justice Specialist at the time of the accident and that he was able to return to work in that capacity without any restrictions or limitations as a result of said injuries. The Arbitrator notes that Petitioner did not describe his job in any detail. However, the security video clearly shows that his job can entail physical encounters with the youth at the facility. The Arbitrator places greater weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 47 years old at the time of the injury. The record reveals that he had a relatively short and uncomplicated regimen of treatment. The Arbitrator notes this was Petitioner's third left knee injury in a 15-month period of time. Over time his condition could improve, stay the same, or get worse. The Arbitrator places some weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, there was no evidence that Petitioner's future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that petitioner sustained a strain injury to his left knee, his third such injury in 15 months. He had one doctor visit and nine therapy appointments over a one-month period. He missed no time from work. Petitioner testified he continues to have limited mobility and range of motion, which makes it difficult for him to move quickly. He testified he has loss in stability, for which he now wears a brace. The Arbitrator notes, however, that the prior Arbitration Decision reflects that Petitioner testified at that hearing to nearly identical complaints, including limited mobility, stiffness, and difficulty with movement and running at work. He also testified that he continued to wear the brace he had been given and took anti-inflammatory medication. It would appear, therefore, that there has been little or no change in Petitioner's condition following the most recent accident. The Arbitrator places significant weight on this factor.

The Arbitrator finds that Respondent is entitled to a credit pursuant to Section 8(e)17 of the Act for the prior award of 7.5% loss of use of the left knee, and the prior settlement of 1% loss of use of the left knee, for a total credit of 8.5% loss of use of the left knee.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained an additional 0% loss of use of the left knee, pursuant to Section 8(e) of the Act. Respondent is not liable for any additional permanent partial disability.

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

Charles Parker,
Petitioner,

vs. No: 15 WC 31065

State of Illinois,
Chester Mental Health Center,
Respondent.

18IWCC0484

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 2, 2018, is hereby affirmed and adopted.

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

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

18IWCC0484

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED:

AUG 6 - 2018

o-08/01/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PARKER, CHARLES
Employee/Petitioner

Case# **15WC031065**

SOI/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

18IWCC0484

On 3/2/2018, 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 1.83% 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
TOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
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

MAR 2 - 2018

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

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
NATURE AND EXTENT ONLY

CHARLES PARKER
Employee/Petitioner

v.

STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **15** WC **31065**

Consolidated cases: _____

18IWCC0484

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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 11, 2017**. By stipulation, the parties agree:

On the date of accident, **July 30, 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 **$103,776.05**, and the average weekly wage was **$1,995.69**.

At the time of injury, Petitioner was **41** years of age, ***single*** with **3** dependent children.

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

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

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 $**755.22**/week for a further period of **125** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **25% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **February 6, 2017,** through **October 11, 2017**, 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

February 28, 2018
Date

ICArbDecN&E p.2

MAR 2 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

18IWCC0484

CHARLES PARKER
Employee/Petitioner

v. Case #: 15 WC 31065

STATE OF ILLINOI/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on July 30, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability.

On the date of accident, Petitioner was 41 years old, single, with three dependent children. He was employed by Respondent as a Laboratory Director. Petitioner testified that on July 30, 2015, he was sitting in a chair with a broken wheel that snagged on the flooring and caused him to flip out of the chair and fall. He testified that he injured his neck, shoulder, and lower hip as a result of the incident. He denied any prior injuries or treatment to his neck or shoulder and denied any prior worker's compensation claims.

Following the accident, Petitioner presented to the emergency room at Chester Memorial Hospital on July 30, 2015. He reported a consistent history of the accident and complained of pain in his lower back that shot up to the right rib area on the side. Lumbar x-rays were normal, as were right rib x-rays. Assessment was chest contusion and low back strain. Petitioner was instructed to follow up with his family physician. PX3.

On August 4, 2015, Petitioner presented to Quality Healthcare Clinics and was evaluated by Physician's Assistant Dana Lakatos. He reported a consistent history of the accident and complained of pain in the back and right-sided ribs, along with some stiffness in his neck and some tingling in his right index finger. Examination revealed decreased range of motion in the neck and palpable tenderness to the occipital muscles. Petitioner was instructed to take ibuprofen and use ice off and on for 24 hours. PX4.

On August 24, 2015, Petitioner underwent a cervical MRI ordered by PA Lakatos. It revealed (1) advanced multilevel degenerative spondylosis; (2) cord impingement, severe at C5-6 and C6-7 with evidence of early chronic myelopathy; and (3) severe impingement of the nerve roots on both sides, particularly right C5, right C6, and bilateral C7 levels. The radiologist noted, "Neurosurgical management is indicated." PX5.

Petitioner returned to Quality Healthcare on August 28, 2015, and was evaluated by Dr. Kelly Wood. He reported continued neck pain that radiated down his arm, numbness and tingling, and difficulty moving his head. On examination, he had limited range of motion due to pain and positive Spurling's sign. Dr. Wood prescribed Prednisone and recommended referral to a neurosurgeon. PX4.

On September 9, 2015, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis. He reported a consistent history of the accident and his treatment to date. He complained of neck pain with headaches, pain into the right trapezius and shoulder, pain down his right arm to his thumb and index finger, and weakness and numbness into his hand. He indicated he had been dropping objects. He also complained of some central low back pain, but indicated that the neck was much worse. On examination, he had pain into his right trapezius, right shoulder, and down his right arm. Range of motion was decreased, and sensation to C6 on the right was decreased. Dr. Gornet reviewed the MRI and noted obvious disc herniations out into the foramen at C4-5, C5-6, and C6-7, particularly at C5-6, where there was a disc osteophyte and acute on chronic disc pathology. He noted that these findings correlated with Petitoner's complaints, which he causally related to the work accident. Dr. Gornet referred Petitioner for injections and dispensed Meloxicam and Cyclobenzaprine. PX6.

On September 17, 2015, Petitioner underwent a right C5-6 epidural steroid injection by Dr. Kaylea Boutwell. On October 1, 2015, he underwent the same injection at right C6-7. PX7.

Petitioner returned to Dr. Gornet on October 8, 2015, and reported that the first injection gave substantial relief but that the pain was returning. He complained of pain in his neck, right trapezius, right shoulder, and down his right arm, as well as headaches and weakness and numbness in the right hand. He continued to have weakness in his right shoulder and arm, decreased motion, and decreased sensation at right C6. Dr. Gornet recommended surgery to consist of disc replacement at C4-5, C5-6, and C6-7. He further recommended a CT myelogram and an updated MRI prior to surgery. PX6.

On December 17, 2015, Petitioner was evaluated by Dr. Keith Wilkey, Respondent's Section 12 examiner. He reported a consistent history of the accident and his treatment to date. Following review of records and a physical examination, Dr. Wilkey opined that Petitioner's disc bulges were caused by his work accident, which also aggravated his preexisting arthritis. He agreed with the need for surgery. PX13.

On January 25, 2016, Petitioner underwent CT myelogram and updated MRI, as ordered by Dr. Gornet. PX10, PX11. He was seen by Dr. Gornet the same day, following the studies. Dr. Gornet noted they showed (1) a circumferential disc bulge with superimposed left lateral recess-foraminal herniation at C6-7, resulting in severe left greater than right foraminal stenosis, ventral

cord flattening, and moderate central canal stenosis; (2) C5-6 circumferential disc bulge with superimposed right lateral recess-foraminal herniation, resulting in severe right greater than left foraminal stenosis, ventral cord flattening and central canal stenosis; and (3) right paracentral herniations at the C3-4 and C4-5 level, resulting in dural displacement at each level with ventral cord flattening at C4-5. Dr. Gornet recommended surgery by way of a three-level disc replacement at C4-5, C5-6, and C6-7 with right-sided foraminal decompression at C5-6 and C6-7. PX6.

On February 3, 2016, Petitioner underwent a three-level disc replacement, at C4-5, C5-6, and C6-7 with decompression of foraminal stenosis. He followed up with Dr. Gornet on February 25, 2016, and reported his headaches were improved, as was the tingling in his hands. He returned on March 17, 2016, and it was noted, "He continues to do significantly well. He is pleased and feels his pain is dramatically improved." He was instructed on a home exercise program and continued on Meloxicam and Cyclobenzaprine. He was released to return to work full duty with no restrictions beginning on March 28, 2016. Petitioner followed up with Dr. Gornet on May 12, 2016, and reported he was continuing to work full duty. It was noted, "He continues to do extremely well." A CT scan done that day showed good decompression with no evidence of any significant subsidence or other mechanical issues. Petitioner was instructed on lifting light weights and high repetitions and was continued on Meloxicam. PX6, PX11.

On July 20, 2017, Petitioner presented to Dr. Richard Katz for an AMA examination at Respondent's request. Dr. Katz is a board certified physician who practices physical medicine and rehabilitation in St. Louis, Missouri. He is a professor of clinical neurology within the Division of Physical Medicine and Rehabilitation at Washington University in St. Louis. He is also one of the editors of the AMA Guides to the Evaluation of Permanent Impairment 6th Edition. RX2, RX3.

Dr. Katz noted that Petitioner had a good surgical outcome, but that his records also demonstrated that he required medication every day to control his pain. Petitioner indicated on the "Pain Disability Questionnaire" that he took medication throughout the day to manage his symptoms. Petitioner also reported that his pain moderately interfered with his work activity, his ability to perform overhead work and lift objects, and his recreational activities, and mildly interfered with personal care activities, traveling, walking and socializing. RX2.

In assessing impairment, Dr. Katz used the diagnosis of multiple level AOMSI (alteration of motion segment integrity) with resolved radiculopathy. He concluded that Petitioner had an impairment rating of 6% of the whole person. RX2.

On August 15, 2016, Petitioner returned to Dr. Gornet. It was noted, "He continues to do remarkably well. He is exceedingly pleased with his progress." He was allowed to continue working full duty with no restrictions. Dr. Gornet dispensed Cyclobenzaprine to help with management of symptoms. PX6.

Petitioner followed up with Dr. Gornet on February 6, 2017. It was noted, "He continues to do exceedingly well. He is working full duty with no restrictions. He had no focal complaints." A CT scan done that day showed no evidence of lucency, subsidence, or other mechanical issues. Petitioner was placed at maximum medical improvement and released from care. It was noted, "He feels the surgery has made a huge difference in his life and his quality of life." PX6, PX11.

Petitioner testified at hearing that he was working full duty without restrictions and was able to perform all of his job activities. Since his return to work from the injury he has received a promotion, though it did not include a pay raise. He testified that he continued to have neck pain and right upper extremity numbness and that his symptoms were aggravated by posture such as when lying down or reading. He notices an increase in symptoms with rainy or cold weather or when he overexerts himself. He takes Meloxicam and Flexeril for his symptoms, as well as over the counter medication. He testified that his quality of sleep has declined, due to waking up intermittently throughout the night. Petitioner testified that he added a second work screen and had his work station adjusted to better accommodate his condition to avoid spending large amounts of time bending his neck down.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a),** Respondent submitted an impairment rating performed by Dr. Katz, who provided an impairment rating of 6% loss of the person as a whole. Petitioner did not submit an impairment rating. The Arbitrator places significant weight on this factor.

In regard to factor **(ii) the occupation of the injured employee,** the record reveals Petitioner was employed as a Laboratory Director at the time of the accident and that he was ultimately able to return to work in that capacity without any restrictions as a result of said injuries. Since his return he has received a promotion to Quality Director. Petitioner testified that activities such as looking down to read aggravate his symptoms, and he adjusted his work station and added a second monitor to mitigate his symptoms. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury,** Petitioner was 41 years old at the time of the injury. He is a younger person and has several work years ahead of him, during which he must deal with his disability. Over time his condition could improve, stay the same, or get worse. However, he appears to have made a good recovery. The Arbitrator places some weight on this factor.

~~In regard to factor (iv) the employee's future earning capacity, there was no evidence~~ that Petitioner's future earning capacity has been or will be impacted as a result of this injury. As such, the Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records,** the Arbitrator notes that Petitioner sustained disc herniations at C3-4, C4-5, and C5-6

with stenosis, which ultimately required surgery of a three-level disc replacement with decompression. Petitioner testified he continued to have neck pain and right upper extremity numbness and that his symptoms were aggravated by posture such as when lying down or reading. He notices an increase in symptoms with rainy or cold weather or when he overexerts himself. He takes Meloxicam and Flexeril for his symptoms, as well as over the counter medication. He testified that his quality of sleep has declined, due to waking up intermittently throughout the night.

Although Petitioner testified to various ongoing complaints, Dr. Gornet's final two notes do not corroborate his testimony, which is the measure of this factor. On August 15, 2016, Dr. Gornet noted, "He continues to do remarkably well. He is exceedingly pleased with his progress." Dr. Gornet noted in his final treatment record of February 6, 2017, "He continues to do exceedingly well. He is working full duty with no restrictions. He had no focal complaints." The CT scan that day showed no evidence of lucency, subsidence, or other mechanical issues. Dr. Gornet went on to note, "He feels the surgery has made a huge difference in his life and his quality of life."

The Arbitrator notes there is some difference between Petitioner's testimony and what is recorded in the final treating medical records, which goes to the assessment of his disability. It is undisputed, however, that Petitioner underwent a three-level disc replacement. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 25% loss of use of the body as a whole (125 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,995.69. The Arbitrator finds his permanent partial disability rate is $755.22, the maximum rate in effect for his date of accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Coughlin,

Petitioner,

vs.

NO: 16 WC 30695

18IWCC0485

Chellino Crane,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice provided to all parties, the Commission, after considering the issues of accident, causal relationship, temporary total disability benefits, medical expenses, prospective medical care and reimbursement of Union health and disability benefits and being advised of the facts and the law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with supporting analysis.

Conclusions of Law

A. Accident

On the threshold issue of accident, the Commission affirms the Arbitrator's finding Petitioner failed to prove he sustained an accidental injury arising out of his employment on August 16, 2016.

Petitioner testified he stepped over a concrete wall and down onto gravel, a distance of 12 inches and felt a sharp pain in his left heel. T. 12-13. From the job site, Petitioner obtained treatment at Morris Hospital emergency room. T. 15. The following colloquy occurred between

Petitioner and his attorney: "Q. If those records reflect that you were walking when you felt a sharp pain in your left heel, would that be accurate? A. Yes. Q. Okay. And were you simply walking or did you -- A. I was briskly walking. I was not running. I wasn't just casual walking. I was trying to get around to the other side. Q. Right. And then that's when you found that there was this unusual drop of 12 inches between the floor that you were on to where you sort of landed? A. Yes." T. 15-16.

On cross-examination, Petitioner testified he did not remember talking to a Dr. Lam by telephone after being treated at Morris Hospital emergency room. T. 34. However, Dr. Lam's August 16, 2016 Telephonic Report, RX4, noted the following: "This is a telephonic report for a 47-year-old male who admitted that he has had a chronic issue of left heel for several weeks presented with a mysterious onset of left heel pain. He said he was simply stepping down, but did not have any accident. He denied specifically slipping on any wet surface or tripping on any object. He specifically denied lifting, pushing, pulling, or carrying anything heavy that would have tilted his balance." Petitioner testified he was simply stepping down and did not appreciate any defect which would cause him to slip or trip. T. 31.

The medical records evidence Petitioner was seen at the emergency room at Morris Hospital on August 16, 2016 for chief complaint of left foot pain. The following history was noted under Mechanism of Injury: "Unknown mechanism. Patient was at work and took a step and had immediate left heel pain today. Patient states he is unable to bear weight after the pain initiated other than walking on his toes." It was noted symptoms were localized at the left heel at the Achilles attachment. Petitioner reported his pain was dull and aching and he rated his pain at 8/10. Petitioner reported sudden onset of symptoms and constant pain. There was no associated ankle pain. Petitioner reported pain with walking. His pain was exacerbated by extension, flexion, inversion, pronation and weight bearing. His pain was relieved by remaining still. Petitioner reported no past medical history of left Achilles pain.

The August 16, 2016 ER Triage Notes indicate Petitioner was seen for left heel pain. The following was noted: "pt states he was walking and developed sharp pain in his heel." The August 16, 2016 ER Nursing Assessment indicates the following under Musculoskeletal Notes: "c/o pain left heel area. pt states was walking at work and felt sharp pain in Achilles area. no trauma or sudden movement. No swelling noted. distal n/v intact. no other complaints." Petitioner was discharged to home in a wheelchair. He was prescribed Norco to be taken as needed and was to follow up with his primary care physician. Petitioner was released to return to work full duty. PX1. The Commission notes there was no mention of an August 16, 2016 stepping down event.

The medical records evidence Petitioner was seen by Dr. Dworsky at Hinsdale Orthopaedics on August 22, 2016 for complaints of left heel pain at the os calcis. Petitioner rated his pain at 3/10. Dr. Dworsky noted Petitioner reported, "The pain has increased in severity over the past 1 week(s). The quality of pain is described as being sharp and stabbing." The following history was noted: "Patient comes in with increased complaints of left heel/calf

pain. He states he was walking at work with his boots on and felt something sharp in the back of his leg. He states it felt like a dog bit him. He went to Morris ER and was told he had tendonitis and was sent back to work. He currently has pain along his calf as well as his heel with visible ecchymosis. He states he is able to walk, but with pain. He states he was doing well after the injection." More history was noted: "Mr. Coughlin is a 47-year-old with left heel and calf pain. He states he was just walking around. He was doing a lot of activities. All of a sudden had a sharp, stabbing pain in the back of his calf down to his heel like a dog bit him. Patient continued to work. He still has significant sensitivity. P noted some bruising." The Commission notes there was no mention of an August 16, 2016 stepping down event. PX2.

The Commission finds the histories provided by Petitioner to Dr. Lam, the Morris Hospital emergency room and Dr. Dworsky are consistent that Petitioner experienced pain while walking which is in direct contrast to Petitioner's testimony at trial. The Commission finds Petitioner's testimony is not consistent with the contemporaneous medical records and is, therefore, not credible.

B. Causal Relationship

Even assuming *arguendo* an accident occurred, the Commission finds Petitioner failed to prove a causal relationship exists between such incident and Petitioner's condition of ill-being. Petitioner testified prior to August 16, 2016, he sought treatment from Dr. Dworsky for left heal pain. T. 22. Petitioner testified he received an injection, but such injection was not located in the Achilles tendon. T. 24.

On cross-examination, Petitioner testified prior to August 16, 2016, he sought treatment for left heal spur beginning in the summer of 2014. T. 34-35. Petitioner testified Dr. Helmer performed surgery for the bone spur in March or April of 2015. T. 35. Following the surgery, Petitioner continued to treat with Dr. Helmer who also performed an injection. T. 37. Petitioner testified Dr. Helmer referred Petitioner to Dr. Dworsky due to continued pain emanating from the inside of Petitioner's left foot. T. 38.

The medical records prior to August 16, 2016 evidence Dr. Helmer evaluated Petitioner on January 15, 2015 at which time Petitioner complained of left heel pain located in the back area over the last several years. There was no significant previous treatment and no history of injury reported. Petitioner reported subjective pain with standing, walking and aggravated by long-term standing. His pain was located at the left heel region, posterior aspect, radiating up the back of his left leg. Dr. Helmer noted there was objective evidence of Achilles tendonitis clinically with palpable evidence of an enlargement of bone in the left retro heel region. There was inflammation with evidence clinically of tinea pedis, pronation syndrome on standing and walking and genu varum. Podiatric findings were retro heel spur, left Achilles tendonitis, pronation and tinea pedis. Dr. Helmer's podiatric diagnosis was left Achilles tendonitis. On January 22, 2015, Dr. Helmer noted the same as above along with chronic fungus infection of the

skin with dystrophy changes. Dr. Helmer noted the same on January 29, 2015, and his treatment was orthotic therapy. RX3.

On February 27, 2015, Dr. Helmer noted Petitioner was improved with orthotic therapy. Dr. Helmer noted on March 12, 2015 Petitioner was still having symptoms despite orthotic therapy. Removal of the left heel spur was discussed, and Petitioner consented to the procedure, which was performed that day. On April 9, 2015, Petitioner underwent post-surgical redressing. He was doing well and was to remain non-weightbearing. Post-surgical redressing and cast revision was done on April 20, 2015. Post-surgical redressing with suture removal was done May 4, 2015. Petitioner reported on May 12, 2015 being somewhat stiff while walking. His range of motion was improved and he was to continue walking as tolerated. He was the same on June 16, 2015 and he was to continue walking as tolerated. RX3.

On October 12, 2015, Dr. Helmer noted Petitioner's complaints of pain in the back of his left heel was chronic. Dr. Helmer noted objectively, Petitioner's left foot Achilles tendonitis was still present post-operatively. Dr. Helmer's podiatric diagnosis was left Achilles tendonitis which was then treated with a cortisone injection. On January 5, 2016, Dr. Helmer noted Petitioner was the same and prescribed medications. On February 29, 2016, Dr. Helmer noted Petitioner was the same and ordered a left foot MRI and provided another injection. Dr. Helmer noted on March 29, 2016 Petitioner was improved with injection therapy. Dr. Helmer noted surgery was still contemplated if necessary. RX3.

The medical records prior to August 16, 2016 evidence Dr. Dworsky initially evaluated Petitioner on June 22, 2016. Dr. Dworsky noted the following history: "David Coughlin is a pleasant 47-year old male who presents today for lt heel pain. Location of pain is the OS calcia. The patient describes the pain as being a 6 out of 10 on a 10-point pain scale. This has been going on for approximately 1 year (s). The quality of pain is described as being sharp and stabbing. Symptoms occur during the entire day…Patient comes in complaining of left heel pain that started about a year and a half ago with no known onset. He states he had a strange sensation along his heel while he would wear boots and decided to proceed with surgery to shave down the bone in May 2015. He states he was in a cast for 4 weeks and did well for a few weeks after the cast was removed, but then developed pain again. He states the pain is now located on the medial aspect of his posterior Achilles…There is a spot on the inner aspect of his heel where it is hypersensitive to the point where it drops him." Dr. Dworsky noted Petitioner underwent x-rays, MRI, cortisone injections and medication, all short-lived. Dr. Dworsky noted Petitioner presented for a second opinion.

On examination of the left foot and ankle, Dr. Dworsky found good range of motion; no weakness; no pain complaints; dorsiflexion at 20°, neutral; plantar flexion at 45°; inversion at 10°; eversion 5°; pronation was not present; hyper pronation was not present; heel valgus was not present; there was no effusion, no ecchymosis, no calf atrophy; normal alignment; tenderness over the hindfoot and posterior heel; heel raises were strong; toe raises were strong. X-rays from St. Joseph's were reviewed and interpreted as showing no acute fracture or dislocation. Dr.

Dworsky injected the tender Achilles tendon insertion. Dr. Dworsky noted, "I do feel that since his sensitivity is so much and it is to palpation more than anything else, this may be more of a neuroma that has developed in that region." Petitioner was to follow up in 10-14 days. On July 1, 2016, Dr. Dworsky noted Petitioner reported the injection helped. Dr. Dworsky noted, "David states that the injection pretty much eliminated all his pain." Dr. Dworsky further noted, "I explained to David that as long as it stays that way we are fine; if it recurs, we know where to go." PX2.

On April 11, 2017, Dr. Dworsky provided testimony via evidence deposition. Dr. Dworsky testified he was a board certified orthopedic surgeon with subspecialty in sports medicine. Dr. Dworsky recited from his records. Dr. Dworsky testified Petitioner's August 22, 2016 presentation was a new condition and different from the condition, a neuroma, for which Petitioner had obtained treatment. PX5, p. 11. After the September 1, 2016 MRI, Dr. Dworsky diagnosed Petitioner with a complete tear of the Achilles tendon in his left leg. PX5, p. 12. Dr. Dworsky testified Petitioner did not have any signs or symptoms consistent with Achilles tendon tear prior to August 16, 2016. *Id.* Petitioner's attorney stated: "Q. Okay. Now, Mr. Coughlin related to me that he wasn't simply walking around, but he stepped down awkwardly down off a 12-inch step. It wasn't the normal rise and run you would see in a normal stair. And when he stepped down off of that step is when he felt the – what felt like a dog biting him. Would that mechanism of injury be something consistent that would cause and aggravate or accelerate in a tear of the Achilles tendon?" Px5, p. 12-13. Dr. Dworsky responded: "A. Any eccentric load where a patient is decelerating, really down from a step, would be enough force to injure an Achilles tendon, especially in a situation where there may be some susceptibility." PX5, p. 13. Dr. Dworsky testified the greater the distance (in stepping down), the greater the force, the more likely the strain would occur in that type of situation. *Id.* Dr. Dworsky opined the Achilles tendon tear is causally related to the incident at work where Petitioner stepped down an awkward 12-inch step feeling a pop in his ankle at the conclusion of that step. *Id.* Dr. Dworsky testified there was a further tearing of the Achilles tendon post-op. PX5, p. 14. A second surgery was recommended but has not been scheduled. PX5, p. 15. Dr. Dworsky opined causation for this procedure to the August 16, 2016 accident. *Id.*

During cross-examination, Dr. Dworsky testified Petitioner's June 22, 2016 visit was a second opinion from Dr. Helmer. PX5, p. 19. At the visit, Petitioner provided a history to Dr. Dworsky of his prior left heel surgery in May 2015. *Id.* Petitioner advised Dr. Dworsky he was experiencing left heel pain for about a year and a half prior to the visit. *Id.* At that visit, Petitioner described sharp and stabbing left heel pain. PX5, p. 20. Petitioner reported a hypersensitive spot on the inner aspect of his left heel which would drop him; Petitioner advised Dr. Dworsky any pressure on that spot would cause him to drop. *Id.* Dr. Dworsky injected the left Achilles tendon region. PX5, p. 21. Dr. Dworsky testified Petitioner's situation was around the medial aspect of the proximal calcaneus, rather than directly into or next to the Achilles tendon; it was on the medial or inner aspect of the heel itself. *Id.* Dr. Dworsky testified this is different from in the note where it says, "Into the left Achilles tendon insertion sterilely." Dr. Dworsky acknowledged cortisone injections into a tendon can weaken the tendon. *Id.* Dr.

Dworsky testified he has never injected into a tendon and especially the Achilles tendon. *Id.* This was an injection for the neuroma, which was Dr. Dworsky's working diagnosis on that date. PX5, p. 23. On July 1, 2016, Petitioner reported he was pain-free and that the pain he was experiencing pretty much eliminated all of this because of the injection. *Id.* Dr. Dworsky testified a neuroma is scar tissue; cortisone has been shown to be quite effective in diminishing scar tissue or decreasing the scarring and inflammation associated with it. PX5, p. 24. Dr. Dworsky was not aware of any prior injections. The only information Dr. Dworsky had previously was that Petitioner underwent prior surgery. *Id.* Dr. Dworsky was not aware of any injection in March 2016 into Petitioner's left Achilles or left heel. *Id.* In his July 1, 2016 notes, Dr. Dworsky indicated Petitioner reported he was pain free and Dr. Dworsky noted if the pain recurs, "we know where to go." PX5, p. 24-25. Dr. Dworsky explained if the injection had limited relief or short-term relief, he would have to excise the nerve. PX5, p. 25.

Dr. Dworsky testified he was aware Petitioner had undergone a prior left heel surgery, but was not aware a second surgery was being contemplated in March 2016. PX5, p. 25. On June 22, 2016, Petitioner reported pain at 6/10 and on August 22, 2016, Petitioner reported decreased pain at 3/10. Dr. Dworsky testified during his August 22, 2016 examination, he could not determine whether the Achilles tendon had torn or not, which is why he did not immediately recommend an MRI. PX5, p. 31. On August 22, 2016, Dr. Dworsky did not specifically diagnose an Achilles tear or rupture. *Id.* Petitioner's physical examination was not distinctly diagnostic of it, and Dr. Dworsky felt he could observe this to see if Petitioner was going to get better or if he was going to continue to have problems. *Id.* Dr. Dworsky testified it is possible that the rupture could have occurred between August 16, 2016 and the September 1, 2016 MRI. PX5, p. 33. Dr. Dworsky testified the February 13, 2017 MRI showed another tear of the Achilles tendon. PX5, p. 36. Petitioner did not mention any specific event which would have caused a reinjury to the Achilles tendon. PX5, p. 36-37. Dr. Dworsky testified he was not provided Petitioner's prior medical records regarding his left heal treatment. PX5, p. 37.

On October 21, 2016, Dr. Vora evaluated Petitioner at Respondent's request pursuant to §12 of the Act. In his November 7, 2016 report, RX1, DepExB, Dr. Vora noted he reviewed Petitioner's medical records and obtained a history from Petitioner who reported pain and discomfort in his left Achilles and heel region. Petitioner reported he underwent surgery in April 2014 or 2015 with Dr. Helmer for an Achilles tendon spur, which was removed. Petitioner reported he was doing well and had no problems afterwards, no foot or ankle problems and was walking without problems, but then stepped down when walking and felt acute onset of pain, a pins and stabbing sensation in the back of his left heel. There was no specific trip or fall. Dr. Vora noted: "He was just doing his normal walking at that time when he took a 12-inch step down and it felt like a dog bit him on the heel on the date of August 16, 2016." Petitioner reported to Dr. Vora he ultimately underwent surgery as there was noted to be evidence of a rupture in his tendon. Petitioner reported he had no problems after his initial surgery in 2014 or 2015 and the initial surgery was to simply remove a bone spur. Dr. Vora noted Petitioner was currently post-op from his most recent surgery; he is non-weightbearing and wearing a boot.

On examination of the left lower extremity, Dr. Vora found a recent surgical incision C-shaped along the posterior insertion Achilles area well healed; lateral incision along the distal calcaneus well healed, just slightly distal and lateral to the acute healing incision; calf atrophy was noted; there was evidence of post-surgical immobilization; lack of plantar flexion or calf squeeze. Dr. Vora reviewed the June 22, 2016 x-rays and noted "evidence of severe insertional calcific changes of the tendo Achilles and large posterior superior prominence Haglund deformity, advanced calcific changes of the tendo Achilles, both within the substance of the tendon as well as distally at the calcaneal insertion with a prominent tuberosity noted." Subsequent x-rays were also reviewed. The September 1, 2016 MRI scan was personally reviewed by Dr. Vora who noted evidence of an insertional Achilles tendon complete rupture.

In his report, Dr. Vora diagnosed "status post left insertional Achilles tendon rupture with previous surgical intervention for 'bone spur' removal, likely previous calcaneal Haglund exostectomy, status post insertional Achilles tendon re-rupture and reattachment repair." Dr. Vora opined no causal relationship existed between Petitioner's current condition and any alleged work-related injury mechanism. Dr. Vora noted: "In my opinion, he did not sustain a work injury and his current condition predates the claimed work injury of August 16, 2016." Dr. Vora opined Petitioner's previous history of "bone spur" removal is consistent with that of previous calcaneal Haglund resection or calcaneal insertional exostectomy and this condition was present prior to August 16, 2016. Dr. Vora opined: "In addition, in the treating provider's medical history and initial visit records dated June 22, 2016, with history of pain a year and a half prior, with previous surgery to "shave down the bone" and subsequent treatment with findings noted to be consistent with that of insertional Achilles tendinitis suggest pre-existing condition. Furthermore, it should be noted that this condition is also a degenerative chronic condition. In addition, the provided records document that the examinee underwent treatment for this condition prior to the claimed work injury of August 16, 2016, and most importantly just prior to the claimed work injury he underwent a cortisone injection, which is more likely an additional implicating factor for the subsequent rupture of the tendon at the insertion. In addition, the description of no specific acute trauma and only that he was walking on August 16, 2016, is more consistent with that of activities of daily living and related to underlying chronic degenerative condition and not a work injury."

Dr. Vora further opined: "In summary, the left lower extremity condition is pre-existing. Prior to the claimed injury date, surgery was performed to 'address' the heel spur, which is a causative condition and the examinee's subsequent insertional rupture, examinee underwent treatment prior to the reported work injury. Further, the reported work injury is inconsequential in terms of mechanics of anything that would be isolated from activities of daily living versus "work-related injury" of some trauma either acute or cumulative, atraumatic, and finally the examinee underwent previous treatment for the current condition and further underwent a cortisone injection, which is a causative factor in the subsequent rupture, which occurred and was identified subsequently."

Dr. Vora also opined: "It should also be noted that in Dr. Dworsky's medical record of August 22, 2016, which is subsequent to the reported injury date of August 16, 2016, it is specifically noted that there is good range of motion of the left ankle, no weakness and no pain. This physical examination would be inconsistent with an Achilles tendon rupture as it relates to the reported work activity on August 16, 2016, as an Achilles tendon rupture would easily be identified on clinical examination. In summary, there is no work-related basis for the examinee's condition based on the multiple reasons as outline above."

Dr. Vora authored an addendum report on January 4, 2017. In this report, RX1, DepExB, Dr. Vora noted he had received a January 3, 2017 cover letter and additional medical records of Petitioner's treatment with Dr. Helmer, which were reviewed and noted. Dr. Vora noted Dr. Helmer's conservative treatment initially was for Achilles tendonitis calcific with a recommendation for orthotics. Dr. Vora requested the Operative Report for "bone spur removal." Dr. Vora opined the subsequent rupture of the Achilles tendon is directly related to the previous surgical procedure performed, lack of post-surgical improvement and multiple (3) cortisone injections placed in the posterior Achilles and retrocalcaneal region, which is well documented to be a risk factor for Achilles tendon rupture. Dr. Vora made the same opinions as in his November 7, 2016 report IME Report. Dr. Vora opined he did not believe Petitioner's condition was accelerated or exacerbated by any work-related alleged injury.

Dr. Vora authored a further addendum report on February 13, 2017. In this report, RX1, DepExB, Dr. Vora noted he received a February 6, 2017 cover letter and Dr. Dworsky's December 13, 2016 letter with responses to questions from Petitioner's attorney. Dr. Vora did not change his opinions based on what he had received. Dr. Vora opined Dr. Dworsky's statement that the injection would not be a contributory factor is not accurate and not supported by the literature. Dr. Vora noted the improvement as of July 1, 2016 does not suggest that the tendon had resolved or symptoms had improved other than to state that the cortisone injection provided transient relief. Dr. Vora noted: "Finally, as noted, stepping off a 12-inch step with a chronically degenerative Achilles tendon with previous surgical treatment and recent cortisone injection, although may have been a causative factor and the ultimate Achilles tendon rupture, is not supported by the medical records of August 22, 2016, when it is clearly documented that the Achilles tendon is otherwise intact. To the contrary, it is stated that the "Achilles tendon is intact" on the date of this visit."

On April 27, 2017, Dr. Vora provided testimony via evidence deposition. RX1. Dr. Vora testified he is a board certified orthopedic surgeon specializing in foot and ankle surgery. Dr. Vora recited from his reports, which are noted above. Dr. Vora opined injecting cortisone around the Achilles tendon can still have the same effect as injecting the tendon directly. RX1, p. 12. Dr. Vora opined multiple injections at that site make the tendon more susceptible to rupture. *Id.* Cortisone injection is for transient pain relief. Dr. Vora opined if Petitioner had a work incident that caused a rupture it would be evident by examination; the records document the Achilles tendon was intact July 1, 2016 and August 22, 2016. RX1, p. 14. Dr. Vora opined a person cannot perform a toe raise with a ruptured Achilles tendon. *Id.* Dr. Vora opined

weakness is the hallmark finding of an Achilles tendon rupture, so if there is no weakness, then there is no complete rupture. RX1, p. 16. Dr. Vora opined "the distal insertional Achilles rupture is almost always preceded by chronic degenerative calcific changes. In simple terms, the tendon turns into calcium because the tendon is diseased and the bone spur, which is called Haglund's deformity – in layman's terms, the Achilles is like a rope and the Haglund's deformity is like a rigid cliff that rubs against the rope and slowly frays it away." RX1, p. 17-18. Dr. Vora was questioned regarding the 12-inch step down and whether it caused Petitioner to rupture his Achilles tendon. RX1, p. 22. Dr. Vora answered, "I don't think that – I think that that probably is when it actually happened, you know, it's a lot of controversy. I can't tell you that for sure because that means that something is wrong, and I don't want to question another doctor's records, but if it happened on that day, there was no way that his Achilles could have been intact with no weakness, so, something doesn't add up." RX1, p. 23. "...But I do know that even if it happened that day, that's not what caused it. He could have stepped out of bed, he could have stepped on – 12 inches stepping down, it was going to go, it just went there; but that's not – that's like no different than activities of daily living." RX1, p. 23.

On cross-examination, Dr. Vora indicated a person does not suffer an Achilles tendon rupture from stepping off or coming off a height. An Achilles tendon rupture is an eccentric sudden acceleration-deceleration. RX1, p. 26. Dr. Vora noted Dr. Dworsky clearly noted on August 22, 2016 Petitioner was able to do a toe rise, which is impossible with an Achilles tendon rupture. RX1, p. 29. The Achilles tendon inserts into the heel region. RX1, p. 32. Dr. Vora opined stepping down 12 inches was an extremely unlikely causative factor that he has never seen before. RX1, p. 35. This is not a cause of an Achilles tendon rupture that is published. *Id.*

On re-direct examination, Dr. Vora testified the September 1, 2016 MRI evidence an Achilles tendon rupture. RX1, p. 36. Based on his review of Dr. Dworsky's records, Petitioner's Achilles tendon was still intact on August 22, 2016. RX1, p. 36. The following colloquy occurred between Respondent's attorney and Dr. Vora: "Q. And we had just went over a broad hypothetical kind of. Do you believe in this specific instance that the step down, the 12-inch step down or whatever the height of it is, if it is 12 inches, caused this Achilles rupture based on the 8/22/16 note in the objective findings on physical examination in that note? A. Impossible." RX1, p. 36-37.

The Commission weighs the competing medical evidence and finds Dr. Vora's opinions more persuasive than those of Dr. Dworsky. Dr. Vora reviewed Petitioner's treatment records prior to August 16, 2016, while Dr. Dworsky did not. PX5, p. 37. Based upon his lack of understanding of Petitioner's prior medical treatment, Dr. Dworsky opined the Achilles tendon tear, found on the September 1, 2016 MRI, is causally related to the August 16, 2016 incident at work. PX5, p. 13. An expert's opinion is only as valid as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC.

In contrast, Dr. Vora possessed a complete understanding of Petitioner's prior medical treatment. Dr. Vora opined Petitioner suffered from a chronic degenerative condition for which

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he received treatment. Further the treatment received for such condition, cortisone injections, is a likely causative factor for Achilles tendon rupture. More importantly, Dr. Vora explained stepping from a height even from 12-inches was not a causative factor for Petitioner's Achilles tendon rupture as such is not a competent mechanism of injury. As the Court noted in *County of Cook v. Industrial Commission*:

> Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to recovery under the Workmen's Compensation Act…'In each case the arbitrator ought to consider whether, in substance, as far as he can judge on such a matter, the accident came from the disease alone, so that, whatever the man had been doing, it would probably have come all the same, or whether the employment contributed to it. 68 Ill. 2d 24, 31-32, 368 N.E.2d 1292 (1977).

Petitioner's condition was degenerated to such an extent any activity would have caused the rupture.

Lastly, Dr. Vora noted the medical records document the Achilles tendon was intact on both July 1, 2016 and August 22, 2016. RX1, p. 14. Dr. Vora noted Dr. Dworsky's physical examination performed on August 22, 2016 which clearly noted Petitioner was able to perform a toe rise, which is impossible with an Achilles tendon rupture. RX1, p. 29. Dr. Vora explained a person cannot perform a toe raise with a ruptured Achilles tendon. RX1, p. 14. Therefore, based on the onions of Dr. Vora, the Commission finds Petitioner failed to prove a causal relationship.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's October 31, 2017 decision is affirmed for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained accidental injuries arising out of his employment on August 16, 2016 and failed to prove a causal relationship, his claim for compensation and medical expenses is hereby denied.

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

DATED: AUG 6 - 2018
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o06/05/18
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L. Elizabeth Coppoletti

Joshua D. Luskin

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DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove accident, and that his current condition of ill-being was therefore not causally connected to the accident on August 16, 2016. I would instead reverse the Arbitrator, and find accident and causation, and find that Petitioner did prove his ruptured Achilles tendon arose out of, and in the course of his employment with Respondent, and that he is entitled to TTD, medical expenses, prospective medical treatment in the form of a revision surgery to the Petitioner's Achilles tendon, and reimbursement to Petitioner's union with regard to medical and disability benefits paid.

Accident

Petitioner met his burden of proof that he sustained an accident arising out of and in the course of his employment. Petitioner was working as an oiler at the time of the accident. Per his testimony, part of his job duties included taking care of everything around the machine and making sure that the site is clear when they are moving stuff. He was assisting the crane operator in functions on a construction site. (T. 8) On August 16, 2016, while walking around a machine, he stepped forward from a level of flooring which opened into another level of flooring that was at least 12 inches lower than the floor from which he was descending. (T. 14) He was not carrying anything at the time, and he did not trip or slip. (T. 31) He immediately had shooting pain. The Petitioner's act of walking in the area around a crane with uneven levels of flooring constitutes a risk that is connected or incidental to the Petitioner's employment. The Arbitrator erred in performing a neutral risk analysis. A risk is distinctly associated with employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58 (1989) Petitioner's injury occurred both as a result of a condition on the employer's premises, and because Petitioner was exposed to a greater degree of risk than the general public in walking around large construction machinery on a closed construction site. The evidence presented at the Arbitration hearing was that while Petitioner was walking around machinery, he stepped forward and there was a 10-12 inch drop in the level of the flooring. Based on these facts, and the fact that the injury was otherwise unexplained, it is reasonable to infer that the condition of premises was the cause of Petitioner's Achilles tendon rupture. Assuming, *arguendo*, the condition of the premises was not the cause per se, the Petitioner was exposed to a risk not common to the general public because he was regularly required to walk around large machinery on a closed construction site. The requirement that the Petitioner keep the area clear and navigate an area where a 12-inch steps exists moves this scenario into the area of employment-related risks.

Causal Connection

Petitioner's current condition of ill-being is causally connected to the work-related accident of August 16, 2016. Petitioner credibly testified as to the mechanism of injury, provided supporting photographic evidence of the accident site, as well as his injury (Px7), as well as Dr. Dworsky's testimony causally linking Petitioner's current condition of ill-being to the work accident of August 16, 2016. Dr. Dworsky's testimony is far more persuasive than the testimony of Respondent's Section 12 examiner, Dr. Anand Vora of Illinois Bone and Joint.

The evidence shows that Petitioner immediately felt pain and sought treatment at the Morris Hospital Emergency Room the same day of the accident. The records indicate that Petitioner reported that he felt a sharp pain in his left heel while walking. (Px1, p. 19) On August 22, 2016, Petitioner followed up with Dr. Bradley Dworsky of Hinsdale Orthopaedics. Respondent presented evidence in the form of a deposition and report of Dr. Vora who opined that Petitioner did not sustain an Achilles tendon tear as of August 16, 2016. Dr. Vora bases this opinion on Dr. Dworsky's records where it is noted that Petitioner was able to perform a "toe raise" on August 22, 2016. Dr. Vora opined that it is not physiologically possible for a human being to perform a toe raise if his Achilles tendon was ruptured and, therefore, the Achilles tendon tear must have happened sometime between the initial visit with Dr. Dworsky on August 22, 2016, and the MRI performed on September 1, 2016. This argument is flawed. First, Petitioner entered into evidence photographs depicting his injury dated August 18, 2016, which show significant bruising on Petitioner's left lower extremity. Second, Dr. Dworsky testified that although he had previously treated the Petitioner's left lower extremity, the problems that manifested on August 16, 2016, were a completely new onset and new diagnosis from what Petitioner presented with previously. (Px5, p. 11) Dr. Dworsky's impressions of the MRI dated September 1, 2016 were that Petitioner had a complete tear of his Achilles tendon involving the left leg. (Px5, p. 12) Petitioner did not have any signs or symptoms consistent with an Achilles tendon tear prior to August 16, 2016. *Id.* When Dr. Dworsky was advised that Petitioner had described his accident as one that occurred when he stepped down awkwardly off a 12-inch step, Dr. Dworsky testified that any eccentric load where a patient is decelerating, down from a step, would be enough force to injury an Achilles tendon, especially in a situation where there may be some susceptibility. This scenario would be more likely if an unusually large step down versus the typical rise and run is involved. The greater the distance, the greater the force, the more likely the strain would occur in that type of situation. (Px5, p. 13) Dr. Dworsky testified that to a reasonable degree of medical certainty, based on his knowledge of the Petitioner before this incident and the August 16, 2016 incident, would be that the Achilles tendon did rupture due to that step. (Px5, p. 13-14)

TTD and Medical

As Petitioner has met his burden of proof in regard to accident and causation, Petitioner should be awarded medical bills for reasonable and necessary treatment rendered. Petitioner

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should be awarded the following bills pursuant to the Illinois Workers' Compensation Fee Schedule:

1) Allied Anesthesia: $1,960.00
2) Silver Cross Hospital: $520.33
3) Presence St. Joseph Hospital: $3,376.00
4) Grundy Pathologists: $38.00
5) Hinsdale Orthopaedics: $16,213.68
6) Athletex: $17,822.00

Petitioner should also be awarded prospective medical in the form of an Achilles Tendon revision surgery. The Petitioner credibly testified that he remains unable to work and has difficulty with movement of his left lower extremity. The medical records show that there remains a full-thickness tear of the Petitioner's left Achilles tendon. Dr. Dworsky has recommended a revision surgery.

The Arbitrator further erred in not awarding temporary total disability. Petitioner has met his burden of proof with regard to accident and causation and therefore is entitled to temporary disability benefits for 46 weeks, from September 2, 2016 through July 20, 2017 representing $65,722.04. The Respondent is entitled to a credit with regard to the disability benefits paid by the Midwest Operating Engineer Welfare Fund in the amount of $9,251.43. Petitioner is therefore entitled to $56,470.61 in temporary total disability benefits. Additionally the Respondent should reimburse the Midwest Operating Engineer Welfare Fund in the amount of $9,505.26 for medical benefits provided.

Based on the above, I would find that Petitioner sustained a compensable accident that arose out of and in the course of his employment and that he is entitled to TTD, reasonable and necessary medical expenses incurred as a result of the August 16, 2016 accident, prospective medical treatment, reimbursement of union benefits paid, and the matter remanded 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).

Charles J. DeVriendt

AUG 14 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

COUGHLIN, DAVID
Employee/Petitioner

Case# **16WC030695**

18IWCC0485

CHELLINO CRANE
Employer/Respondent

On 10/31/2017, 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 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

1433 McANANY VAN CLEVE & PHILLIPS
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505 N 7TH SUITE 2100
ST LOUIS, MO 63101

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STATE OF ILLINOIS)
) SS
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) 8(a)

David Coughlin
Employee/Petitioner

v.

Chellino Crane
Employer/Respondent

Case # 16 WC 30695

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

FINDINGS

On the date of claimed accident **August 16, 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.

Petitioner's average weekly wage was **$3,838.80.**

On the date of accident, Petitioner was **47** years of age, **single** with **1** dependent children.

Respondent ***does not owe*** for any medical services.

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

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

ORDER

Petitioner failed to prove he sustained an accident on August 16, 2016, that arose out of and in the course of his employment with respondent.

Petitioner's claim is hereby denied and case is dismissed.

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

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

Christine M Day

Signature of Arbitrator

10/29/2017

Date

IC ArbDec19(b) p. 2

OCT 31 2017

18IWCC0485

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Coughlin	)	
Petitioner,	)	
vs.	)	**No. 16 WC 30695**
Chellino Crane	)	
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Kankakee under the provisions of §19b/§8a on July 20, 2017. The parties agree that on August 16, 2016, Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They agree petitioner's average weekly wage was $3,838.80.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment with respondent;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury;
3. Whether respondent is liable for the unpaid medical bills;
4. Whether petitioner is entitled to payment for prospective medical treatment; and
5. Whether petitioner is due Temporary Total Disability.

STATEMENT OF FACTS

Petitioner had been employed by respondent, since May or June, 2016, as an operator/oiler. On August 16, 2016 he was working as an oiler. He was wearing work boots. He testified he stepped over a concrete wall with his left foot, came down on gravel and felt something give in his left foot. Petitioner thought it was an unusual drop down.

He did not measure it, only eyeballed it and estimated the drop down was between 10 and 12 inches. He took a picture of the site on August 18, 2016 (PX.7). In the picture, the area where petitioner stepped down was covered with a scaffold.

Petitioner did not recall speaking with Dr. Lam over the phone when he was receiving medical treatment at Morris Hospital on August 16, 2016. He next sought treatment on August 22, 2016 by Dr. Dworsky.

He had previously seen Dr. Dworsky on June 22, 2016; who performed an injection; the injection was not into Achilles tendon. He indicated the prior problem for which he received treatment was with a bone spur in the left heel. The pain was in the bottom of his foot. He denied having previous discoloration to his heal as depicted on the photo taken on August 18, 2016 (PX.7).

At the August 22, 2016 visit with Dr. Dworsky, petitioner testified he leaned on a table in order to go up on his tippy toes.

An MRI was done on September 1, 2016. On September 12, 2016 Dr. Dworsky recommended surgery. Petitioner underwent surgery by Dr. Dworsky at Silver Cross Hospital. He followed up with Dr. Dworsky in October and November, 2016. He also received physical therapy at Athletex. In January, 2017, Dr. Dworsky ordered more physical therapy. On February 6, 2017, Dr. Dworsky recommended another MRI. The February 13, 2017 MRI showed a full thickness tear; for which petitioner now needs surgery. He continues to see Dr. Dworsky on a monthly basis.

At the time he testified he was on restricted work; but his job requires him to be on his feet all day. He wants to have the additional surgery as prescribed by Dr. Dworsky, but is unable to get insurance to cover it.

Petitioner denied telling Dr. Dworsky on June 22, 2016 that he had a strange sensation in his left heel while wearing his boots, or that there was a sensitive spot on his heel that would drop him.

He agreed he returned to work within a day of the incident on August 16, 2016 and continued to work for two weeks.

Petitioner insisted that the prior problem was in the left heel that began in the summer of 2014, was a bone spur. Dr. Helmer surgically removed the bone spur in March or April, 2015. Within a couple of months after surgery, petitioner was having problems with his heel and ankle. He saw Dr. Helmer on a monthly basis until he was referred to Dr. Dworsky for further treatment. The pain was located on the inside of the left foot after the surgery by Dr. Helmer. Petitioner denied Dr. Helmer discussed possible second surgery at the March 29, 2015; he only administered an injection.

Morris Hospital Records (PX.1)

Petitioner was seen in the emergency room on August 16, 2016. On the ER Registration Check in form petitioner wrote under reason for visit: "Hurt left heel while walking" Recorded under mechanism of injury was: "Unknown mechanism. Patient was at work and took a step and had immediate left heel pain today."

Hinsdale Orthopaedics Records (PX.2)

Petitioner was first seen by Dr. Bradley Dworsky on June 22, 2016 with complaints of left heel pain that had been going on for approximately one year. Petitioner reported he had pain about a year and a half ago with no known onset. He had a strange sensation along his heel while wearing boots. In May, 2015, petitioner had surgery to shave down the bone. After a few weeks, the cast was removed and the pain returned. He had X-rays, MRI, cortisone injections and medication; with short term relief. He was seeing Dr. Dworsky for a second opinion. He was not working. (91)

An injection into the region of the left Achilles tendon insertion was administered (92). Dr. Dworsky thought it might be a neuroma (93). Petitioner was to return in 10-14 days (93).

Petitioner returned to Dr. Dworsky on July 1, 2016. He reported the pain was eliminated. Dr. Dworsky advised if the condition reoccurs "we know where to go". (90)

Petitioner returned to Dr. Bradley Dworsky for the left heel pain on August 22, 2016. The history recorded was "Location of pain is the os calcis. The patient describes the pain as being a 3 out of 10…This has been going on for approximately 1 year…the pain has increased in severity over the past week…He states he was walking at work with his boots on and felt something sharp in the back of his leg." (16)

Dr. Dworsky noted the toe raises were strong and the heel raises were weak. Dr. Dworsky thought petitioner had plantaris rupture or possibly derangement including soleus and/or scar breakage due to previous surgery. Petitioner reported he was just walking around when the pain started. He was to return PRN (16-17)

Petitioner returned to Dr. Dworsky on September 12, 2016 after obtaining an MRI. Dr. Dworsky determined petitioner needed repair of the distal Achilles tendon. (14)

He returned to Dr. Dworsky on September 26, 2016 with right knee pain which Dr. Dworsky believed was the result of gait abnormality secondary to the ankle injury. (10-12)

On October 6, 2016, Dr. Dworsky surgically repaired petitioner's Achilles tendon rupture of the left leg (35-36). Petitioner was seen on October 20, 2016 for suture removal and post-op check (25). On November 14, 2016, petitioner was doing well; physical therapy was started (22).

Petitioner returned on December 12, 2016 with pain in the medial right knee which Dr. Dworsky attributed to abnormal gait from the left heel issue. Physical therapy was continued. Dr. Dworsky noted the scar was well healed; there was a slight defect but evidence of an intact tendon. (19)

On January 19, 2017 Dr. Dworsky injected petitioner's right knee (31). On February 6, 2017, Dr. Dworsky was a concern there was an incomplete repair of the Achilles tendon and ordered an MRI (28).

The February 13, 2017 MRI showed distal Achilles tendon full thickness rupture with retraction (108).

At the March 3, 2017, petitioner reported bilateral knee pain, right hip and right elbow pain which he attributed to falling off the scooter he was using while recovering from surgery. Dr. Dworsky was not sure when the Achilles tendon re-ruptured but attributed to the delay in approval for the surgery weakened the tendon. (103-105)

At petitioner's March 20, 2017 exam, Dr. Dworsky recommended to proceed with surgery as soon as possible.

Silver Cross Hospital Records (PX.3)

Dr. Bradley Dworsky performed surgical repair of petitioner's Achilles tendon on October 6, 2016 at Silver Cross Hospital.

Athletex Physical Therapy Records (PX.4)

Petitioner received physical therapy from November 18, 2016 through June 21, 2017.

Dr. Bradley Dworsky April 11, 2017 Deposition (PX.5)

Dr. Bradley Dworsky, board certified orthopedic surgeon who specializes in sports medicine, testified in behalf of petitioner (5-6). Dr. Dworsky had seen petitioner prior to August 16, 2016 for a diagnosed neuroma in petitioner's left heel (8). Petitioner returned to Dr. Dworsky on August 22, 2016 with a history of walking at work with his boots on and felt a sharp pain as if a dog bit him [in his left heel] (9). Dr. Dworsky felt it was something different than the neuroma (10-11).

Petitioner returned to Dr. Dworsky on September 12, 2016, after obtaining an MRI (11). After reviewing the MRI, Dr. Dworsky's diagnosis was a complete tear of the Achilles tendon (12). Petitioner's attorney related to Dr. Dworsky that petitioner had told his attorney he stepped off a 12-inch step (12). Based upon that description, Dr. Dworsky agreed that "any eccentric

load where a patient is decelerating, really down from a step, would be enough force to injure an Achilles tendon, especially in a situation where there may be some susceptibility" (13).

Dr. Dworsky has recommended an additional surgery (14). Dr. Dworsky believed that both the first and now the second surgery were related to the incident on August 16, 2016 (15).

Dr. Dworsky believed the right knee condition is age-related, but has been accelerated or aggravated by the abnormal gait related to the left Achilles tendon tear (15-16).

Dr. Dworsky clarified that the injection he administered on June 22, 2016 was not administered into the Achilles tendon itself, but rather into the medial aspect of the calcaneus (19-21). He confirmed he was treating for a neuroma when he performed the injection (24).

Dr. Dworsky had no records of the treatment petitioner received prior to his first visit with petitioner on June 22, 2016. The only information available to Dr. Dworsky of the previous treatment was that petitioner had surgery. Dr. Dworsky was unaware that petitioner had received an injection into the left Achilles/heel in March, 2016. (24)

What Dr. Dworsky meant by his statement at the time of the July 1, 2016 visit with petitioner when he indicated "We know where we go from here" was that surgery to excise the neuroma would be necessary in the future if the pain reoccurred (24-25). Dr. Dworsky was unaware that additional surgery was contemplated by Dr. Helmer in March, 2016 (25).

As of June 22, 2016, Dr. Dworsky could not determine whether petitioner had an actual Achilles tear or rupture; therefore, he wanted to observe only (30-32). Dr. Dworsky agreed something could have happened between August 16, 2016 and September 1, 2016, when the MRI was done (33). However, Dr. Dworsky did not believe that there was actually something that happened between the time of his examination of petitioner on August 22, 2016 and the time he obtained the MRI on September 1, 2016 that showed the Achilles rupture (37-38).

Petitioner could not point to any specific incident that trigger the additional tear in the Achilles tendon per the office visit of February 6, 2017 (36).

Midwest Operating Engineers Benefit Payments (PX.6)

Petitioner received payments of wage benefits totaling $9,251.43 and medical benefits totaling $9,505.18.

Photos (PX.7)

Petitioner identified four photos which he took on August 18, 2016. The first two photos purportedly depicted the area generally of where he had stepped down and felt the pain in his heel. (Although the actual area where petitioner had stepped down was covered by a scaffold in the photos.) The other two photos where of petitioner's left heel.

Medical Bills (PX.8)

$1,960.00 Allied Anesthesia Associates (10/06/2016)
$24.23 ER Medical Associates of Palos Ltd. (Balance)
$520.33 Silver Cross Hospital
$3,376.00 Presence St. Joseph Hospital (09/15/2016)
$336.03 Presence Health (Balance due)
$312.93 Dr. M Ansari/PMG New Lenox (11/15/16-01/17/2017)
$38.00 Grundy Radiologists
$115.37 Palos Health (Balance)

Dr. Anand Vora April 24, 2017 Deposition (RX.1)

Dr. Vora, a board certified orthopedic surgeon who specializes in treatment of foot, ankle and lower extremity, testified in behalf of respondent (3-4). Dr. Vora evaluated petitioner on October 21, 2016, and reviewed medical records and diagnostic studies (6-7). He authored an initial and two addendum reports (7-9).

Dr. Vora believed it is a negative to inject petitioner's ankle around the area of the Achilles as it can cause the tendon to rupture (10-11). Dr. Vora indicated that because petitioner had good movement and no weakness at the time of his exam with Dr. Dworsky on August 22, 2016, it was not likely petitioner had a ruptured Achilles at that time (16). Dr. Vora found that petitioner's surgery in 2015 did not alleviate petitioner's pain (18; 29; 30). Dr. Vora opined that petitioner had a chronic Achilles tendinopathy that ruptured because it was chronic and probably accelerated by the injections around the Achilles (22).

Dr. Vora thought the rupture probably occurred at that time petitioner stepped down 12 inches, not that it caused the rupture (22-23). According to Dr. Vora it could have happened when petitioner stepped out of bed (23).

Dr. David King April 3, 2017 Report (RX.2)

Dr. David King completed a records review for respondent relative to petitioner's right knee complaints. Dr. King concluded that because there was no causal relationship between the left Achilles rupture to the claimed work accident of August 16, 2016, there was no relationship between the right knee condition that was allegedly the result of a deviated gait from the ruptured Achilles.

Dr. Daniel Helmer Records (RX.3)

Petitioner was first seen on January 17, 2015 by Dr. Helmer for left heel pain over the last several years. Diagnosis was Achilles tendinitis.

Petitioner returned on January 29, 2015 for the left heel pain as well as chronic fungus. Oral fungus medication was prescribed. He returned on March 2, 2015 as follow up to the fungal infection.

On March 12, 2015, petitioner's fungus infection continued. Dr. Helmer discussed removal of the bone spur of the left heel.

Petitioner was seen post-operatively on April 20, 2015, May 4, 2015, May 6, 2015 and May 12, 2015.

On May 27, 2015, petitioner underwent removal of glass fragment in the subcutaneous planter posterior right foot that was present over the last several days since accident at home.

Petitioner followed up on June 16, 2015. On August 17, 2015 petitioner was released after the bone spur removal surgery.

On October 12, 2015, petitioner continued to have problems relative to the Achilles tendinitis. Dr. Helmer administered a steroid injection in to petitioner's heel.

On January 6, 2016 petitioner continued to have problems with the left heel.

Petitioner followed up on January 18, 2016.

On March 3, 2016, Dr. Helmer recommended an MRI and orthotic consult for fabrication. Surgery to decompress the osteochondritis was being considered.

Casting for the orthotics was performed on March 10, 2016.

On March 29, 2016, petitioner reported improvement with injection; surgery was still being contemplated.

Dr. Louis Lam August 16, 2016 Telephonic Report (PX.4)

According to this report, petitioner related to Dr. Lam that he had a chronic issue of left heel for several weeks with a mysterious onset of left heel pain. Petitioner stated he was simply stepping down, but did not have any accident. He denied specifically slipping on wet surface or tripping on any object, or lifting, pushing, pulling or carrying anything heavy that would have tilted his balance.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

The Arbitrator calls into question petitioner's credibility as his testimony does not match the histories contained in any of the medical records; before or after August 16, 2016.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

The Arbitrator finds petitioner failed to prove he sustained injuries from an accident that arose out of and in the course of his employment with respondent. Petitioner purportedly was in the course of his employment at the time he experienced problems with his left heel. Therefore, he would have been in the course of his employment at the time of the occurrence. The issue is whether the injury arose out of his employment with respondent on August 16, 2016.

Petitioner testified he stepped over a wall and down onto gravel, at most a distance of 12 inches, when he felt a sharp pain in his left heel. However, his testimony does not match the histories petitioner provided.

Specifically, the Arbitrator notes petitioner related to Dr. Lam on August 16, 2016 that he was simply stepping down; he denied slipping, tripping, lifting, pushing, pulling or carrying anything heavy that would have tilted his balance. The history at the emergency room on August 16, 2016, indicated petitioner reported he hurt his left heel while walking; he took a step and had immediate left heel pain.

The original history to Dr. Dworsky on August 22, 2016 was that he was walking at work with his boots on and felt something sharp in the back of his leg. In his deposition, Dr. Dworsky initially reiterated this same history provided by petitioner. It was not until petitioner's attorney provided Dr. Dworsky with the history of petitioner stepping down 12 inches that Dr. Dworsky agreed this act would be enough force to cause the injury.

Assuming arguendo petitioner's Achilles injury occurred when he stepped down, at most 12 inches, the Arbitrator does not find this act did not exposed petitioner to a risk greater than that of the general public. The Arbitrator finds the opinion of Dr. Vora to be persuasive on this issue. Dr. Vora believed it was petitioner's chronic Achilles tendinopathy, that had been accelerated by the injections, was the cause of the rupture. The act of stepping down merely provided the opportunity for the Achilles to rupture as it could have happened at any time; even by stepping out of bed.

For these reasons, the Arbitrator finds petitioner's claimed left heel injury did not arise out of his employment on August 16, 2016.

As the Arbitrator determined petitioner was not injured in an accident that arose out of his employment with respondent, the claim is denied and all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEPHANIE WEATHERSBY,

Petitioner,

vs.

NO: 16 WC 16247
16 WC 24650 (cons.)

ZF LEMFORDER,

Respondent.

18IWCC0486

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 causation, temporary disability, medical expenses, and prospective medical treatment, and being advised of the facts and law, corrects and clarifies 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).

While the Commission agrees the causal connection dispute is properly resolved in Petitioner's favor, we find the evidence clearly demonstrates Petitioner's condition of ill-being following her undisputed June 23, 2015 accident reached maximum medical improvement on September 1, 2015, and her current condition of ill-being and need for further treatment is causally related to the May 22, 2016 accident. In so finding, the Commission emphasizes that following the June 23, 2015 injury Petitioner underwent a brief course of conservative treatment after which her condition stabilized leaving her with only minimal residual complaints. She

thereafter returned to her pre-injury job which she performed successfully for nine months without the need for further treatment. Then, on May 22, 2016, she experienced an acute change in her condition while performing her work activities. The Commission notes Petitioner described the second accident as being worse than the first; we find Petitioner's testimony credible and consistent with the medical records evidencing her consistent complaints of severe symptoms which, unlike in 2015, did not resolve with physical therapy and have yet to return to baseline, although Petitioner did have a positive response to the initial epidural steroid injection.

The Commission finds the undisputed May 22, 2016 accident is not a continuation of the 2015 accident but rather is an independent event. The Commission further finds Petitioner has yet to reach maximum medical improvement, and her current condition of ill-being and need for ongoing treatment is attributable solely to the May 22, 2016 accident. Given this finding, the Commission strikes Paragraph "O" from page 5 of the Arbitrator's Decision.

The Commission additionally makes the following corrections:

1. The Commission observes there is an internal inconsistency between the Order and the Decision as to the temporary disability benefits awarded. The Commission corrects the Order to reflect Petitioner was temporarily totally disabled for 43 6/7 weeks, representing July 7, 2015 through September 1, 2015; July 14, 2016 through September 12, 2016; and September 14, 2016 through March 21, 2017. Respondent is entitled to a credit of $2,773.36 for temporary total disability benefits paid.

2. Regarding the medical expenses award, the Commission corrects the first sentence of the second paragraph on page 4 to reflect the name of the facility is not Diversey Medical Center but rather Peterson Medical Surgicenter and the charges incurred for the September 2, 2016 date of service are $4,720.00. PX3. Further, our review of Petitioner's Exhibit 2 evidences the charges incurred at Jackson Park Medical Associates total $7,841.00: $305.00 for the May 24, 2016 evaluation with Jared Thomure, DC; $3,094.00 for the May 27, 2016 through July 19, 2016 dates of service with Thomas Bilko, MD; and $4,442.00 for the July 28, 2016 through October 6, 2016 dates of service with Divya Agrawal, MD. PX2. The charges incurred total $12,561.00 and the Commission orders Respondent to pay these expenses pursuant to Sections 8(a) and 8.2.

3. Both the Order and paragraph 4 of page 4 of the Decision order Respondent to "authorize and pay the costs of the cervical epidural injections" as prescribed by Dr. Agrawal. The Commission strikes that language and instead, consistent with Section 8(a), orders Respondent to provide and pay for the cervical epidural steroid injection recommended by Dr. Agrawal. The Commission clarifies Dr. Agrawal has only prescribed a single cervical epidural steroid injection and we find that recommendation to be reasonable, necessary, and causally related to the May 22, 2016 undisputed accident.

4. The Commission corrects the typographical error in the first sentence of the third paragraph on page 3 to reflect Petitioner attended physical therapy from May 27, 2016 through July 12, 2016.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 10, 2017, as amended above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $346.67 per week for a period of 43 6/7 weeks, representing July 7, 2015 through September 1, 2015; July 14, 2016 through September 12, 2016; and September 14, 2016 through March 21, 2017, those being the periods of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any. Respondent is entitled to a credit of $2,773.36 for temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $12,561.00 for medical expenses as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for a cervical epidural steroid injection as recommended by Dr. Agrawal as provided in §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 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.

18IWCC0486

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,200.00. 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 6 - 2018

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mck

O: 6.27.18

43

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

WEATHERSBY, STEPHANIE
Employee/Petitioner

Case# **16WC016247**

16WC024650

ZF LEMFORDER
Employer/Respondent

18IWCC0486

On 5/10/2017, 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 1.01% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

2965 KEEFE CAMPBELL BIERY & ASSOC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

18IWCC0486

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)

Stephanie Weathersby
Employee/Petitioner

v.

ZF Lemforder
Employer/Respondent

Case # **16** WC **016247**

Consolidated cases: **16WC024650**

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 **LynetteThompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **3/21/17**. 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

18IWCC0486

FINDINGS

On the date of accident, **6/23/15 & 5/22/16,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**27,040.52**; the average weekly wage was $**520.01**.

On the date of accident, Petitioner was **25** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of $**2,773.36** for TTD, $**0** for TPD, $**0** for maintenance, and $ for other benefits, for a total credit of $**2,773.36**.

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

ORDER FOR 16 WC 16247 & 16 WC 24650

Medical benefits
Respondent shall pay reasonable and necessary medical services of $12,256.00, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $346.67/week for 43 & 5/7 weeks, commencing 7/7/15 through 9/1/15 and 2/14/16 through 3/21/17 as provided in Section 8(b) of the Act.

Prospective Medical Care
Respondent shall authorize and pay the costs of the cervical epidural injections per the fee schedule, as prescribed by Dr. Agrawal.

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

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

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FINDINGS OF FACT 16WC016247

The disputed issues in this matter are: 1) causal connection; 2) medical bills; 3) temporary total disability; and 4) is Petitioner entitled to prospective medical treatment. *See,* AX2.

Petitioner testified that on May 22, 2016, she was performing her normal job duties for Respondent, working on the same supply line pulling down torque guns overhead with both arms, rapidly and continuously, when she experienced much worse and intense pain in her left shoulder and neck. Petitioner initially sought treatment at St. Margaret Hospital's emergency room. Thereafter, Petitioner sought treatment at Jackson Park Medical Associates, coming under the care of Dr. Agrawal. The Jackson Park records document Petitioner's intense and worsening pain in her left shoulder and neck from her work as an assembler doing overhead work with torque air guns on May 12, 2016. Petitioner was diagnosed with cervical and shoulder sprains and cervical radiculopathy and brachial radiculitis. Dr. Agrawal opined that Petitioner had an acute exacerbation of her neck and left shoulder conditions, secondary to her work duties for Respondent on May 22, 2016 (PX 2).

Petitioner was referred for physical therapy at Beverly Park Medical Center from August 24, 2016 to July 19, 2016, which Petitioner testified did not provide any real help with her pain. Petitioner had a cervical MRI and left shoulder MRI/arthrogram on July 14, 2016. On July 28, 2016, Dr. Agrawal opined that Petitioner had evidence of disc herniations at C3-4 and C4-5, and that Petitioner's MRI findings and cervical spine and radicular symptoms were causally related to her May 22, 2016 accident. Petitioner was referred for a cervical epidural injection, which was certified by utilization review as medically necessary and performed on September 2, 2016. Petitioner was last seen by Dr. Agrawal on October 6, 2016. At that time, Dr. Agrawal repeated his prior diagnosis and prescribed a repeat cervical epidural injection to treat Petitioner's ongoing cervical pain and radicular pain and radicular symptoms, as supported by the MRI findings of cervical disc herniations. Dr. Agrawal's records note that Petitioner has been unable to return to work since July 14, 2016. (PX 2).

Petitioner testified that she was seen by Respondent's examining physician for lee than 5 minutes on September 1, 2016. Petitioner testified that she has remained off work due to her ongoing severe left arm and neck pain except for 1 day - September 13, 2016, during which she tried to work unsuccessfully due to her pain. Petitioner testified she was sent home by her supervisors the next day after 15 minutes. Petitioner testified that she wants the repeat cervical epidural injection as prescribed by Dr. Agrawal because of her pain, but has been unable to return to the doctor or obtain the injection because of a lack of funds. Petitioner testified that she has had no other accidents since May 22, 2016. Petitioner testified that she notices her severe neck and left arm pain on movement with her neck, sitting, standing and lifting objects. Petitioner testified she feels her pain is growing worse, and interferes with her sleep, as she cannot lay down comfortably. Petitioner testifies she takes non-prescription medications for the pain, which do not help.

18IWCC0486

CONCLUSIONS OF LAW 16WC016247

F. CAUSAL CONNECTION

The Arbitrator finds Petitioner's testimony as to her severe and ongoing pain following the May 22, 2016 accident to be credible and consistent, including her inability to work after trying unsuccessfully to do so on September 13, 2016. The Arbitrator finds the opinions of her treating physician, Dr. Agrawal to be more persuasive regarding the necessity of further cervical epidural injections, based on Petitioner's ongoing symptoms and MRI findings, than Respondent's examining physician. The Arbitrator finds Petitioner's current condition of ill-being to be causally related to the May 22, 2016 accident.

J. MEDICAL EXPENSES

Based on the Arbitrator's findings regarding causal connection, the Arbitrator awards the unpaid medical bills of Jackson Park Medical Associates in the amount of $7,536.00 (PX 2), and Diversey Medical Center in the amount of 44720.00. Respondent shall have full credit for all medical expenses paid. (PX 3).

K. TEMPORARY TOTAL DISABILITY

Based on the Arbitrator's findings regarding causal connection, the opinions of Dr. Agrawal and Petitioner's testimony, the Arbitrator awards 35 4/7 weeks T.T.D., from July 14, 2016 through September 12, 2016, and September 14, 2016 through March 21, 2017, the date of hearing. The Arbitrator finds Petitioner to be temporarily and totally disabled.

O. PROSPECTIVE MEDICAL CARE

Based on the Arbitrator's findings regarding causal connection, Respondent shall authorize and pay the costs of the cervical epidural injections per the medical fee schedule, as prescribed by Dr. Agrawal.

FINDINGS OF FACTS - 16WC024650

The disputed issues in this matter are: 1) causal connection' and prospective medical care. *See,* AX1. Petitioner testified that on June 23, 2015 she was working on the supply line for Respondent, pulling torque guns down from an overheard position, rapidly and continuously, when she experienced pain in her left shoulder, upper back and neck. Petitioner was referred to Concentra Medical Center, where she treated from June 24, 2015 to August 31, 2015. Petitioner received a course of physical therapy and work conditioning from August 19, 2015 to August 31, 2015. Petitioner had a cervical MRI on August 11, 2015, after having been seen by Dr. Garelick at Concentra on August 3, 2015. Petitioner was also seen by Dr. Salehi at Concentra on August 11, 2015 and August 14, 2015. (PX 1).

Petitioner testified she was off work from July 7, 2015 through September 1, 2015 and paid temporary total disability. Petitioner testified she returned to work for Respondent thereafter at her prior full job duties, working in a full duty capacity. Petitioner testified that she continues to have left shoulder and neck pain, which was manageable.

CONCLUSIONS OF LAW - 16WC024650

F. CAUSAL CONNECTION

Based on the records from Concentra, and Petitioner's testimony, the Arbitrator finds Petitioner has proven, by a preponderance of the evidence that her left shoulder and cervical condition of June 23, 2015, is causally related to work.

O. PROSPECTIVE MEDICAL CARE

Based on the Arbitrator's findings regarding causal connection, Respondent shall authorize and pay the costs of the cervical epidural injections per the fee schedule, as prescribed by Dr. Agrawal.

18IWCC0486

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
16WC16247 & 16WC24650
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

May 10, 2017
Date of Decision

MAY 10 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICARDO SANCHEZ,

Petitioner,

vs.

NO: 13 WC 14367

CITY OF HARVEY,

18IWCC0487

Respondent,

DECISION AND OPINION ON REVIEW

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

Petitioner's injuries occurred on December 24, 2012, so the five factors in Section 8.1b of the Act are applicable in determining a permanency award. The Commission notes that, although the Arbitrator indicated that he gave "weight" to the occupation and age factors, the basis for denying a permanency award seems to have solely been the lack of "recent" medical records. The Commission views the evidence differently and weights this factor as a moderate indicator of disability.

At the hearing on January 13, 2018, Petitioner testified that his left shoulder hurts when he "pulls ceilings" (punching holes in the ceiling with a pick and pulling down with force to open the ceiling up) while fighting a fire because he has to extend his arm so he switched the grip and now does it with the opposite arm. T.18. He also notices that his left shoulder is affected when he pulls hose.

The final record of Dr. Jimenez on June 13, 2013 indicates that Petitioner was "greatly improved with shoulder tendinitis" and he was released to full duty. However, although

18IWCC0487

Petitioner had improved range of motion and strength, Dr. Jimenez noted that Petitioner still had pain on forward flexion and abduction. The physical therapy discharge note on June 14, 2013, indicates that Petitioner had met 7 out of 8 goals but still had limitation with reaching behind his back.

Although Petitioner's last treating medical records were not "recent," in our analysis of the five factors we find that the medical records at the time of his medical release still corroborate Petitioner's credible testimony about how his left shoulder tendinitis continues to affect his occupation as a firefighter. Therefore, we award permanent partial disability of 2% of the Petitioner as a whole under Section 8(d)2 of the Act.

Based on Petitioner's average weekly wage of $1,160.80, his permanent partial disability rate is $696.48 per week.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $696.48 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 2% of Petitioner 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.

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

DATED: AUG 6 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 7/25/18
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANCHEZ, RICARDO
Employee/Petitioner

Case# 13WC014367

CITY OF HARVEY
Employer/Respondent

18IWCC0487

On 1/18/2018, 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 1.60% 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:

2675 COVEN LAW GROUP
MARK J SCHECHTER
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

1295 SMITH AMUNDSEN LLC
GAIL A GALANTE
3815 E MAIN ST SUITE A-1
ST CHARLES, IL 60174

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

Ricardo Sanchez,
Employee/Petitioner

v.

City of Harvey,
Employer/Respondent

Case # 13 WC 014367

Consolidated cases: _____

18IWCC0487

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 M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **01/03/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On December 24, 2012, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $60,361.74; the average weekly wage was $1,160.80.

On the date of accident, Petitioner was 54 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 **$29,682.81 for PEDA/full salary/salary continuation when he was off work from 12/25/2012 to 6/21/2013.**

ORDER

The sole claim at issue in this case for permanent partial disability is denied. The Petitioner sustained no permanent partial disability as a result of the work accident.

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

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

Robert M. Harris

Signature of Arbitrator

January 17, 2018
Date

JAN 18 2018

18IWCC0487

The Arbitrator makes the following Findings of Fact and Conclusions of Law:

Findings of Fact:

Petitioner testified that Petitioner has been employed by Respondent, City of Harvey, as a Firefighter since August 12, 1991. Petitioner works 24 hours, 7 a.m. to 7 p.m., every 3 days. Petitioner is 59 years old. Petitioner is right handed.

Petitioner testified that on December 24, 2012, he was working for the City of Harvey as a firefighter. Petitioner responded to a house fire in a trailer. Petitioner pulled the hose into the trailer. The hose got caught on the outside stairs. His left shoulder popped. Petitioner did not think much about it at the time. Then it got worse. When Petitioner returned to the fire station, he was sent to Ingalls Occupational Health.

On December 24, 2012, Petitioner saw a physician assistant, Collins, at Ingalls Occupational Health. Petitioner complained of left shoulder pain. Examination showed full range of motion of the left shoulder with some discomfort. There was no tenderness to palpation. X-ray of the left shoulder was normal. The diagnosis was left shoulder pain. Motrin and range of motion exercises were prescribed. Petitioner was released to work with minimal use of the left arm and rare overhead use. On December 27, Motrin and exercises were prescribed. Petitioner was released to work with a 10-pound left upper extremity restriction and no overhead use. On January 3, 2013, physician assistant Dusak made a diagnosis of left shoulder pain. Left shoulder examination showed negative crossover and impingement tests. There was full range of motion with some discomfort. Naproxen was prescribed. Petitioner was released to work with a 10-pound left upper extremity restriction, no overhead, ladders or repetitive left arm work. (Pet. Ex. 1)

On January 8, 2013, Petitioner saw Dr. Akhtar at Ingalls Occupational Health. Left shoulder examination showed full range of motion with some discomfort, no tenderness to

palpation, and equivocal empty can test. Hawkins, O'Brien's and impingement tests were negative. The diagnosis was left shoulder pain and strain. Physical therapy and Naproxen were prescribed. Petitioner was released to work with a 10-pound restriction and no overhead, ladder or left arm repetitive work. On January 15, Petitioner stated that Petitioner felt that physical therapy exacerbated his pain. The diagnosis was left shoulder pain. A left shoulder MRI was prescribed. Petitioner was placed off work. (Pet. Ex. 1)

On January 30, 2013, an MRI arthrogram of the left shoulder showed no evidence of tears in the supraspinatus tendon, superior glenoid labrum or anterior labrum. There was thickening of the coracohumeral ligament and the middle glenohumeral ligament which may represent contusion to these ligaments. There were no tears in the ligaments. The tendon of the long head of the biceps and the subscapularis tendon were intact. The radiologist stated: "In view of the minimal findings, close clinical correlation is suggested." (Pet. Ex. 4)

On February 6, 2013, Petitioner saw Dr. Akhtar. Petitioner complained of left shoulder pain with no improvement. Left shoulder examination showed decreased range of motion. There was discomfort with range of motion and reluctance to extend 90 degrees. There was left shoulder tenderness. Crossover test was painful. There was negative impingement. Petitioner had facial grimacing and hesitation with left arm movement. Dr. Akhtar found that the MRI revealed no acute or chronic abnormality. The diagnosis was left shoulder pain and strain. Petitioner was released to work with a 10-pound left upper extremity restriction and no overhead or repetitive left arm work. Petitioner was referred to a shoulder orthopedist but the name of the referral is not on the medical record. (Resp. Ex.1; Pet. Ex.1) Petitioner received no further treatment from Dr. Akhtar or Occupational Health.

Petitioner testified that he was referred to Dr. Nigro by Ingalls Occupational Health.

On February 13, 2013, Petitioner first saw Dr. Nigro at Ridge Orthopedics. Petitioner complained of left shoulder pain. Petitioner stated that physical therapy did not help. Examination showed left shoulder pain with range of motion and decreased strength. Left shoulder x-rays showed a normal glenohumeral joint and mild AC joint degeneration. Dr. Nigro made an assessment of left shoulder rotator cuff tendonitis and partial thickness tearing. Dr. Nigro administered a subacromial cortisone injection. Dr. Nigro prescribed physical therapy, 2 times per week for 6 weeks. Petitioner was placed off work for 6 weeks. (Pet. Ex. 2)

On April 5, 2013, Petitioner returned to Dr. Nigro. Petitioner stated that the injection did not help him "whatsoever." Petitioner had no improvement with physical therapy. Petitioner complained of left shoulder pain and stiffness. Dr. Nigro noted that the shoulder stiffness was the "more salient part of his clinical picture." Dr. Nigro did not think the cortisone injection helped because it was placed in the subacromial space. Dr. Nigro administered a left shoulder glenohumeral injection to treat rotator cuff tendonitis. Petitioner was placed off work for 4 weeks. Petitioner was to return in 4 weeks. Petitioner did not return to Dr. Nigro. (Pet. Ex. 2)

Petitioner testified that he noticed no change after the second left shoulder injection. Petitioner was still the same.

Petitioner testified that his attorney referred him to Dr. Matthew Jimenez, an orthopedic surgeon, at Illinois Bone & Joint Institute.

On May 2, 2013, Petitioner first saw Dr. Jimenez. Petitioner complained of left shoulder pain. His medications were Lisinopril for 4 years and Metformin for 2 months. Examination of the left shoulder showed pain with flexion and abduction. There was evidence of rotator cuff tendonitis on shoulder range of motion. Pulses, motor and sensory were normal. "Radiographs of the shoulder are negative. MRI negative." Dr. Jimenez reviewed the January 30, 2013,

MRI/arthrogram. Dr. Jimenez found that there were no tears in the muscles, the supraspinous muscle was normal, and there was no evidence of glenoid labral, cartilaginous or muscular issues. Dr. Jimenez stated that it was an "essentially negative MRI, but Petitioner clearly has evidence of tendinitis clinically and on physical examination related to" the work injury. The diagnosis was left shoulder tendinitis. Physical therapy was prescribed, 2 to 3 times per week for 4 weeks, for range of motion and strength under a diagnosis of left shoulder tendonitis. Petitioner was placed off work. (Pet. Ex. No. 3; Resp. Ex. No.2)

From May 21, 2013 to June 14, 2013, Petitioner received physical therapy at Ingalls Memorial Hospital as prescribed by Dr. Jimenez under a diagnosis of left shoulder tendonitis. On May 21, 2013, Petitioner complained of left shoulder pain. Petitioner stated that he returned to driving a stick shift and turning the wheel was still difficult. On June 10, Petitioner was 80% improved. Left and right upper extremity range of motion was full and normal. Left and right upper extremity strength was normal at 5/5. There was no tenderness to palpation. The physical therapist stated that Petitioner had significant improvement in range of motion and strength.

On June 14, 2013, Petitioner completed 8 physical therapy visits. Petitioner stated that therapy was very beneficial and Petitioner felt prepared to return to work full duty. The physical therapist stated that Petitioner met 7 of 8 goals. The goal for reaching behind his back was still in progress, with mild complaints of pain. Petitioner made significant progress in therapy. Petitioner was able to lift floor to shoulder without difficulty or pain. Petitioner was discharged from therapy and was released to return to work full duty starting June 22, 2013. (Resp. Ex. No. 2)

On June 13, 2013, Petitioner last saw Dr. Jimenez. Petitioner stated that he was improving with physical therapy and felt nearly ready to return to work. Examination of the left shoulder showed improved range of motion and strength compared to the last visit. Pulses were strong and

full. Motor and sensory examinations were normal. Dr. Jimenez found that Petitioner was greatly improved with left shoulder tendinitis. Between June 13 and June 22, Petitioner should continue the home exercise program and physical therapy. Dr. Jimenez released Petitioner to return to work full duty with no restrictions as of June 22, 2013. The diagnosis was left shoulder tendinitis. Petitioner received no further treatment. (Resp. Ex. No.2; Pet. Ex. No. 3)

Petitioner testified that as of June 2013, he was not taking any medication for his left shoulder. Petitioner received no further left shoulder treatment since June 13, 2013.

Petitioner was off work from December 25, 2012 to June 21, 2013. Petitioner was paid full regular salary/salary continuation, pursuant to PEDA (Public Employee Disability Act), 5 ILCS 345, in the amount of $1,160.80 per week or $29,682.81 from December 25, 2012 to June 21, 2013. (Stipulation of the Parties, Arb. Ex. No. 3; Resp. Ex. No. 5)

At Arbitration on January 3, 2018, Petitioner testified that he returned to work as a Firefighter without restrictions on June 22, 2013. Petitioner returned to work on June 22, 2013, and at the present, he noticed left shoulder symptoms while doing ceiling work in his firefighter job. Petitioner testified that he cannot pull the ceiling as well as before the accident. Petitioner started to use his right arm to punch holes in the ceiling with the tool. Petitioner notices his left shoulder symptoms at work while fighting fires. Petitioner testified that outside work, he used to drive with his left hand and now he drives with his right hand. Petitioner used to have a stick shift and now he uses an automatic because he has difficulty shifting with the left hand/arm. Before thee work accident, Petitioner exercised 1 hour per day with a bike, elliptical and weights. Petitioner stopped using free weights since the accident as it makes his shoulder sore. Petitioner still exercises every day, but for 40 minutes, on the bike and elliptical.

Petitioner testified that he had no prior left shoulder injury. Petitioner had no subsequent left shoulder injury.

Petitioner testified that on November 27, 2016, he injured his right knee when he slipped on stairs at a home on a call while working for Respondent as a firefighter. Petitioner did not injure his left shoulder and it was not affected at all.

Petitioner testified that he continues to work for Respondent as a Firefighter.

The Arbitrator makes the following Conclusions of Law:

(F) Whether Petitioner's current condition of ill-being is causally related to the injury:

The Arbitrator finds and concludes a causal connection exists between the accident and Petitioner's current condition of ill-being. Petitioner injured his left shoulder on December 24, 2012 while pulling a hose while fighting a fire. Petitioner received medical treatment from December 24, 2012 to June 14, 2013 under a diagnosis of left shoulder pain, strain and tendonitis. The Arbitrator finds that Petitioner's treatment and diagnoses are both causally related to the December 24, 2012 work accident. Petitioner testified that he had no prior left shoulder injury. Petitioner had no subsequent left shoulder injury. The record from Dr. Jimenez regarding his office visit on May 2, 2013 also support a finding of causation; e.g., "Ricardo Sanchez injured his left shoulder on 12/24/12 in a work-related event. He states he injured his shoulder. He felt pain and a snap while at work and prior to this injury, he had no pain in his shoulder, ***so there is clear causation***." (Pet. Ex. 1). The Arbitrator notes that this opinion (regarding causation) was never challenged.

(L) What is the nature and extent of Petitioner's Injury:

The Findings of Fact and Conclusions of Law as stated above are adopted herein.

The Arbitrator finds and concludes that Petitioner sustained left shoulder pain, strain and ***tendonitis*** as a direct result of the December 24, 2012 work accident. The Arbitrator finds that Petitioner sustained no permanent partial disability as a result of this injury.

"With respect to factual matters, it is within the province of the Commission to judge the credibility of the witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences therefrom." *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill.App.3d 665, 674, 928 N.E.2d 474, 482 (2009). Here, there is a conflict noted in the medical records between the diagnoses (two) of Dr. Nigro and that of Dr. Jimenez, who both happen to be Petitioner's treating physicians.

Regarding the medical conflict in the records regarding Petitioner's diagnosed condition, the Arbitrator further finds and concludes that Petitioner's condition was tendinitis and ***not*** a "partial thickness tearing" of the supraspinatus, which is what Dr. Nigro opined on February 13, 2013 after his review of the January 30, 2013 MRI. On February 13, 2013 Dr. Nigro's diagnosis was "left shoulder rotator cuff tendinitis and partial thickness tearing." Inexplicably, Dr. Nigro's diagnosis next on April 5, 2013 was "Left shoulder adhesive capsulitis" (a condition not identical to a tendon tear or tendinitis). There was no mention of the prior "partial thickness tearing" on April 13. Petitioner then stopped seeing Dr. Nigro. This change in diagnoses is confusing and unexplained – and therefore not credible. Dr. Nigro's view of the MRI conflicts with those of both the radiologist who performed the study (Dr. Chimata) and Dr. Jimenez. Therefore, the Arbitrator resolves this conflict in favor of Drs. Chimata and Jimenez, whose opinions/diagnoses are deemed more credible and consistent than those of Dr. Nigro.

The Arbitrator applies the mandatory Section 8.1b criteria to reach his determination that Petitioner sustained no permanent partial disability as a direct result of this injury.

Sec. 8.1b of the Act controls the issue of the determination of permanent partial disability.

Section 8.1b states as follows:

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.

(Source: P.A. 97-18, eff. 6-28-11.)

The Arbitrator considers the five factors indicated above to determine the level of permanent partial disability, as follows:

i. There is no impairment rating. The Arbitrator therefore gives no weight to factor 8.1b(i).

ii. Petitioner is a Firefighter. Petitioner Arbitrator gives weight to this factor.

iii. Petitioner was 54 years old at the time of the injury. The Arbitrator gives weight this factor.

iv. There is no evidence in the record regarding future earning capacity. Petitioner returned to his former position as a Firefighter at full, unrestricted duty, and the Arbitrator infers he did so with no loss of pay or benefits. The Arbitrator gives no weight to this factor 8.

v. The medical records in evidence support the finding and conclusion that Petitioner sustained no permanent partial disability as a result of the work accident. The Arbitrator gives greatest weight to this factor. The Arbitrator further finds and concludes that Petitioner's trial testimony regarding his current symptoms and complaints was not credible nor corroborated by any recent medical evidence or opinion (see below). Petitioner is right handed. Petitioner's left shoulder injury therefore involves his non-dominant upper extremity. Petitioner received conservative treatment to his left shoulder consisting of physical therapy, Motrin/Naproxen and 2 injections under a diagnosis of left shoulder pain, strain and tendonitis. The left shoulder MRI arthrogram showed no tears or any abnormal findings. The radiologist stated that there were no ligament or tendon tears. Dr. Akhtar also stated that there were no abnormal findings. Dr. Jimenez stated that the MRI and the radiograph were negative. Petitioner has taken no medication for his left shoulder since January 2013 – even though he testified to a litany of complaints at the hearing. As of June 2013, Petitioner had full, pain-free range of motion of the left shoulder and normal strength. At his last visit with Dr. Jimenez on June 13, 2013, he noted that Petitioner"...is greatly improved with shoulder tendinitis." The physical therapist noted that Petitioner returned to driving a stick shift. Very significant is the fact Petitioner was released to return to work without

any restrictions or limitations as a Firefighter as of June 22, 2013. Another very significant fact is that Petitioner has continued to work as a firefighter without any restrictions since June 22, 2013. Further, and of considerable significance, is the fact that Petitioner has received no medical treatment of any kind to his left shoulder since June 2013. This absence of any medical visit or treatment since June 22, 2013 (4-1/2 years ago) suggests a lack of true symptomology or exaggeration. There is no medical evidence in the record of objective abnormal findings to support Petitioner's current subjective complaints. Petitioner had shoulder tendonitis which resolved years ago. In other words, the only evidence offered even suggestive of disability is Petitioner's own uncorroborated trial testimony. The medical evidence, or lack of it, does not support his testimony. The Arbitrator further notes with emphasis that Petitioner did not attempt to admit any ***recent medical evidence of disability***, for instance, from any of his treating physicians, or another treating physician, or an expert opinion regarding disability pursuant to Section 12 of the Act. In his notes for the final time he saw Petitioner on June 13, 2013, Dr. Jimenez did ***not*** indicate that Petitioner's shoulder condition (tendinitis) was "permanent" in nature or that he had "permanent disability." To the contrary, his full duty, unrestricted release belies that conclusion. .Therefore, the record has no recent evidence that Petitioner's condition is "permanent" in nature or that there is today in the record any recent evidence of "permanent disability."

Based on the above, Petitioner has failed to prove he sustained any permanent disability as a result of his accidental injury sustained on December 24, 2012.

Robert M. Harris

Robert M. Harris, Arbitrator

January 18, 2018

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

CALVIN WILLIAMS,

Petitioner,

vs. NO: 16 WC 21757

STATE OF IL DOC PAROLE DEPT,

18IWCC0488

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation 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.

On the issue of causal connection, the Commission agrees that the Petitioner has met his burden of proof. However, the Commission strikes any reference to *Voykin v. Deboer*, 192 Ill.2d 49 (2000) made by the Arbitrator in support of the Arbitrator's reasoning regarding causal connection.

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 3% loss of use of man as a whole.

For the first factor, the Arbitrator found that "an AMA impairment rating was offered by neither party, and is therefore not considered and given no weight." (Dec. 7). The Commission affirms the Arbitrator's analysis.

Regarding the second factor, the "occupation of the injured employee," the Arbitrator wrote that Petitioner was employed as a "Parole Agent who must sit in a confined space in a squad for long periods of time, and also confront and be prepared for altercations with parolees, who can be violent." (Dec. at 7). We agree with the Arbitrator's finding that this factor deserves greater weight.

For the third factor, the Arbitrator found that Petitioner was 45 years old at the time of the

18IWCC0488

injury. We affirm 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 had suffered two previous work-related car accidents, both prior times causing injury to his back. Following the accident of December 27, 2015, Petitioner did not suffer any fracture or subluxation, but was noted to have degenerative changes. Petitioner was cleared to work without restrictions as of June 7, 2016. Although the Commission agrees with the Arbitrator that Petitioner's six-month course of treatment was lengthy, Petitioner only missed one week of work and was able to resume his full duties upon completion of treatment. Petitioner additionally had other comorbidities which may have caused or contributed to cause his disability, unrelated to the December 27, 2015, accident. 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 3% loss of use of man as a whole. The decision is further modified to reflect the corrections noted above. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 15 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 3% loss of use of man as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,975.00 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.

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

DATED: AUG 6 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O:072518
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

WILLIAMS, CALVIN
Employee/Petitioner

Case# **16WC021757**

STATE OF IL DOC PAROLE DEPT
Employer/Respondent

18IWCC0488

On 3/7/2018, 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 1.83% 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:

0924 BLOCK KLUKAS MANZELLA & SHELL
MICHAEL D BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT 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

MAR 7 - 2018

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

18IWCC0488

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

CALVIN WILLIAMS
Employee/Petitioner

v.

STATE OF IL DOC PAROLE DEPT.
Employer/Respondent

Case # 16 WC 21757

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 **GEORGE ANDROS**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 20, 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 **12/27/2015**, 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 **$87,100.00**; the average weekly wage was **$1,675.00**.

On the date of accident, Petitioner was **45** 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(received service connected days)** 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 **$1,297.00** under Section 8(j) of the Act.

Medical benefits

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

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $ to , $ to , and $ to , as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services of $**1,975.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $**1,297.00** 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 with 8.1b language (For injuries after 9/1/11)

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 **parole agent** 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 see Award. Because of this the Arbitrator therefore ***greater*** weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. Because of age, the Arbitrator therefore gives ***greater*** weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes only a future, potential effect. 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 **as set forth in the Award**. Because of this, 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 7% (seven) permanent disability under **§8(d)(2) of the Act.**

CORRECTION- ADDITION: IT IS THEREFORE ORDERD THAT RESPONDENT PAY TO PETITIONER AND HIS ATTORNEY THE SUM OF $755.22 PER WEEK FOR A PERIOD OF 35 WEEKS , AS PROVIDED IN SECTION 8(D)2 OF THE ACT, FOR THE REASON THAT THE INJURIES SUSTAINED CAUSED 7% (SEVEN) LOSS OF USE TO 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.

#001 Arb George Andros CORRECTED DECISION March 5, 2018

Signature of Arbitrator | Date

STATEMENT OF FACTS 16 WC 021 757

Petitioner, a 45-year old Parole Agent since Spring, 2001 and a 17-year employee of the Department of Corrections, was performing duties in a squad when another vehicle attempted to make a right-hand turn from the left lane while Petitioner was in the right lane. The other vehicle, in attempting to make this right-hand turn, turned in front of Petitioner, hit the front driver's side corner of his vehicle and scraped across the front of the vehicle. The Petitioner's testimony is consistent with his Incident Report, (Pet's. Ex. 7) and the Chicago Police Department Report, (Pet's. Ex. 8). Petitioner testified he felt severe vibrations, both parties stopped their cars, and his adrenaline was running as he was concerned that the other vehicle's occupants were gang bangers. After the crash both drivers reported to the Police Station and filled out reports. Accident was stipulated to, but is important for mechanism of injury.

Petitioner had prior treatment as appears in the Pet's Ex. 3B, the records of Dr. Jain, who treated both his two prior injuries which resulted from on the job vehicular crashes. Prior treatment is also reflected in Petitioner's Exhibit 1, the records of Dr. Robinson of Primary Health Care Associates, where Dr. Robinson saw Petitioner and provided physical therapy. Petitioner's testimony was that following maximum medical improvement from these prior accidents, he had soreness in the low back that he had been dealing with before, especially with regard to the confined space in his squad car. The squad had a cage to transport parolees, which would not allow the seat to move back, and also had a computer. That configuration, while wearing a bullet proof vest, were quite confining.

He also testified that his symptoms before this accident were left radicular pain which for the most part had diminished.

Following this collision, he noticed some back pain (Pet's. Ex. 7) and within 12 hours later he was starting to have symptoms like spasms in his mid and lower back. He testified that these spasms were new. The following day he returned to the same doctor who had treated him prior, Dr. Jain, with a history that his mid to lower back was stiff and sore (Pet's. Ex. 3, p. 12). Lumbar and thoracic X-rays showed degenerative changes with no fracture or subluxation (*Id.* @ 23, 24). Ultram was added to previous medications (Id. @ 14). January 5, 2016, returned to Dr. Jain, with complaints of joint pain, back pain, stiffness and arthritis, as well as thoracic spine pain. In his testimony, Petitioner referred to spasms, which he called tightness, which would be akin to the stiffness reported that date.

Thereafter, he began physical therapy January 25, 2016. He advised the therapist that he had been in a car accident in which he was stopped and a car turned into him attempting to turn, scraping along the front of the car. He reported severe low back pains since that time, which increases with carrying groceries such as a case of water. He also reported not sleeping well due to his sinus and his back pain. Walking was ok, but sitting increased the pain, especially with a hard chair, so he has to be in a chair with a back (Pet's. Ex. 1A, p. 8).

On May 10, 2016, Dr. Jain felt Petitioner had a lumbar radiculopathy, noting that the lumbar spine was improving with 90-degree flexion but decreased range of motion, and thoracic spine tenderness (Pet's. Ex. 3).

At Petitioner's final therapy visit, June 1, 2016, Petitioner reported that his back was better, but that weather was a huge factor in his increased pain levels, although base level at the visit was 2/10 (Pet's. Ex. 3, pg. 56). The exam at physical therapy showed a moderate loss of extension with pain, and that strength of lumbar extension was 3/5 (Pet's. Ex. 1A @ 94). Treatment goals included an increase of range of motion to allow for Petitioner to get in and out of the car without pain, something about which Petitioner testified. In light of his having to drive in a confined space, a secondary goal was being to increase range of motion in the lumbar flexion to 50%, along with other goals, including increasing strength and gait pattern. Petitioner was discharged June 1, 2016 "in good understanding of managing his symptoms and compliant with his HEP." (Id. @ 95 – 96). So he clearly remained symptomatic six months after the accident.

The only current medical evidence in the record is the Petitioner section 12 exam, an Occupational Medicine Specialist, dated July 25, 2017, (Pet's. Ex. 4), and his Deposition of September 25, 2017, (Pet's. Ex. 6). The Arbitrator takes note that the Doctor has extensive experience as a treater, in academia and as a consultant for the Liberty Mutual Insurance Company after being an employer in house doctor for a steel company. See Drs CV as a dep exhibit.

The complaints to Dr. Coe included pain in the mid and lower back made worse by prolonged sitting and driving and weather changes, occasionally causing lower back "spasms." He also complained of stiffness in the mid and lower back (Pet's. Ex. 4, p. 4). In Dr. Coe's summary he found Petitioner suffered both acute and chronic multifactorial mid and lower back pain (facetogenic and myofascial pain as well as sacroiliac joint pain) which resulted in trigger points in the mid and lower back, tenderness of the

thoracolumbar facet joints and sacroiliac joints bilaterally and decreased range of motion in the lumbar spine in extension. The doctor found a causal connection between the vehicular accident of December 27, 2015 and the current mid and lower back symptoms and state of impairment to a reasonable degree of medical certainty, causing permanent disability due to now chronic multi-factorial pain (*Id.* @ 6).

At deposition Dr. Coe testified to mechanism of injury, that we have a side impact in a somewhat immobilized large man. The mechanism of accident is an acute, unexpected, unanticipated, unbalanced strain, resulting in uncontrolled movements within the spine with this type of impact. The facet joints are joints between each pair of vertebrae, and the myofascial is the soft tissue, muscles, tendons and ligaments that hold the spine together and move in controlled movements. He felt the facet joints and the soft tissues were things that were stretched, strained and torqued by the side impact, and in some individuals, there type of joint injuries may be significant as they were in Petitioner's case (Pet's. Ex. 6, pp. 17 – 19). Dr. Coe felt that the prognosis was guarded because he has had pain for a year and a half and he expected it to persist (Id. @ 20). He had some discomfort from prior when sitting in the car, which he would do six hours a day, and the December 17, 2015 accident aggravated some pre-existent degenerative changes in his back. Further, having multiple accidents does pre-dispose to more persistent pain (Id. @ 21 - 22).

Dr. Coe testified that there was nothing he had seen in the records he reviewed, which were all after the accident of December 27, 2015, that would lead him to a conclusion that he had a true chronic multi-factorial pain problem before December 27, 2015, which is what he has now (*Id.* @ 22-23).

This problem is worse, and it is more specifically identified to anatomical sources, the facet joints, the soft tissues with trigger points and the sacroiliac joints. It is more specific and focused after the accident of December 2015 (*Id.* @ 23).

With respect to the facet joint as a pain generator, there is a nerve in each one of these joints, which are true joints like finger knuckles, small but true joints. They have nerve innervations and fine nerve endings which go into these little joints, and when sprained or strained sometimes it goes away, but when it doesn't go away there is persistent inflammation of the joint lining referred to as the synovian and with that persistent inflammation there is a small amount of effusion or swelling, which you can't see but is enough to put pressure on the nerves to cause facet joint mediated pain, which in many people are slow to calm down or may be persistent or chronic (*Id.* @ 23 – 24). He testified that Petitioner was a big guy weighting an estimated 320 lbs. and being 5 feet 11 inches tall, a large, muscular man like a football lineman. He testified that all the treatment was reasonable and necessary and casually related to the accident (*Id.* @ 24 – 25).

Dr. Coe hadn't seen the records from the prior accidents (*Id.* @ 26), nor had he read the record where Petitioner reached MMI after the 2014 accident (*Id.* @ 28). However, the records of Dr. Jain reflect MMI prior to the accident on May 5, 2015 (Pet's. Ex. 1, p. 180). Dr. Coe also noted that people with multiple accidents do seem to increase their susceptibility to further injury and persistent symptoms (*Id.* @ 29). Dr. Coe admitted that it is always a possibility that his condition of ill being could be related to the prior accidents, but it is not his opinion based on what he learned in this case (*Id.* @ 31).

However, Dr. Coe testified that Petitioner told him he had some discomfort following the prior accident, as Petitioner testified before the Arbitrator. That appeared to be credible. With this accident he was worse and did seek and undergo regular treatment (*Id.* @ 31 – 32).

In Support of the Arbitrator's Decision regarding (F) causal connection, see general findings of fact, Supra. The only opinion to a reasonable degree of medical certainty as to causal connection was that of Dr. Coe, which that there was causal connection. His opinion is supported by the testimony that after being released for work over six months earlier, Petitioner had some symptoms of soreness and did take medication on 1 or 2 occasions, but other than that there was no treatment for that period of time. So, his spine was in relatively good health. The chain of events is that the spine required no further modalities of treatment until the accident in question in which was followed by six months of physical therapy, a period much longer than would be expected for a minor injury. Causal connection is supported by the tightness, stiffness or what Petitioner called spasms which he testified only followed this accident. Further, under *Voykin v. Deboer*, 192 Ill. 2d 49 (2000), evidence of prior treatment lacks relevance unless there is expert testimony to show the relevance of prior problems, which does not exist in this case.

A review of Dr. Jain's records supports that Petitioner sustained a new injury either independent of or superimposed upon prior injuries, or a combination thereof. As to the prior accidents, the Supreme Court in *Voykin* made it clear that were there is a prior condition, the responsible party would not be relieved of liability because the only injury suffered was an aggravation of a previous injury, and thus for a prior injury to be

relevant to causation, the prior injury must make it less likely that the responsible party's actions caused any of the Plaintiff's injuries or an identifiable portion thereof (192 Ill. 2d @ 58). Here, the contrary is to true, especially in light of Dr. Coe's testimony that a true chronic multi-factorial condition only existed following this accident, with no evidence to the contrary. Thus, certain settlement contracts are a rejected exhibit.

In Support of the Arbitrator's Decision regarding "L" (Nature and Extent of the Injury), the Arbitrator makes the following findings and conclusions: See Arbitrator's General Findings of Fact, *Supra*.

Respondent offered as Exhibits the prior Settlement Contracts for the purpose of showing the percentage disabilities awarded, which were denied on the basis that such credits were not appropriate in a case involving person as a whole under Section 8(d)(2).

Regarding the factors under Section 8.1b(b) the first element, an AMA Impairment Rating, was offered by neither party, and is therefore not considered and given no weight.

The Second Element, the occupation of the injured employee, which is that he is a Parole Agent who must sit in a confined space in a squad for long periods of time, and also confront and be prepared for altercations with parolees, who can be violent. Further, he can be out in the elements of Chicago for periods of time. Thus, his occupation will have an effect on his back and is given greater weight.

The Third Element is the age of the employee which at the time of injury, was 45 years old, so he still has a significant number of years of work ahead of him, and this is given greater weight.

The Fourth Element, the employee's future earning capacity, by Petitioner's testimony he is earning the same wages now as he was at the time of the accident, and there is no other evidence of loss of future earning capacity other than Petitioner has a permanent back condition which could potentially affect a pre-employment physical should he retire from the State and seek employment elsewhere. It is given lesser weight.

The Fifth Element is the evidence of disability, corroborated by the treating medical records. They show the Petitioner required six months of treatment, including physical therapy, medication including a new medication specifically for muscle tightness or spasms, and that Dr. Jain had diagnosed a radiculopathy and thoracic and low back pain. There records corroborate evidence of disability, especially that he required six months treatment when, if only a back strain, it would be expected to heal within 6 to 12 weeks.

Even though Petitioner was released to full duties June 1, 2016, he returned to Dr. Jain December 27, 2016 where his lidoderm patches were re-prescribed, to apply one patch daily to the back area, as well as his Ultram to be taken as needed for pain (Pet's. Ex. 3A p. 26). The doctor gave him a 90-day supply of the pills to take as needed at that time by his testimony.

Petitioner further testified that he will get spasms one time a week during a good week, and will get them two or three times a week in a bad week. He testified that sitting in his vehicle for long periods of time, as a confined space, will bring on symptoms, and weather changes will also bring on symptoms.

He will also have symptoms when he turns one way or the other either to turn to his computer in the squad or to enter or exit the squad. These spasms feel like mid and low back pain like a tightening type of pain and soreness. Additionally, after sitting at trial herein for 35 minutes on a hard, standard wooden chair, Petitioner had to get up and stretch, and appeared to be in pain and stiff to the Arbitrator.

Dr. Coe's diagnosis was based on the same medical records of Dr. Jain and the therapist, and it was uncontradicted that Petitioner suffered a multi-factorial and significant thoracic and lumbar injury to the facet joints, the sacroiliac joints and the myofascial soft tissues which affects him while working in a confined space and potentially in altercations. This element is given greater weight.

Accordingly, the Arbitrator sets the disability under Section 8(d)2 as set forth in the cover page of the Award herein.

In Support of the Arbitrator's Decision regarding (J) (Medical), the parties stipulated that the bills of Dr. Jain for $678.00 and the bill of Ingalls Memorial Hospital for $1,297.00, the latter which was paid for by Cigna, the group carrier, would be admitted without objection, and that Respondent would have a credit for any sums paid and with respect to any group payments would hold Petitioner harmless therefore as required by Statute.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TED BEYER,
Petitioner,

vs.

NO: 09 WC 8947

THE HENRY PRATT COMPANY,
Respondent,

18IWCC0489

DECISION AND OPINION ON REVIEW

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

The Commission, having heard Respondent's oral Motion to Strike the Petitioner's brief, and considering the facts and law in support of same, denies Respondent's Motion.

IT IS THEREFORE ORDERED BY THE COMMISSION Respondent's Motion to Strike Petitioner's brief is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $56,247.00. 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.

18IWCC0489

DATED: AUG 7 - 2018

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 072518
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEYER, TED
Employee/Petitioner

Case# **09WC008947**

THE HENRY PRATT COMPANY
Employer/Respondent

18IWCC0489

On 8/2/2016, 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 0.39% 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 PORRO NIERMANN & PETERSEN
MICHELLE D PORRO
821 W GALENA BLVD
AURORA, IL 60506

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT T NEWMAN
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

18IWCC0489

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ted Beyer
Employee/Petitioner

v.

Case # 09 WC 08947

Consolidated cases: none

The Henry Pratt Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Brian Cronin, Arbitrator of the Commission, in the cities of Geneva and Elgin on July 15, 2015 and November 19, 2015, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ 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 exposure?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS

On **April 4, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an exposure to an occupational disease, that arose out of and in the course of employment.

Timely notice of this exposure *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 **$56,077.41**; the average weekly wage was **$1,078.41**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$4,599.26** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$4,599.26**.

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

ORDER

RESPONDENT SHALL PAY PETITIONER $619.97/WEEK FOR 75 WEEKS AS PETITIONER HAS SUSTAINED A LOSS OF USE OF HIS PERSON AS A WHOLE TO THE EXTENT OF 15%, PURSUANT TO SECTION 8(D)2 OF THE ACT.

With respect to prescription medical bills issued by the Injured Workers Pharmacy, the Arbitrator finds Respondent shall pay Petitioner the amount of $4,001.06, in accordance with Section 8(a) and subject to Section 8.2 of the Act. Respondent is allowed credit for all payments issued.

Respondent shall pay $718.94/week for 7-6/7 weeks because Petitioner was temporarily totally disabled from 2/12/08 through 4/6/08, pursuant to Section 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.

Signature of Arbitrator

August 1, 2016
Date

ICArbDec p. 2

AUG 2 - 2016

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

Ted Beyer
Petitioner

v. **Case # 09 WC 08947**

The Henry Pratt Company
Respondent

FINDINGS OF FACT

TESTIMONY OF PETITIONER TED BEYER

Petitioner Ted Beyer testified that on April 4, 2007, he was employed by Henry Pratt. He was an assembler. His job included cleaning parts with solvents.

One of the solvents was called barsul. He had to clean a machine that injected epoxy to seal valves. He had to clean the internal parts of the machine. He had to take the machine apart and use a solvent to clean the parts.

Petitioner showed the Arbitrator a photograph of a bucket that he used and a picture of the epoxy-injecting machinery. Pet. Ex. F

Petitioner testified that he noticed sores on his hands developing on April 4, 2007. He notified the safety coordinator. Petitioner and the safety coordinator applied a cream on Petitioner's hands that the company had in stock.

After a week, Beyer asked to go to a doctor. He continued working with the chemicals. He went to Dreyer Clinic and saw Dr. Evans. Pet. Ex. A

Dr. Evans came out to Henry Pratt and looked at the facility. The management did make a change. The management had Petitioner work in different areas. The management provided different kinds of gloves for Petitioner to use.

Petitioner testified that he was off work for two months in 2008. He then returned to work on or about April 8, 2008 and continued to work through September 1, 2009.

Until Petitioner stopped working in 2009, he worked at different tasks that management assigned to him in assembly and in the stock room. He tried wearing gloves at work, but at times the sores on his hands got worse within the gloves.

Petitioner testified that he went off work for his back surgery in 2009, and at that time he stopped working. He had lower back surgery in October of 2009 and had a second back surgery.

Petitioner's Counsel stated on the record, that Petitioner is not claiming that he had to stop work because of the condition of his hands.

Petitioner's hands have kept blistering and bleeding.

Each time that occurs, it takes a while for the sores to settle down.

The blisters are like sores filled with water and then they open. The open sores burn. Then the sores heal.

It seems like every three weeks the sores fester. Petitioner Beyer testified that it seems there is no point when he has no sores on his hands.

Petitioner has a bill from the Injured Workers' Pharmacy, but he does not know the amount. He received medication from the Injured Workers' Pharmacy. Such medications include Halobetasol and Doxicyclene. And he has another, new type of cream to apply on the hands. But he does not know the name of the new cream. The records reflect that it is Elidel. Pet. Ex. K

Petitioner testified that he still sees Dr. Evans for his hands and his feet.

Petitioner opined that without the medications, his breakouts are worse. He has more lesions without the medication, on both of his hands and his left leg.

Petitioner testified that he has had photos taken of his lesions when he has had outbreaks. He testified that the photos accurately depict what the hands and the feet have looked like when they have broken out. Pet. Ex. D, and I

Petitioner testified that he puts the cream inside his sock to prevent further sores on the feet.

Petitioner testified that if he gets soap in the open sores when he takes a shower, it burns. If he washes dishes and gets soap in open sores, it burns. His hands itch and burn in the shower and when he does dishes.

Petitioner testified that at one time Dreyer Clinic he tried UV soaks, but they did not help.

Petitioner testified that he uses antibiotics from time to time.

Petitioner testified that since he stopped working, he has had no improvement in his hands.

Presently, Petitioner notices that he feels a burning sensation in the back of the hand and has trouble coordinating movements with his hands. When he is developing the blisters, he finds the little lumps to be bothersome. He has a hard time controlling the breaking out of his hands.

Petitioner testified that he is not sure exactly when the sores on his feet developed, but it could have been in 2012 or 2013. He did not recall what type of footwear that he was wearing when he developed the foot sores. He did not notice if there is any type of footwear he could use and not have the sores on his feet.

THE ARBITRATOR'S OBSERVATIONS

The Arbitrator viewed the Petitioner's hands. Beyer has 10 lesions on the dorsum his right hand. The lesions are reddish in color. Each lesion is approximately ¼ inch in diameter. He has 4-5 lesions on the dorsum of his left hand. Each left-hand lesion is also about ¼ inch in diameter. Additionally, Petitioner exhibits little lumps under the surface of the skin on the dorsum of his hands.

The Petitioner also showed the Arbitrator his feet. The Petitioner has 3 mottled purple spots on the left calf but these were not open sores. He did not have any open sores on either of his feet. He did not have any sores at all on the right foot or leg.

DALE DARBY

Dale Darby is a senior supervisor with Henry Pratt Company. He did know Petitioner Ted Beyer in 2008 and 2009. He knew Petitioner Ted Beyer for many years before that time.

Between April 8, 2008 and September 1, 2009, Petitioner Beyer was working with restrictions. Dr. Evans had advised Beyer to avoid epoxy and barsul.

Mr. Darby testified that there were many jobs that Petitioner Beyer could do within the plant while abiding by the restrictions. There were assembly tasks that Petitioner could perform. Also, Petitioner could work in the stock room collecting parts and tools for some assemblies.

Petitioner Beyer did perform useful work during this time.

The witness Dale Darby testified that Beyer performed his work very well, with regard to the tasks he was asked to do.

The witness Darby testified that Petitioner Beyer continued to earn his prescribed union wages as long as he actively worked.

DR.COE'S REPORT

Dr. Coe saw Petitioner on June 23, 2009. At that time, Dr. Coe observed multiple areas of hypopigmentation and lichenification on the dorsal surface of his hands. He also observed evidence of healing lesions, but no open lesions on his hands. Dr. Coe found a causal relationship between the bilateral hand dermatitis and the chemical exposure at work with Respondent. Pet. Ex. G.

DR EVANS TESTIMONY PET Ex. A

CREDENTIALS

Dr. Evans is a board-certified dermatologist. He is affiliated with Dreyer Clinic. He is not an occupational specialist. He examines people for the entire range of skin conditions that might be presented. He treats teenage acne. He treats those who are concerned about developing skin cancer.

Dr. Evans, when he testified via deposition, did have an independent recollection of Mr. Beyer.

INITIAL VISIT

The first visit was September 5, 2007.

Mr. Beyer had complaints of itchiness and burning on the backs of his hands. He was working in a valve factory. His work involved the use of epoxy resin, epoxy hardener and solvents.

Mr. Beyer had already been seen by an occupational doctor by the name of Dr. Woodward.

Dr. Evans conducted an examination. He noted pink and de-pigmented plaques. These were raised and inflamed areas on the backs of the hands and fingers. These findings were not observed anywhere else on the body.

The de-pigmented areas are similar to scarring.

The recommendation was for topical ointments.

The ointment was called Clobetasol. He also prescribed Azithromycin.

Dr. Evans agreed with the use of gloves at work as a barrier against contact of the hands with the irritant substances.

Dr. Evans saw the patient Beyer two weeks later. Beyer still had complaints of weeping sores and itchiness to the backs of the hands.

Dr. Evans called this dermatitis of the hands. He continued the treatment and added Prednisone as an anti-inflammatory medication. That did not really help him. Dr. Evans tried a treatment in which a medication named Psoralin is applied and then his hands are exposed to ultraviolet light. The ultraviolet light activates the medication. This treatment was not effective for Mr. Beyer.

MATERIAL SAFETY DATA SHEETS

Mr. Beyer presented some material safety data sheets. One had a description of epoxy resin. Another had a description of the epoxy hardener. There was one in Chinese and one in English for a water-based rust inhibitor.

There was a material safety data sheet for a type of grease. The epoxy resin, epoxy hardening and the grease all indicate the use of gloves and avoidance of skin contact. Dr. Evans reinforced those recommendations.

There was an MSDS for a lubricant made with silicone. This silicone did not seem to have warnings concerning skin exposure.

Dr. Evans noted in some of his letters to avoid exposure to barsul. Dr. Evans said this was a word that he learned from Petitioner and he did not have any information about what barsul might mean.

PLANT VISIT

Dr. Evans did make a visit to the Henry Pratt plant. Mr. Beyer showed him the large valve assembly area. Mr. Beyer and Dr. Evans were accompanied by a man from management. Dr. Evans did not recall the name of the man. Dr. Evans said that Mr. Beyer showed him that there was a viscous, thick, amber-colored grease that was on some of the valves and Mr. Beyer thought that this was a substance that irritated his skin. However, Dr. Evans was unable to identify what the amber grease was.

CAUSATION OPINION

Dr. Evans concluded that the Petitioner Beyer did have a primarily contact irritant dermatitis. He opined that it could be caused by any of several substances encountered at the workplace based on the material safety data sheets. He testified that no one causative agent was identified but he thought there were several irritants to which Mr. Beyer could have been exposed in the workplace.

Dr. Evans said that the kind of patch testing done by dermatologists is done with a strip that exposes the patient to 36 different substances and then the doctor can see which, if any of these, provoke a reaction. This strip is manufactured and does not contain similar substances to what is used at work.

An allergist would do a patch test with a sample of a substance to be tested; a dermatologist would not perform such test.

COURSE OF CARE

Mr. Beyer is being seen on approximately a monthly basis and has been seen on a monthly basis for some years. The current treatment consists of oral Doxycycline and a medicated cream called Elidel or its generic Pimecrolimus.

Some months Dr. Evans prescribes Minocycline and some months he prescribes Doxycycline. Both are medications with antibiotic properties and anti-inflammatory properties. Mr. Beyer continues to have flare-ups every three to four weeks. Flare-ups consist of swelling under the skin and the development of open sores. After the sores develop, they tend to heal. Sometimes, but rarely, Mr. Beyer has no open sores on his hands. Usually he has at least some open sores when Dr. Evans sees him each month.

FOOT CONDITION

The foot condition seemed to develop in February of 2013, which was 3-1/2 years after Mr. Beyer last worked at the Henry Pratt factory.

Dr. Evans opined that the foot condition is related because the skin of the dorsal surface of the feet is similar to the dorsal surface of the hands.

Dr. Evans testified that the foot condition is milder in comparison to the hand condition.

Dr. Evans said that he had written on March 7, 2008 that Mr. Beyer should avoid exposure to clothing with dyes and woolen socks as those might be irritating. He also said that he counseled Mr. Beyer to avoid antibacterial soaps that would be available over-the-counter and avoid fragrance products. He had mentioned that dermatitis tends to be more prevalent during winter because of dry skin.

However, Dr. Evans did not say that a separate cause brought about the development of the foot dermatitis.

PROGNOSIS

Dr. Evans expected the dermatitis of Petitioner's hands to continue and, secondarily. the feet. But he did not expect the problem to occur elsewhere, given the current treatment regimen.

TEMPORARY DISABILITY

Dr. Evans testified that he had allowed Petitioner to be off work for a time in 2008, but he allowed him to return to work in 2008. He documented that Petitioner was working on May 21, 2008 and had some increased symptoms. Yet, he allowed Mr. Beyer to continue to work with restrictions until September of 2009. In September of 2009, Mr. Beyer stopped working because of his back condition. Even after that date - on multiple occasions in 2010 and 2011 - Dr. Evans wrote that Petitioner would still be able to work with restrictions of using gloves if he had not been disabled by his back condition.

DR CONIBEAR'S REPORTS

Dr. Conibear examined Petitioner on November 25, 2014. She issued a report of that date and a supplemental report dated July 8, 2015. Dr. Conibear noted that there is a basis in evidence-based medicine that dermatitis in one area of the body could be seen years after an exposure to an offending agent in another part of the body, especially in the case of allergic contact dermatitis. She noted that in *Contact & Occupational Dermatology, 3rd Edition*, cases in which the most severe dermatitis appears in an area distant from the apparent site of contact are due to one of two factors; one is the transfer of sensitizing agents to adjacent sites by touching such as hands to face or vaporization and the other is the susceptibility of the different body sites to respond to different agents. She did not believe that the sores on Mr. Beyer's feet were diabetic foot sores.

Dr. Conibear opined that "a workplace cause of Mr. Beyer's dermatitis is supported by the physician notes from February to April 2008, during which time he was taken off work … A causal connection is supported by the temporal relationship early in the course of the condition in 2007 and 2008." Dr. Conibear went on to state: "the fact that the condition has continued long after he left employment does not contradict a causal relationship. The medical literature shows that only about 25% of those diagnosed with either an irritant or allergic dermatitis resolve completely when they leave employment where the condition started. About 50% suffer re-occurrences and 25% do not improve significantly. The reason for this is not well understood." Pet. Ex. H and J

CONCLUSIONS OF LAW

With regard to issue (F) "Is the Petitioner' current condition of ill-being causally related to the injury (exposure)?", the Arbitrator finds:

The evidence reflects that Petitioner has a current condition of ill-being of the right and the left hand that is causally related to epoxy exposure while in the employ of Respondent.

The dispute is to whether or not the conditions of ill-being of Petitioner's feet are causally related to the occupational exposure.

The report of Dr. Conibear indicates that Petitioner could have developed an allergy to epoxy substances because of his exposure in the workplace and the allergy could have caused a lesion or lesions on his feet. Pet. Ex. H and J.

When the Arbitrator viewed Petitioner's feet on July 15, 2015, he noted that Petitioner did not have any open sores or lesions on either of the feet.

The Arbitrator therefore concludes that Petitioner has proved that a causal relationship exists between the current condition of ill-being of his hands and an April 4, 2007, occupational exposure while working for Respondent. Despite the fact that the Arbitrator did not observe any open lesions on Petitioner's feet, and the

fact that the photographs of Petitioner's feet are dated November 4, 2013 (Pet. Ex. I), he finds that Petitioner has proved that his current condition of ill-being of his feet is causally related to such occupational exposure. The Arbitrator relies on Petitioner's testimony and Dr. Conibear's opinions, as well as on the fact that Petitioner continues to treat for his dermatitis with medications.

With regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator finds:

The medical benefits at issue are bills from the Injured Workers Pharmacy in the amount of $6,236.92.

The medications provided to Petitioner are all appropriate medications and have been prescribed by Dr. Matthew Evans.

The issue is with regard to the amounts charged by the Injured Workers Pharmacy.

The Illinois Workers Compensation Fee Schedule for prescriptions that are filled within a licensed pharmacy provides as follows

"***How should prescription drugs be paid?***

Before 6/28/11, all prescriptions were paid at the usual and customary (U&C) rate. Our regulations do not define U&C. If there is a dispute, the parties would take the issue before an arbitrator.

Effective 6/28/11 (Section 8.2(a-3) of the Act), each prescription filled and dispensed outside of a licensed pharmacy shall be reimbursed at or below the Average Wholesale Price (AWP) plus a dispensing fee of $4.18. AWP or its equivalent as registered by the National Drug Code shall be set forth as published for that drug on that date in Medi-span. Prescriptions filled at a licensed pharmacy will continue to be paid at U&C."

Respondent has presented information on the amounts charged by three pharmacy chains for the same four medications that are being used by Petitioner. Walgreen's, CVS and Wal-Mart prices are very similar to one another for the four medications being used by Petitioner during the period at issue.

The Walgreen's prices are fairly representative of the three.

Petitioner's Exhibit K is reflects a claimed total of $6,236.92, but an email to Petitioner's attorney states that the balance has been properly discounted to date for $5,056.91. This Exhibit is not clear in establishing the sums to which the Injured Workers Pharmacy claims to be entitled.

Applying the Walgreen's prices to the prescriptions, in the quantities listed on Petitioner's Exhibit K, the Usual and Customary amount for these medications sums up to $4,001.06 and this is the amount awarded.

With regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds:

The date of exposure alleged in this case precedes the adoption in 2011 of the AMA Guides to the Rating of Permanent Partial Impairments. 820 ILCS 305/8.1b. The Arbitrator is required by 820 ILCS 305/19(e) to regard the Commission's decisions as precedent.

In *Velmont v. Pyonics Rubber Company*, 10 IWCC 607, the Commission awarded a loss of use of the person as a whole to the extent of 3%. In *Velmont*, claimant assembled mallets using epoxy. He developed an allergy to epoxy resin and had to avoid any job that would involve exposure to epoxy resin.

The cases of *Hein v. Eaton Corporation*, 02 IIC 0753, and *Ducett v. Elmhurst Memorial Hospital*, 02 IIC 0277, involve allergic dermatitis with limitations on occupational activities. In both cases, the Commission awarded 10% loss of use of the person as a whole. In the case of *Hein*, the contact allergic dermatitis was caused by formaldehyde, solvents and other chemicals used in a molding process. A change of job duties was required. In *Ducett*, the allergy was to latex, and claimant had to use steroid ointments and special non-latex gloves to continue in home health work.

In *Randall K. Rote v. Kelly Springfield Tires*, 00 IIC 0702, claimant developed an allergy to latex and contact dermatitis of the hands at work. He had to change his job and his lifestyle. There was a risk of developing a rash on the hands, a systemic allergy resulting in shortness of breath, generalized edema and shock. The Commission awarded 25% loss of use of the person as a whole.

In the case at bar, Petitioner's contact dermatitis on his hands has resulted in open wounds that itch and burn, ooze and bleed. Mr. Beyer has lived with for this condition for over 8 years. Dr. Evans and Dr. Conibear have both opined that this is a condition that is unlikely to ever resolve. He will require oral medication, medicated ointments, a humidifier, lotions and creams for the rest of his life.

Based on the foregoing, the Arbitrator finds that as a result of his occupational exposure to epoxy, Petitioner has sustained a loss of use of his person as a whole to the extent of 15%.

Brian T. Cronin

Brian Cronin
Arbitrator

8-1-2016
Date

STATE OF ILLINOIS)
)
COUNTY OF WINNEBAGO)

☐ 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

Dan Rosenbalm,
Petitioner,

vs.

No. 09 WC 3956

18IWCC0490

Walker Construction and the
Illinois State Treasurer, as
ex-officio custodian of the
Injured Workers' Benefit Fund,
Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund (IWBF), and notice given to all parties, the Commission, after considering the issues including notice to employer, average weekly wage, causation, duration of disability, nature and extent of disability, and liability of IWBF, modifies the Decision of the Arbitrator as to average weekly wage. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

18IWCC0490

Regarding Petitioner's average weekly wage, the Arbitrator found it to be $1,100.00. The Commission modifies this figure to **$700.00**. At hearing, Petitioner was unable to offer pay stubs or copies of checks because his employer, Walker Construction, paid him in cash. Petitioner testified that he was paid either $15 per hour or $20 per hour, depending on the type of job he was performing. His employer guaranteed him 40 hours of work per week, and Petitioner did work at least 40 hours every week. (Tr. 10). The Commission finds Petitioner's average hourly wage to be $17.50. This hourly wage multiplied by 40 weeks yields an average weekly wage of $700.00.

This figure of $700.00 is consistent also with Petitioner's testimony regarding his final payment from Walker Construction. He testified that he collected $600 from his employer for his last work week, after he got out of the hospital. Petitioner's accident (and last day of work) had occurred on Thursday, a day before the regular Friday payday. Thus, the $600 he collected was earned for work that had been rendered over the course of 6 days. (Tr. 24-25). Extrapolation from the foregoing yields earnings of $700.00 over the course of 7 days, i.e., a week.

Lastly, the Commission notes that the Arbitrator's $1,100 figure is considerably at variance with Petitioner's own stipulation. In the parties' Request for Hearing form, Petitioner asserted that his average weekly wage of $750.00. The Commission's determination of $700.00 hews more closely to Petitioner's own assertion.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed on January 12, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent, Walker Construction, shall pay Petitioner temporary total disability benefits of **$466.67 per week** for **55 and 3/7 weeks**, commencing **October 10, 2008** through **November 2, 2009**, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent, Walker Construction, shall pay Petitioner permanent partial disability benefits of **$420.00 per week** for **20.5 weeks**, because the injuries sustained caused **10%** loss of the **right hand**, as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent, Walker Construction, shall pay Petitioner permanent partial disability benefits of **$420.00 per week** for **225 weeks**, because the injuries sustained caused **45%** loss of the **person as a whole,** as provided in Section 8(d)2 of the Act.

IT IS FURTHER ORDERED THAT Respondent, Walker Construction, shall pay reasonable and medical services of **$27,498.68**, as provided in Sections 8(a) and 8.2 of the Act.

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

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

18IWCC0490

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 07, 2018

o-06/27/18
jdl/ac
68

AUG 7 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROSENBALM, DAN
Employee/Petitioner

Case# **09WC003956**

WALKER CONSTRUCTION AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0490

On 1/12/2017, 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 0.59% 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.

2489 BLACK & JONES
TRACY JONES
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0000 WALKER CONSTRUCTION
JEREMY WALKER
7858 WAGON WHEEL LN
ROCKFORD, IL 61109

5946 ASSISTANT ATTORNEY GENERAL
HELEN LOZANO
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dan Rosenbalm
Employee/Petitioner

Case # **09** WC **3956**

v.

18IWCC0490

Walker Construction and the Illinois State Treasurer AS Ex-Officio Custodian of the Injured Workers Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **December 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. ☒ 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 9, 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's average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **1** dependent children.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$733.33**/week for **55 3/7** weeks, commencing **October 10, 2008** through **November 2, 2009**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$27,498.68**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$660.00**/week for **20.5** weeks, because the injuries sustained caused the **10%** loss of the **right hand**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$660.00**/week for **225** weeks, because the injuries sustained caused the **45%** 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

JAN 12 2017

January 10, 2017
Date

FACTS:

The parties appeared for hearing on December 16, 2016 before Arbitrator Erbacci under the Illinois Workers' Compensation Act. Petitioner was represented by counsel. Petitioner attempted to provide notice of the hearing date to Respondent, Walker Construction, by certified mail. (Px. 5). The letter was provided to the address listed on Respondent's business card at Exhibit 3. As Respondent did not have workers' compensation insurance coverage, the Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund. (Px. 4).

Petitioner testified that on October 9, 2008 he was employed for Walker Construction owned by Jeremy Walker. He obtained this job after meeting with Jeremy Walker in May 2008 at a bar located in Illinois. They agreed that Petitioner would be working as a construction laborer. They reached an agreement that he would be compensated by being paid $18 an hour for normal construction/remodeling work and $20 per hour when working on roofs. He was paid in cash, and not by check, every week by Jeremy Walker. Petitioner testified that he did not wear a uniform but he was given a stack of business cards to hand out. A copy of the business card was offered into evidence as Petitioner's Exhibit 3. Petitioner worked from 7 a.m. to approximate 5 p.m. each day. He worked 55 to 60 hours per week. Because Jeremy Walker wasn't able to drive, Petitioner testified that he would drive to Jeremy's house where they would both get into Jeremy's work vehicle. Petitioner would then drive them to the job site each day. The jobs were located in Illinois. Petitioner testified that in addition to himself, there were four other employees who worked for Walker Construction. Petitioner testified that Walker Construction's place of business was Jeremy Walker's house located in Leaf River, Illinois. Petitioner testified that the work he performed for Walker Construction involved remodeling, altering, or demolishing structures, electrical work, use of sharp tools such as hammers, box knives, mud knives, miter saws, sawsall's and skill saws. He also had to use generators or other gasoline and power driven equipment consistent with 820 ILCS 305/3 (1, 2, 8, 15).

Petitioner testified that while working on October 9, 2008, he was at a job site with Jeremy Walker located in Oregon Illinois. They were installing a roof on a house. Petitioner picked up Jeremy at approximate 7 a.m. in Leaf River and drove to the job site in Oregon Illinois. Petitioner testified that he was climbing up an extension ladder to place 50 pound packages of shingles on the roof. At about 1:30 in the afternoon he grabbed a 50-pound package of shingles and began to climb the ladder. When he was about 15 to 18 feet off the ground, the bottom of the ladder, which was placed on gravel, slipped and fell to the side. There were two saw horses set up below the ladder, so when the ladder slipped, Petitioner jumped outwards to avoid them. He landed and experienced immediate pain in his right foot and ankle and his right wrist. He was working with Jeremy Walker and three other workers at the time of the injury. The owner of the house, Harvey Boyd, was also present. Jeremy Walker and Harvey came over and assisted Petitioner into Jeremy's truck. One of the other coworkers then drove Petitioner to the emergency room at KSB Hospital. There, he was diagnosed with a right calcaneal fracture which was comminuted and a right distal radius fracture. (Px. 6). Dr. Yeager recommended surgery on the ankle and Dr. Gabriel recommended casting of the hand. Petitioner was admitted to the hospital and underwent an open and reduction internal fixation of the right calcaneus fracture with use of cancellous bone chip on October 10, 2008. Petitioner testified that he spoke by phone to Jeremy Walker the first day he was admitted to the hospital but

did not speak with him after that. He was discharged on October 12, 2008 and was not allowed to return back to work.

Petitioner underwent follow-up treatment with Dr. Yeager and Dr. Gabriel for both the right hand and right ankle. Dr. Yeager applied a new cast on October 24, 2008 while Dr. Gabriel applied a new splint to the hand on October 27, 2008. (Px. 6, 7). He underwent a second surgical procedure to the ankle on November 14, 2008 by Dr. Yeager for a wound dissonance debridement which then was repeated again on November 17, 2008. On that date, he was started on a wound VAC system. (Px. 7). On November 19, 2008 it was clear that the hardware would have to be removed and he was placed in the hospital and put on IV antibiotics. A debridement was done on November 21, 2008 while he was still on antibiotics and surgery was then again performed November 23, 2008. Another debridement procedure was performed November 26, 2008 and the wound VAC was finally removed on December 8, 2008. (Px. 6, 7). During this entire time petitioner testified that he remained off of work and was not paid any benefits.

Petitioner continued to be kept off of work until March 11, 2009 when Dr. Yeager indicated that he could slowly return to activities as tolerated. (Px. 7). He continued to treat with Dr. Yeager through November 3, 2009. On November 2, 2009 Dr. Yeager recommended an additional surgery to fuse the ankle bones. (Px. 7). Petitioner was diagnosed on April 6, 2012 with subtalar joint arthritis due to the calcaneal fracture and was given a series of three injections. (Px. 7). On June 8, 2012 Dr. Yeager ordered a subtalar joint fusion procedure. He was also referred for a second opinion of the UW Madison where the doctor agreed that a subtalar joint fusion could be indicated. (Px. 8). Due to the ongoing pain and the inability to undergo another surgery, Petitioner was referred to medical pain management where he underwent pain management including injections and medications with Dr. Minore. (Px. 9). Petitioner did not have health insurance and Mr. Walker refused to pay any of the medical bills. Petitioner admitted $27,473.68 in unpaid medical bills as well as $25.00 in out of pocket expenses related to his treatment. Petitioner testified that at the time the accident he was 30 years old, single, with one dependent child.

Petitioner testified that he continues to experience occasional pain in his right hand which did improve since the initial treatment. However, the pain in his right foot and ankle remains constant. Petitioner testified that he is unable to stand or walk for long periods of time without feeling significant pain. He takes prescription medication including Vicodin on a regular basis. He notes that his ankle and foot swell daily and he has burning sensations in the foot. When he is at home, he has to elevate his foot, apply ice, and massage it to relieve the pain. Petitioner testified that he has attempted to return back to work several times in a job that would allow him to do sit-down work as recommended by Dr. Yeager. Petitioner testified that he has held two jobs since his injury; the first was in July 2010 for Aztec Mobile Screens. He was unable to maintain that job for more than a month. The second job began in January 2011 for Woods Equipment Company. Petitioner was terminated shortly thereafter due to his inability to stand throughout the day. Petitioner testified that he had no prior injuries to his ankle or foot and no prior injuries to his right hand before falling off the letter on October 9, 2008.

Notice of the trial date was served on the Respondent. (Px. 5). Petitioner offered a certificate of noncompliance from the NCCI confirming that Respondent failed to have insurance. Finally, Petitioner offered exhibits 1 and 2 which were the original Application for Adjustment of Claims and

the amended Application for Adjustment of Claims, adding the Injured Workers Benefit Fund is a party to the case. All issues were in dispute at the time of trial.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (A.), Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the Petitioner and Respondent were operating under and subject to the Illinois Workers' Compensation Act on October 9, 2008. Petitioner testified that he was approached by Jeremy Walker to do construction labor for Walker Construction. This conversation and job offer took place in the state of Illinois. Walker Construction maintains a place of business located in Leaf River Illinois. Also, the injury itself took place in Oregon, Illinois. Therefore, jurisdiction is proper here in Illinois.

Petitioner testified that his job was as a construction laborer for Walker Construction involving the remodeling, altering or demolishing of structures, the use of sharp edged cutting tools such as hammers, knives, miter saws, and more. The work also involved use of electric or gasoline powered driven equipment, such as generators, and required electrical work to be performed by Petitioner. Therefore, the work is subject to the Illinois Worker's Compensation Act consistent with 820 ILCS 305/3(1, 2, 8, 15).

The provisions of the Act apply automatically to any business or enterprise in which electric, gasoline, or other power driven equipment is used in the operation thereof, businesses engaging in the erection, maintaining, removing, remodeling, altering, or demolishing of structures, construction, or any enterprise in which sharp edged cutting tools are used. The Arbitrator finds Petitioner's testimony credible and finds automatic coverage under Section 3 of the Illinois Workers Compensation Act on October 9, 2008.

In Support of the Arbitrator's Decision relating to (B.), Was there an employee-employer relationship, the Arbitrator finds and concludes as follows:

The Arbitrator finds that there was an employee-employer relationship between Petitioner and Walker Construction. Petitioner testified that he was hired by Jeremy Walker to perform construction labor for Walker Construction. Petitioner testified that he and Jeremy Walker reached an agreement as to the days he would work, the hours he would work, how he would travel to and from job sites, the hourly rate to be paid for the various jobs he performs, and the number of hours to be worked each week. All of this information went uncontradicted at trial. Further, the Arbitrator finds Petitioner credibly testified to his employment relationship with Respondent. Therefore, the Arbitrator finds that there was an employee-employer relationship between Petitioner and Walker Construction on October 9, 2008.

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 Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment with Respondent on October 9, 2008. Petitioner testified that on that day, while ascending a ladder and carrying a 50 pound package of shingles to the roof, he fell to the ground after the ladder slipped on gravel. Petitioner's emergency room record indicated that while at work, he fell off a ladder from a height of approximately 15 feet and sustained fractures to his right ankle and right hand. He was immediately provided treatment for those injuries. Petitioner's testimony regarding the accident was uncontradicted at trial and is clearly supported by the treatment records. As such, the Arbitrator finds that Petitioner suffered an injury that arose out of and in the course of his employment with Walker Construction on October 9, 2008.

In Support of the Arbitrator's Decision relating to (D.), What was the date of the accident, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the date of the accident was October 9, 2008. The initial Application for Adjustment of Claims noted an accident date of October 11, 2008. Petitioner's counsel moved to amend the injury date to October 9, 2009 at the beginning of the hearing. The Arbitrator granted the request. The medical records support an injury date of October 9, 2008. As it conforms to proofs, the Arbitrator finds that Petitioner's accident occurred on October 9, 2008.

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 Arbitrator finds that Petitioner provided timely notice of the accident to Respondent, Walker Construction. Petitioner testified that he was working with the owner of Walker Construction, Jeremy Walker, at the time of his injury. Petitioner testified that Jeremy Walker assisted Petitioner off the ground and into the truck. Mr. Walker then instructed a coworker to drive Petitioner to a hospital. No evidence was provided to contradict Petitioner's testimony. Therefore, the Arbitrator finds that timely notice was given by Petitioner to 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:

The Arbitrator finds that Petitioner's present condition of ill-being is causally related to the injury that occurred on October 9, 2008. On the date of injury, Petitioner was immediately transported to the emergency room where he was diagnosed with a right calcaneal comminuted fracture and a right distal radius fracture. Based on the medical records, there is a clear chain of events which connect the hand fracture and ankle fracture to the accident. Petitioner testified that he did not have any prior injuries or conditions in the right hand or right foot. Based on the records of Dr. Yeager and Dr. Gabriel, the multiple procedures he had done to the right foot and ankle were related to the accident. The Arbitrator also finds that the treatment at Medical Pain Management for the ongoing symptoms

to the right foot and ankle is causally related to the accident. Petitioner continues to experience difficulty walking and putting weight on his foot. He continues to need to ice and elevate his foot to relieve swelling and pain. He also continues to have occasional pain in his right hand. His ongoing symptoms are consistent with the injuries suffered and no contradictory medical evidence was admitted at trial. Therefore, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to his October 9, 2008 injury.

In Support of the Arbitrator's Decision relating to (G.), What were Petitioner's earnings, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner earned $1,100.00 per week. Petitioner testified that depending on the job he was performing, he was either paid $18 or $20 per hour. At the time that he was injured he was doing roof work for which he was paid $20 per hour. Petitioner testified that he worked 7 a.m. to 5 p.m., totalling 55 to 60 hours per week. That testimony went unrebutted. Petitioner was unable to offer pay stubs or copies of checks because he was paid in cash by Respondent. The Arbitrator finds that even at the minimum of 55 hours a week, and as Petitioner was being compensated $20 per hour while working on the roof, he was making an average weekly wage of $1,100.00.

In Support of the Arbitrator's Decision relating to (H.), What was Petitioner's age at the time of injury, the Arbitrator finds and concludes as follows:

Petitioner testified that he was born on July 11, 1978 and was 30 years old at the time of his injury. Respondent offered no evidence to refute Petitioner's testimony. His medical records confirm his date of birth. Therefore, the Arbitrator finds that Petitioner was 30 years old at the time of his injury on October 9, 2008.

In Support of the Arbitrator's Decision relating to (I.), What was Petitioner's marital status at the time of injury, the Arbitrator finds and concludes as follows:

Petitioner testified that he was single, with 1 dependent child under the age of 18 at the time of his October 9, 2008 injury. The Respondent offered no evidence to refute Petitioner's testimony. Therefore, the Arbitrator finds that Petitioner was single and with 1 dependent child at the time of his October 9, 2008 injury.

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 finds that the medical services provided to Petitioner were reasonable and necessary for the injuries he sustained on October 9, 2008. The Arbitrator notes that the medical records, diagnoses, treatment carried out, and treatment recommendations are noted in the

Statement of Facts. The Arbitrator finds that the Respondent failed to offer any evidence to refute the reasonableness and necessity of the medical treatment received by Petitioner for his injuries. Therefore, the Arbitrator finds that the treatment Petitioner received at KSB Hospital, Medical Pain Management Services, and UW Hospital and Clinics were reasonable and necessary for his injury.

Based on the Arbitrator's findings that the Petitioner suffered an injury that arose out of and in the course and scope of his employment for Respondent, Walker Construction, and that the treatment Petitioner received was reasonable and necessary, the Arbitrator finds that the Respondent is liable for the treatment provided, as set forth in Petitioner's Exhibit 10. As such, the Respondent is liable for the unpaid medical bills, pursuant to the medical fee schedule, totaling $27,473.56. Further, Petitioner is to be reimbursed for the $25.00 out of pocket expenses paid to Medical Pain Management Services.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner is owed Temporary Total Disability benefits from October 10, 2008 through November 2, 2009 for a total of 55 & 3/7 weeks at the rate of $733.33 per week.

Petitioner was off work following his injuries, and underwent multiple surgical procedures to treat his fractures and the wound dehiscence that occurred in his ankle from October 10, 2008 through November 2, 2009. Petitioner's medical records note that he required physical therapy and continued to experience significant symptoms through November 2, 2009. On November 2, 2009, Petitioner was released by Dr. Yeager to regular shoe gear. Dr. Yeager noted that Petitioner would likely require a fusion surgery on his right ankle in the future. Petitioner did not wish to undergo the procedure and did not actively treat for over 2 years after that visit. As such, the Arbitrator finds that Petitioner reached maximum medical improvement as of November 2, 2009. As such, Petitioner is entitled to Temporary Total Disability benefits from October 10, 2008 through November 2, 2009.

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:

Having found that Petitioner's work injury of October 9, 2008 occurred in the course of his employment for Respondent, Walker Construction, and that the Petitioner's current condition of ill-being is causally related to that injury, the Arbitrator finds that Petitioner sustained a permanent loss of use of the person as a whole and to the right hand. Petitioner's injury to his foot has left him with the permanent restriction of sedentary work only. He credibly testified to the ongoing symptoms and difficulties ambulating due to his right foot pain. As such, he is awarded 45% loss use of the whole person representing a loss of career as his restriction of sedentary work only renders him unable to continue to work as a construction laborer. The Arbitrator also finds that Petitioner suffered 10% loss use of the right hand as a result of the injury. The Arbitrator orders the Respondent to pay to Petitioner 255.75 weeks of permanent partial disability benefits pursuant to Sections 8(d)(2) and 8e of the Act at the Permanent Partial Disability rate of $660.00.

STATE OF ILLINOIS)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDWARD SCANLON,
Petitioner,

vs.

No. 12 WC 20817

18IWCC0491

ADRIAN RIVERA, Individually And D/B/A EGA LANDSCAPING & DESIGN, And The Illinois State Treasurer As *Ex Officio* Custodian Of Injured Workers' Benefit Fund,
Respondents.

DECISION AND OPINION ON REMAND FROM THE CIRCUIT COURT

This matter returns to the Commission pursuant to the April 19, 2018 Order of the Circuit Court of Cook County (Judge Daniel J. Kubasiak) under its case number 17 L 50698. That Order was issued upon judicial review, sought by Petitioner, of the Commission's July 3, 2017 decision. In that decision, the Commission generally affirmed the Arbitrator, who denied benefits. The Arbitrator, who entered his decision on February 2, 2016 after hearing held on December 3, 2015, had found that Petitioner, Edward Scanlon, was an independent contractor, and not an employee, of Adrian Rivera, individually and d/b/a EGA Landscaping & Design ("Respondent"). The Commission concurred that there was no employee-employer relationship, but modified the findings, stating that "rather than acting as an independent contractor, Petitioner was more akin to a working partner and co-venturer."

On April 19, 2018, the Circuit Court found that that Petitioner was an employee of Respondent and that an employee-employer relationship existed at the time of accident. The Circuit Court reversed the Commission and remanded the matter to address the remaining issues in Petitioner's claim. Pursuant to that Order, the Commission makes the following findings of fact and conclusions of law, and discusses them below.

STATEMENT OF FACTS

Petitioner testified that, at the time of his asserted accident of June 8, 2012, he was 32 years old, single, and was working as a general manager/foreman at EGA Landscaping & Design, a business owned by Adrian Rivera. Petitioner's job duties included maintenance and landscaping at fourteen Chicago Public Schools. He testified that each week, he would set the schedule and the route for the landscaping crew, with whom he performed the maintenance and landscaping tasks, using power machinery including hedgers and mowers. This job was seasonal, from March through October. In the 52 weeks preceding his accident, he worked approximately 12 hours per week for 32 weeks at a rate of $14.00 per hour. (Tr. 11-15, 34-36). He was paid in cash, taxes were not withheld, and he did not receive any W-2's from Respondent. (Tr. 35-36, 43).

On June 8, 2012, while trimming weeds on the grounds of Owens Scholastic Academy, he fell into an 8-foot-deep hole that had been hidden by tall grass. He testified that he felt immediate and immense shooting pain in his right leg. (Tr. 19-20). A co-worker pulled him out by his wrists, and Petitioner presented to Mercy Hospital ER that day. There, he was diagnosed with right knee sprain, was put in a knee brace, and provided with pain medications. (PX 4). Petitioner testified that he informed Adrian Rivera of the accident that day by telephone. (Tr. 22).

On June 18, 2012, Petitioner presented to Integrated Pain Management, where Dr. Tian Xia ordered an MRI of the right knee and recommended a surgical consultation. (PX 7). The MRI revealed a lateral meniscus tear and bone contusions. The next day, Petitioner consulted with orthopedic surgeon Dr. Gabriel Levi of Orthopaedic and Rehabilitation Centers, S.C. Dr. Levi recommended right knee arthroscopy and placed him off-work. (PX 5). While awaiting surgery, Petitioner was prescribed pain medications and physical therapy; the physical therapy was had on various dates between June 26, 2012 and September 24, 2012. (PX 8).

On October 1, 2012, Dr. Levi performed a right knee arthroscopy with partial meniscectomy and chondroplasty of the tibia at Fullerton-Kimball Medical & Surgery Center. The post-operative diagnoses were right knee lateral meniscus tear and chondromalacia of the lateral tibial plateau. (PX 6). After the arthroscopy, Petitioner underwent additional physical therapy. (PX 8).

On October 9, 2012, Petitioner reported to Dr. Levi that his pain had significantly improved and he was ambulating without assistance. (PX 7). During direct examination, Petitioner testified that the last time he had medical treatment for his right knee was October 29, 2012 with Dr. Xia, who released him to work with no restrictions that day. (Tr. 28-29).

Petitioner testified that he never returned to work at EGA Landscaping & Design after the date of accident, and that its owner, Adrian Rivera, had refused his claim and cut of all contact. EGA Landscaping and Mr. Rivera did not participate in the arbitration.

Petitioner testified that he held a second job at Mobile Rail Solutions on the date of the accident. He stated that he worked there for 12 weeks prior to his date of accident, approximately 27 hours per week, at a rate of $9.00 per hour. (Tr. 15-16). He further testified that Mr. Rivera was aware of his concurrent employment at Mobile Rail Solutions. (Tr. 38). He stopped working at Mobile Rail Solutions on the date of his accident and did not return to employment there. (Tr. 43).

Petitioner testified that, since mid-2013 up through the time of the arbitration hearing, he has been employed as a handyman for Chicago's Mr. Handyman, where his tasks included snow removal, installing drywall, painting, tiling and other property maintenance. (Tr. 31, 45). He testified that he continues to experience right knee pain, particularly during prolonged periods (about two hours) of being on his feet, and has difficulty with climbing and kneeling. He takes aspirin for this pain. (Tr. 30-32).

Adrian Rivera and EGA Landscaping & Design did not participate in these proceedings. Petitioner provided general testimony that Mr. Rivera refused to be involved in his claim. Petitioner testified, "He [Adrian Rivera] was notified about everything every step of the way up until we stopped having contact." Petitioner has "no idea" approximately when Mr. Rivera cut off contact, other than it was "when he decided that he wanted nothing to do with paying me or having anything to do with this case." (Tr. 40-41). Petitioner submitted a certified letter to Mr. Rivera giving notice of the arbitration hearing as well as an NCCI certification showing that he was without insurance. (PX 15; PX 16).

OPINION AND ORDER AS TO DISPUTED ISSUES

As noted above, Respondent, Adrian Rivera d/b/a EGA Landscaping & Design, did not participate in the arbitration proceeding. As between Petitioner and the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund ("IWBF"), the disputed issues were: (A) whether Respondent was operating under and subject to the Act; (B) employee-employer relationship; (C) occurrence of accident that arose out of and in the course of employment; (D) date of accident; (E) timely notice of accident to Respondent; (F) causal connection between injury and current condition of ill-being; (G) Petitioner's earnings; (H) Petitioner's age; (I) Petitioner's marital status; (J) medical services; (K) temporary total disability; (L) nature and extent of injury, and (O) whether EGA Landscaping had workers' compensation insurance.

As noted above, as to issue (B), the Circuit Court has determined that an employee-employer relationship existed. The Commission addresses the remaining issues as follows.

Issue A: Was Respondent operating under and subject to the Act?

Petitioner presented sufficient, credible evidence that he performed landscaping and maintenance work for Respondent, which work subjected Respondent to the automatic coverage provisions of §3 of the Act. The Commission finds that Respondent was operating under and subject to the Act.

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

Petitioner presented sufficient, credible evidence that his right leg was injured while he was performing landscaping work at Owens Scholastic Academy for Respondent. His unrebutted testimony, supported by medical records, provides sufficient evidence that his accident arose out of and in the course of his employment by Respondent. The Commission so finds.

Issue D: What was the date of accident?

Petitioner presented sufficient, credible evidence, supported by medical records, that his accident occurred on June 8, 2012. The Commission so finds.

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

Petitioner presented sufficient, credible evidence that he telephoned Adrian Rivera on the date of accident and informed him of the accident. His unrebutted testimony provides sufficient evidence that he timely gave notice of accident to Respondent. The Commission so finds.

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

Petitioner presented sufficient, credible evidence regarding the causal relationship between his current ill-being and his injury. His unrebutted testimony is that he continues to have occasional right knee pain and difficulty with climbing, kneeling, and prolonged periods of being on his feet. It is credible that Petitioner's right knee injury would continue to cause him occasional pain. No evidence was admitted regarding any preexisting conditions or intervening causes. He has provided sufficient evidence that his current condition of ill-being is causally related to the injury. The Commission so finds.

Issue G: What were Petitioner's earnings?

As to earnings from Respondent, Petitioner testified, without rebuttal, that during the 52 weeks preceding the accident, he worked approximately 12 hours per week for 32 weeks at a rate of $14.00 per hour. As to earnings from his second, concurrent job at Mobile Rail Solutions, Petitioner testified, without rebuttal, that during the 52 weeks preceding the accident, he worked approximately 27 hours per week for 12 weeks at a rate of $9.00 per hour. Petitioner further testified that Respondent was aware of this concurrent employment. While the documentary evidence is scant, Petitioner has presented sufficient evidence that his combined average weekly wage was $ 411.00. The Commission so finds.

Issue H: What was Petitioner's age at the time of the accident?

Petitioner presented sufficient, credible evidence that he was 32 years old at the time of accident. The Commission so finds.

Issue I: What was Petitioner's marital status on the date of the accident?

Petitioner presented sufficient, credible evidence that he was single, with no dependent children, on the date of accident. The Commission so finds.

Issue J: Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

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Petitioner has presented sufficient, credible evidence that as a result of the injuries sustained on June 9, 2012, he incurred medical expenses, which were as a result of reasonable and necessary medical treatment for his injuries. Petitioner submitted into evidence bills from: Mercy Hospital and Medical Center; Orthopaedic and Rehabilitation Centers; Fullerton Kimball Medical Center; Integrated Pain Management; RX Pain Management; Fullerton MRI; Radiological Physicians; EqMD.; Prescription Partners; and EQM of Chicago. The Commission finds that these medical services were reasonable and necessary, and that Respondent has made no payments regarding the charges for these bills.

Issue K: What temporary total disability benefits are in dispute?

Petitioner presented sufficient, credible evidence that he was medically restricted from work from June 9, 2012 until October 29, 2012. Medical records contain work restrictions supporting the contention that he was placed off-work or had significant lifting restrictions placed by physicians starting June 9, 2012. Petitioner testified that he was released to full duty work with no restrictions by Dr. Tian Xia on October 29, 2012. The Commission finds that Petitioner was entitled to TTD benefits for the period commencing June 9, 2012 through October 29, 2012, totaling 20 and 3/7 weeks.

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

For injuries that occur after September 1, 2011, the determination of extent of permanent partial disability is governed by §8.1b of the Act. This section outlines five factors to be used by the Commission in determining the level of permanent partial disability: (i) the reported level of impairment (also known as "AMA impairment rating," as contained in the physician-prepared disability impairment report described in this section); (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.

In the instant case, no AMA impairment rating has been submitted. Regarding the remaining factors of §8.1b, the Commission makes the following analysis:

- **Occupation**: At the time of hearing, Petitioner testified was employed as a handyman with job duties including snow removal, installation of drywall, painting, tiling and other property maintenance. The physical nature of his occupation militates towards a finding of a higher level of permanent disability. (However, that he is able to perform these physical tasks militates against a finding of the same.)
- **Age**: Petitioner was 32 at the time of accident. While he is a younger person -- youth usually has been found to militate towards a finding of a higher level of permanent disability, insofar as a young claimant is presumed to be foregoing income over the course of many years in his or her remaining lifetime – Petitioner recovered well from his right knee surgery. In this instant matter, Petitioner's relative youth militates little towards a finding of extensive permanent disability.
- **Earnings capacity:** Petitioner did not testify as to any loss in future earning capacity. He provided no evidence that his injury has diminished his future earnings. This lack of evidence militates against a finding of extensive permanent disability.
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Evidence of disability: The medical records indicate that Petitioner underwent, without incident, a right knee arthroscopy for meniscal tear and that he recovered well. Petitioner has not required any further treatment for his right knee since October 29, 2012. At hearing, Petitioner testified that he experiences residual pain in his right knee and has difficulty with extended periods of being on his feet, for which he takes aspirin. Petitioner testified that he is able to perform the physical tasks in his current occupation of handyman. The medical records and Petitioner's testimony regarding the mildness of his current complaints and his ability to perform physical tasks weigh significantly against a finding of extensive permanent disability.

In consideration of the above factors, and based on Petitioner's testimony and treatment records, the Commission finds that Petitioner sustained a **12.5% loss of use of his right leg** pursuant to §8(e) of the Act.

Issue O (Other): Did Respondent have workers' compensation insurance on the date of accident?

Petitioner presented sufficient, credible evidence that Respondent did not maintain workers' compensation insurance on June 8, 2012, in the form of a certification from the National Council on Compensation Insurance. (PX 15). The Commission so finds.

Penalties and Fees against Respondent

Lastly, Petitioner sought during the initial review before the Commission -- but not at the arbitration level -- penalties and fees against Adrian Rivera. That Mr. Rivera has neglected his responsibilities under the Act is a reasonable assumption. As described above, Petitioner attested generally that Mr. Rivera refused his claim. However, Petitioner has provided no details or other evidence by which one can conclude that Mr. Rivera's conduct rises to a sanctionable level. For example, Petitioner has submitted no evidence of the written demand for payment of medical or temporary total disability benefits as expressly required in §19(l). The Commission denies Petitioner's tardy request for penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $ 274.00 per week commencing June 9, 2012 through October 29, 2012 (20 and 3/7 weeks), that being the period of temporary total incapacity for work under Section 8(b) of the Illinois Workers' Compensation Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay the reasonable and necessary charges for medical services provided to Petitioner under Section 8(a) and subject to the fee schedule under Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of **$ 246.60 per week** for a period of **26.88 weeks**, as the injury sustained caused permanent partial disability to the extent of **12.5% loss of use of the right leg** under Section 8(e) of the Act.

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

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 7 - 2018

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-06/27/18
jdl/ac
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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pamela Pistorius,
Petitioner,

vs.

NO: 14 WC 25274

Zurich North America,
Respondent.

18IWCC0492

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical 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 6, 2017, 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 - 2018
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

PISTORIUS, PAM
Employee/Petitioner

Case# **14WC025274**

14WC025275

ZURICH NORTH AMERICA
Employer/Respondent

18IWCC0492

On 11/6/2017, 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 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
DENNIS M LYNCH
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
STEVE MURDOCK
33 N DEARBORN ST SUITE 1825
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)/8(a)

PAM PISTORIUS
Employee/Petitioner

v.

ZURICH NORTH AMERICA
Employer/Respondent

Case # 14 WC 25274

Consolidated cases: 14 WC 25275

18IWCC0492

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 **Chicago**, on **February 23, 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. ☒ 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 _____

18IWCC0492

FINDINGS

On the date of accident, **May 27, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$90,612.02**; the average weekly wage was **$1,294.42**.

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

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

Respondent shall be given a credit of **$9,384.40** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,384.40**.

Respondent is entitled to a credit of **$97,696.56** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner failed to prove that she sustained injuries which arose out of and in the course of her employment on May 27, 2014.

As a result, all benefits are denied.

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

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

Paul V. Gallagher

Signature of Arbitrator

October 25, 2017
Date

NOV 6 - 2017

STATEMENT OF FACTS

The Petitioner worked for Respondent as a claims handler. She testified that she had her own secretarial/paralegal business and then worked for a law firm before starting her employment with Respondent in May 2004. She attended some community college, and was certified in law enforcement, working as an

auxiliary police officer for 4 years for Rolling Meadows. The Petitioner began her employment with the Respondent as an Auditor I, handling legal bill compliance then was promoted to Auditor II and then Auditor III by 2005/2006, which involved reviewing more complex and larger legal bills. She subsequently moved to construction liability as a Tier 1 claim representative, initially handling property damager and lower value claims, and then was promoted through the case value ranks until moving to the Recovery / Subrogation unit in approximately May of 2009, where she remained until leaving the Respondent's employ in 2014. Within that Recovery unit, she started handling Workers' Compensation, eventually being promoted to a Level 5 for high value New York and New Jersey claims. At that time of her 5/27/14 incident, she had obtained a Level 6 position in the Construction defect / General Liability Recovery unit, which included being the unit member who handled multimillion dollar environmental claims. Julie Colianni had been her supervisor since she started in that unit in 2009. She testified that she had approximately 200 assigned recovery files at the time of her alleged accidents.

Her job duties in April and May of 2014 involved reviewing her assigned claims for subrogation potential, obtaining experts if needed, obtaining and reviewing any necessary contracts to determine a responsible party, and attempting to recover attorney fees. She would make a demand and, if denied, prepare for arbitration, retain counsel when needed, forward documentation to counsel and to review discovery documents. She would sometimes attend mediations, prepare case summaries to obtain settlement authority and if possible settle claims within authority. The Petitioner testified she enjoyed the job, especially investigations, and she enjoyed her co-workers.

In April and May of 2014, she was working for Respondent on the 7th floor of Tower 2 of their two facility towers in Schaumburg. She testified the facility is locked and restricted to only employees. She would scan her badge to obtain entry to the elevators. She testified that some floors were then open, while others were locked to anyone who was not authorized to swipe in. She testified the 7th was a locked floor, she would have to swipe in, and if anyone not authorized to that floor wanted to enter they would have to call for entry. Because the doors on the stairs were locked, the only way to enter her floor was by the elevator. She could only access open floors and locked floors that she was authorized to enter.

The Petitioner testified that she sustained an alleged 4/10/14, work-related right ankle injury, which is the subject of companion case 14 WC 25275. There is no evidence that she had any lost time as a result leading up to the alleged 5/27/14 accident in the case at bar. The 4/10/14 ER report from Advocate Good Shepherd Hospital indicates she complained of left shoulder and right ankle pain. She reported she was walking her dog when it bolted and she fell on her left shoulder. She reported she also twisted her right ankle at work. The dog pulled so hard that something snapped in her shoulder. She didn't know if she had a pinched nerve, but she had pain from the shoulder joint down the left arm. The report notes: "She states she is really here for the shoulder but wanted her ankle to be looked at as well." She denied neck pain or back discomfort. There were no acute findings on left shoulder and right ankle x-rays. Exam noted mild swelling over the right lateral malleolus and lateral foot. She was diagnosed with sprains of both body parts, with possible rotator cuff injury, and given a sling and air-cast. Norco was prescribed and she indicated she was to follow up with Dr. Cummins. (Px8). Petitioner testified that she continued to work after this incident.

At Lake-Cook Orthopedics on 4/14/14, Petitioner reported left shoulder pain rated at 9/10, again relating the onset of pain to her dog pulling on the leash she was holding to chase another dog. A 5/24/14 therapy note states that when the dog yanked her arm "she went flying to the ground" with immediate pain and went to the ER, noting numbness and tingling down to her hand. She was diagnosed with a strain, and it was noted that due to guarding, it was difficult to assess more. Conservative treatment was recommended for the time being. At follow up on 4/29/14, Petitioner indicated she could not take steroids due to severe depression and a history of

being suicidal." She reported developing right elbow pain from overuse due to the left shoulder injury, and was diagnosed with lateral epicondylitis. A left shoulder MRI was within normal limits, and on 5/16/14 the left shoulder was injected and therapy was prescribed. (Px4).

On 5/27/14, the Petitioner testified she still had right ankle soreness, and had a prior cervical fusion in March 2008 with Dr. Brebach, but that she had no prior right shoulder or low back problems, and that her neck, right shoulder and back were fine when she arrived at work on this day. She was headed to the elevators to go downstairs for a break and testified that, while going to enter the elevator, the door hit her posterior right shoulder and upper back areas, which caused severe pain in the shoulder and a "shaking pain" in her back. On cross exam, she indicated her recall was that the elevator door to her right was coming at her, and that the "document guy" was in the elevator. She didn't feel good when she got outside after this, so she came in and told the security guard what happened before going back upstairs and reporting the incident to her manager, Julie Colianni, who gave Petitioner a Ziploc bag for ice and asked if she needed to make a claim. Petitioner said she responded, "I hope not", wanting to first see if she would get better. She attempted to ice the shoulder and continued to work. When she got home she laid down and iced the shoulder.

A 7/1/14 "Workers Compensation Information" form completed by Petitioner for Lake-Cook Orthopedics states: "I was 2/3 of the way in entering (the elevator) on right hand side and doors closed on me, striking me directly in my right bicep towards back of bicep & upper back at bra line. I think the doors continued to close because I scooted in as quick as I could." (Px4).

The Arbitrator viewed video of the elevator incident, which was submitted as Rx3. The Petitioner is seen walking towards the elevator as the doors are closing, and a man is inside with a cart. As she enters, she basically walks into the closing door to her right, bumps it and takes a step back, and the doors reopen. She then enters the elevator and leans back against the wall that was to her right. There did not appear to be anything in her hands. Nothing appears out of the ordinary, and at some floor, the man with the cart exits. At that point the Petitioner moves from the elevator wall to face the doors. She then touches and kind of rubs her right arm, them lifts the sleeve and looks at her bicep area, as if looking for a mark, before exiting the elevator at her floor. There is no sound, so any discussion that may have occurred with the man with the cart cannot be heard, but the video does not appear to show them talking to one another. (Rx3).

Petitioner testified that when she woke up the next day and "could tell something was not right." Her back didn't feel right, her right leg felt weak and her right shoulder hurt. After driving to work and walking in, she said her right leg felt very weak and she felt shaky. She worked for a couple hours, but when she returned from a break outside, she said she felt very shaky, and as she was walking back to her cubicle, her right leg just gave out and she went down. She was taken by ambulance to Alexian Brothers, but the Arbitrator could not locate the report of this ER visit in the voluminous record of evidence.

On 6/5/14, Petitioner saw Dr. Brebach and reported an elevator door closed on her at work on 5/27/14. She reported initially having shoulder pain and a backache, but now noticed increasing low back pain, upper thoracic pain and right leg radicular pain and weakness. Dr. Brebach, noting he had performed her prior 2007 cervical fusion at C5/6, stated: "The shoulder pain has improved. She does have some intermittent numbness in the shoulder but today we are really focusing on that lumbar area and right leg weakness." Petitioner reported she no prior similar symptoms. She was wearing a brace on the right ankle and had an antalgic gait, but had no complaints of foot weakness. Exam noted positive straight leg raise on the right, lumbar spasm and loss of motion. Diagnoses were lumbar spinal stenosis, thoracic or lumbosacral neuritis or radiculitis, and displaced lumbar disc. Petitioner was restricted to working at home. A prescribed 6/13/14 lumbar MRI showed mild bulging of the T12/L1 and L2/3 discs but no evidence of spinal or foraminal stenosis. (Px4).

On 6/18/14, Petitioner reported increased low back pain, despite working from home, and increased right shoulder pain that was radiating into the right hand with numbness and tingling in the 3rd, 4th and 5th fingers. She was taking Norco. Dr. Brebach noted no acute or significant problems on lumbar MRI and recommended physical therapy for the back and shoulder. He prescribed ibuprofen, noting he didn't think it was causing her reported diarrhea, and indicated she should see her primary provider, Dr. Thayu, for Norco. She was held off work. (Px4).

On 6/27/14, Petitioner followed up with Dr. Cummins' Assistant, PA Lauren Baruch, for left shoulder strain and right lateral epicondylitis. While she noted improvement with the injections, Petitioner reported elevator doors closed on her and hit her right shoulder, which was now her main complaint. On 7/10/14, Dr. Brebach noted Petitioner reported continued back pain, but improved radicular symptoms, and straight leg raise was now negative. Therapy had not been approved, and he indicated "I do not feel returning her to work in this condition is going to be helpful to any party involved here." He continued her off work pending therapy approval, noting he didn't otherwise have much more to offer Petitioner, as there was no indication for lumbar surgery or epidural injections. Petitioner saw Dr. Cummins himself on 7/15/14 for left shoulder follow up, and reported an elevator door hit her in the posterior right shoulder with significant pain in that area since. The diagnosis was right shoulder contusion and conservative treatment was recommended. While he noted Dr. Brebach had her off work as to her back, as to the right shoulder she was restricted to no right shoulder use. (Px4).

Respondent had the Petitioner examined by orthopedic surgeon Dr. Jacker on 7/28/14. Petitioner reported an elevator door closed on her, striking her in the right shoulder and posterior right arm and upper back, with immediate severe pain in the shoulder and upper back, and her spine felt shaky. She noted she tried to ice the shoulder at work, and iced it at home that night, but awoke with mid and low back pain as well as pain in the right shoulder blade and across the upper back. Her right leg felt "numbish", she felt weak driving to work and had difficulty walking. She reported her right leg gave way at work, she had to lay on the floor and was taken by ambulance to Alexian Brothers. She currently reported "incredible" pain across the right shoulder blade, pain in the right hip and groin to the knee, and occasional tingling in the right 4th and 5th fingers. Following examination and review of records, x-rays and MRI, Dr. Jacker concluded Petitioner sustained a right shoulder and upper chest wall contusion, but that she had exquisite hypersensitivity to touch, pain with right shoulder range of motion that was inconsistent with the degree of injury reported, and inconsistent straight leg raising findings with symptoms disproportionate to the described injury. He opined that physical therapy "for reassurance and to help her gain good functional use of the right upper extremity and address symptoms of pain in the lower back may be beneficial", and that 4 weeks would provide her with maximum benefits. He believed she could return to work, but given her marked symptoms he was unable to predict when she might reach maximum medical improvement (MMI). (Rx10).

On 8/5/14, Petitioner told PA Baruch the elevator incident was a "very significant injury", and that she continued with 8/10 right shoulder pain that inhibited her progress in therapy. Exam was positive for impingement, and a right shoulder MRI and off work were recommended. With Dr. Brebach on 8/7/14, Petitioner was favoring her right hip and reported ongoing significant pain and no improvement with therapy. Dr. Brebach stated he had no diagnosis he could offer for Petitioner, and saw nothing surgical in the lumbar spine, indicating he would like to see what the Respondent's independent examiner determined, and otherwise could only offer referral to pain management or a physiatrist. He advised her to finish the prescribed therapy, after which she would be released to return to work as of 9/2/14, and would follow up with Dr. Cummins for the shoulder. (Px4).

On 8/26/14, Dr. Cummins indicated that Petitioner had undergone extensive treatment with steroid injection and rehab as to the left shoulder, but remained symptomatic with pain with overhead activities and an inability to lift 10 pounds overhead. Dr. Cummins diagnosed left shoulder pain, with possible subacromial bursitis and/or biceps labral pathology, and he performed a subacromial steroid injection into the left shoulder. Surgical management was also discussed for the left shoulder, but "part of that depends on timing with regards to her right shoulder as well." An 8/26/14 right shoulder MRI arthrogram was negative with no abnormal findings indicated. At Petitioner's 8/29/14 follow up, Dr. Cummins noted the MRI was essentially normal, but Petitioner continued to complain of severe pain up to 9/10. Noting "at this point we need to get her pain down", the right shoulder was injected, and the diagnosis was right shoulder impingement syndrome "status post shoulder contusion." He released her to return to work with no lifting over 10 pounds, no overhead use of the right arm and no repetitive use of the right arm. (Px4).

On 9/4/14, Petitioner reported to Dr. Brebach that she returned to work but was unable to type due to her shoulder. She reported her back was improved, but that she had increasing neck and right shoulder pain. Therapy and full duty were continued for the back and neck, but Brebach deferred to Dr. Cummins regarding the right shoulder. At 9/16/14 follow up for the right shoulder and neck pain, Dr. Cummins noted Petitioner had no benefit from the injection, and given this and the negative MRI, he opined that the majority of her symptoms appeared to be cervical and that further management would be via Dr. Brebach. If that didn't help, he indicated he had little more to offer her, and she might need a pain management specialist. He released her to light duty: "no lifting more than 10 pounds, no overhead use of the right arm or repetitive use. Sher may type up to 15 minutes per hour and 2 hours per day. I believe she should be okay to use Dragon (voice recognition)." (Px4).

Petitioner saw neurologist Dr. Anderson on 9/18/14. The doctor noted her last visit was on 3/20/14. Petitioner reported the 5/27/14 elevator incident, with right shoulder and back pain since. Noting this was workers' compensation, Dr. Anderson indicated she would not order any tests related to the neck, right shoulder or right arm. She reported she was doing better without significant headaches until the elevator incident, which was now causing neck pain to radiate to her head. (Px4).

On 9/19/14, Petitioner called Dr. Brebach's office, reporting extreme pain in her neck and shoulder blade that was "messing with my depression", and indicated she had taken pain medication and had a few cocktails. The nurse noted that when asked specific questions about her pain, Petitioner was having difficulty staying focused on the conversation, and out of concern she called Petitioner's husband, who said he would go check on her. (Px4).

On 9/24/14, Dr. Brebach noted Petitioner had a difficult month mentally, and had some ongoing back and neck pain. He noted she had returned to work per his instructions, and credited the employer for flexibly working with Petitioner on ergonomics and getting her the Dragon program. Based on the increased shoulder complaints and the note of Dr. Cummins, he recommended a cervical MRI. At 9/25/14 follow up with Dr. Anderson, Petitioner reported she saw Dr. Didenko a few days prior and told him she was having suicidal ideation, but she did not want to be admitted to the hospital. She also reported falling down the night before and injuring her neck again and was waiting for a call back from Dr. Brebach's office. She reported awakening that morning with tingling and numbness on both sides of her face, around her mouth bilaterally and down both arms, and was afraid she might have a pseudoseizure. Dr. Anderson believed the numbness was due to the medication, Pristiq. (Px4). On 9/28/14, Petitioner went to the ER at Advocate Good Shepherd, reporting a three day history of tingling in her hands and feet, hallucinations, sleepiness and anxiety. She noted her meds were being changed, due to suicidal thoughts, and it could be related to that. She was to restart Pristiq to avoid withdrawal symptoms and stop the new medication. A 9/29/14 telephone note from Dr. Anderson notes the Petitioner saw multiple doctors on an emergency basis in the past week and was getting conflicting recommendations. Dr. Anderson

noted that "this is a psychiatric issue", and if the Petitioner did not want to follow her plan, she needed to see her psychiatrist. (Px6).

Petitioner testified she had continued to work for a few weeks after her 5/27/14 accident before Dr. Brebach took her off. When she tried to return to light duty in September 2014, she testified she was unable to use her right arm repetitively, while the job involved typing all day, so she was sent home pending installation of a Dragon voice recognition program. When she was called to return, she testified that it was difficult to learn the program and get it to recognize her voice, which was frustrating. Physically, she continued to have a lot of neck, back and shoulder pain at that time, and indicated that sitting in her desk chair without neck support was quite painful. She testified she would go to her car hourly to recline in the seat for 15 minutes, and that she would often lay in there and cry due to the pain.

Petitioner testified she was unable to keep up with her work and got behind on her required case activities, which would show up in red on her productivity system. She testified she already had a backlog to catch up on when she first came back to work, because two of the five other workers in her unit were terminated, and their 500 files redistributed to Petitioner and the unit, and no one had really picked up her slack while she was off. Thus, her testimony was that she returned to work already behind, got further behind, and this was exacerbated further by the added cases. Her unit's job was to "produce", i.e. to bring in subrogation money, and the failure to complete the tasks timely impacted her monetary bonuses. She was required to meet with her manager monthly to discuss diary management, how much money was recovered versus the goal, and any red late diary entries. Petitioner testified she felt she was on a sinking ship. She also had the ongoing pain and frustration with the Dragon program, and testified she therefore ended up doing some typing when she wasn't supposed to. As a perfectionist, she was worried she'd get in trouble if she was seen typing, resulting in anxiety.

On her last day with Respondent, which she believed was between 9/23 and 9/25/14, it was a usual day frustrated and in pain. She testified that she was getting pressure about catching up, couldn't take it anymore and "something just broke." She said she just happened to get a call from the human resources representative that had been helping her, Nicole Golliday. She told Golliday she was sorry but she just couldn't take it anymore, that no one was helping her. She was crying and indicated she had a scissors in her hand and wanted to cut her wrists. Golliday told her she understood, asked her to go home, to see a doctor if needed, and indicated she would speak to Julie Colianni. Petitioner testified she doesn't recall a lot after that, but did go home and called Dr. Brebach's office and left a message for the nurse. She testified she then took "a bunch" of different pills, then drank beer and liquor. She then called Dr. Brebach's office indicating they didn't need to call her back because she was self-medicating. They called her husband and kept her on the phone until he got home. She testified: "I remember him walking up and he said, what's going on? That's really all I remember until like October, at some point, when I was home." Petitioner testified she went into inpatient treatment at Alexian Brothers and continued to see Dr. Didenko. She also did a seven week Intensive Outpatient Program (IOP) at Alexian for anxiety, which was all day and included group sessions and one-on-one with assigned counselor. She testified that: "I had a lot of work to work on how you face these anxieties. . . .It was painful. It was brutal." She testified that she had to sit in an elevator for an hour a day for a while because they "kind of freaked (her) out," and she didn't like the memories they conjured up. Petitioner testified the Respondent initially covered the claim but began to deny the claim after obtaining independent examinations, and this upset the Petitioner as it made her feel like she was being accused of being a liar.

On 10/2/14, Petitioner was admitted to the Alexian Brothers Behavioral Health Hospital. Noting the 9/19/14 incident, Dr. Didenko stated that at a recent visit, the Petitioner grabbed a bottle of Ativan in an attempt to take the pills. The hospital discharge note of 10/19/14 indicates Petitioner had been struggling with depression for many years, but recently had become significantly worse. The report notes her father died 2 months prior, after

being diagnosed with brain cancer only two months prior to that, and she was feeling very depressed, suicidal and tearful with difficulty concentrating. It was noted that, due to pseudoseizures 2 years ago, she was started on Pristiq, but its effectiveness lessened about 6 months ago, so cross tapering was attempted with Fetzima over the last two weeks, "which seemingly triggered the significant bout of depression and worsening of suicidality." She noted the work injury with the elevator with neck and back pain, that her kids all left for college, that she had hypothyroidism, and that everything was basically happening at once for her, including a medication change. The initial admission also noted she also had undergone a gynecological ablation procedure in May 2014, and had since been taking estrogen and progesterone supplements. A triage safety assessment noted she had been hurt at work and "my workers' compensation claim is horrible. They treat me like I'm a criminal." She reported she stayed home for weeks, and that the workers' compensation claim exacerbated her depression. Petitioner reported severe anxiety and up to three panic attacks per day, as well as significant hallucinations. As the Petitioner had not had seizure activity for over a year, she was to be put back on Effexor, which had worked well for her in the past until the pseudoseizures began. Petitioner underwent multiple rounds of electroconvulsive therapy (ECT) at the hospital, and ultimately did well with it and the resumption of Effexor, and she was discharged on 10/19/14 with a plan to obtain ongoing ECT on an outpatient basis. Petitioner reported significant improvement since admission and no further suicidal ideation. It was noted that this was the Petitioner's third psychiatric hospitalization. A 10/7/14 note also references that Petitioner had tried at least 13 different psychiatric medications in her life. (Px5).

10/23/14 cervical MRI showed the prior C5/6 fusion with residual thin syrinx. There were disc-osteophyte complexes at C3/4 and C6/7 with severe right and moderate left foraminal narrowing, respectively. There also was left foraminal narrowing at C2/3 causing mild left foraminal stenosis with no disc involvement. The bulges were noted to be very minimal. (Px4). On 10/30/14, Dr. Brebach noted Petitioner's mental state was noticeably improved since the last visit, with inpatient care for a couple of weeks, but she had the same ongoing physical complaints. Dr. Brebach's review of the MRI indicated it was pretty good, with a solid fusion at C5/6 and an unchanged syrinx since 2008. He noted the C3/4 foramina was a little tight, with possibly a bit of a disc herniation, and that this could be causing her incapacitating right shoulder symptoms. As such, a C3/4 epidural was prescribed and she was continued off work. The epidural was performed at right C3/4 on 12/9/14 by Dr. Schneider. Dr. Schneider also noted that additional films showed more spinal stenosis than was depicted on MRI, particularly at C3 to C5. (Px4).

On 12/17/14, the Petitioner was taken by ambulance to the Advocate Good Shepherd ER with a history of seizure/convulsions, and a billing entry indicated it as "work related." She reported dizziness and weakness since the 12/9 epidural. A note of RN McMurry states: "Comment: Patient discussed the suicide attempt s/p all the stresses and frustrations of father dying quickly from CA, her medical condition/pain, inability to get in to see or speak with the physician." She noted she had a suicide attempt in September after taking steroids, and didn't know if cortisone injections were also impacting her. She reported having fallen seven times in the last week. She expressed feelings of sadness and depression. The EMT report notes the paramedics were familiar with Petitioner's seizures and witnessed one when they arrived. A brain CT scan was unchanged versus 12/11/13 with no acute abnormalities. A cervical CT scan showed postsurgical changes at C5/6 and multilevel facet degeneration. Petitioner denied any lower extremity weakness, but at times had fallen due to generalized weakness. She also reported she didn't think she had been eating for the past few days. Diagnoses included acute intractable neck and back pain with multiple falls, acute pseudoseizure versus seizure and acute generalized weakness with dehydration. (Px8). An initial PT evaluation report from the hospital the next day noted Petitioner complained of 10/10 low back pain radiating to the right leg, chronic low back pain and sciatica, and that she wanted a walker to avoid falls because her right knee gives out on her. She also reported pain in the right upper extremity from her neck. The PT note further states: "Pt reported that she's been falling a lot bec of sciatica." (Px8).

A 12/17/14 neurology consult notes Petitioner believed the elevator incident resulted in multiple cervical and lumbar disc herniations, and that her complaints were vague. The Petitioner questioned why she was being seen in neurology since her seizure had actually been a pseudoseizure, and that the one she had in the ambulance was due to stress and anxiety from the difficulties of treating her back and neck problems. She didn't want a neurologic evaluation of her back and neck because she needed to see workers' compensation doctors for that. She was referred for a consult with orthopedic surgeon Dr. Perlmutter on 12/18/14. He noted she was well known to his practice, and had undergone cervical fusion with Dr. Brebach in 2009. Petitioner had a diffuse list of complaints: neck pain, bilateral shoulder pain, bilateral hand numbness and tingling, pain radiating down the right arm to her thumb, and give way of the right leg. A cervical CT did not show any acute findings, "just some bulging discs." Noting no acute orthopedic or spinal issues, she was to follow up with Dr. Brebach. (Px8).

The Petitioner did not then follow up with Dr. Brebach until 1/12/15. He noted she was looking better and getting around better, but had the same neck, back and right shoulder complaints, and she related them all back to the elevator incident. He recommended continued therapy "really to help her gain some confidence in what she can and cannot do." As she remained off work psychiatrically, he had nothing more to offer, noting a 12/9/14 C3/4 epidural was not overtly helpful. She was to follow up as needed. (Px4).

Petitioner was examined by orthopedic surgeon Dr. Graf on 2/23/15 at the request of the Respondent. He noted multiple inconsistencies in Petitioner's exam and multiple non-organic pain signs, including non-anatomic symptom distributions and pain out of proportion to the evaluation. While he stated that Petitioner may have sustained a cervical or thoracic strain on 5/27/14, there were no objective findings to support her "myriad" of subjective complaints. He opined that she was at maximum medical improvement, needed no further treatment and was objectively capable of returning to her regular job. (Rx4).

On 3/2/15, Dr. Brebach recommended a second opinion, given that Petitioner's depression was now under control, which Petitioner requested be done at Northwestern. He noted Petitioner's neck and shoulder pain was possibly C6/7 related, with advancing degeneration at that level, but he saw no surgical indication. (Px4). A 3/2715 cervical MRI revealed findings consistent with an anterior spinal fusion at C5/6 with facet and uncinated degenerative changes at C3/4 and C4/5 "relatively stable" when compared to the prior study. A lumbar MRI of the same date showed mild degenerative changes. (Rx2). On 4/16/15, Dr. Brebach noted he hadn't yet received a report from Northwestern, but Petitioner indicated she wasn't "overly impressed: with the evaluation or response there. The Arbitrator did not find an evaluation from Northwestern in the record of evidence. Dr. Brebach noted the updated MRI showed some osteophytic change at right C4/5 which could be causing some of her symptoms. While he felt an epidural at that level would be ideal, he declined because epidurals increased her somnolence. Dr. Brebach noted there was no doubt Petitioner had improved in the last year, but felt she should consider therapy versus chiropractic treatment. While surgery at C4/5 could be helpful, he wasn't eager to recommend it at this point. He ordered an upper extremity EMG/NCV, which was performed on 5/8/15 and indicated no evidence of peripheral neuropathy, brachial plexopathy or cervical radiculopathy. (Px4 & Px11).

On 6/6/15, Dr. Graf issued an addendum report after viewing a video of the Petitioner's elevator incident. He essentially reported that not only did what he saw not change his opinions, it further supported them. (Rx4).

On 6/15/15, Dr. Brebach noted Petitioner was in therapy and chiropractic care, and "it has helped immensely", particularly cervical traction. He advised Petitioner to continue this care and to start weaning from Norco and Tramadol. He again noted he had nothing more to offer, and that Petitioner's psychiatrist was controlling her work status. (Px4).

On 11/19/15, Petitioner was taken by ambulance with complaints of two days of left chest pain. Following examination and testing, it was not believed to be cardiac related. Petitioner noted her psychiatrist took her off of Seraquil 4 days prior, and her symptoms started soon after that. (Px8).

From 11/4/15 to 2/17/16, Petitioner underwent pain management with Dr. Andrew Yu, which included multiple cervical facet nerve blocks, cervical radiofrequency ablation (RFA), lumbar epidurals, lumbar facet nerve blocks, and right hip injection and trigger point injections. (Px11).

Petitioner followed up with Dr. Cummins on 12/4/15, indicating no significant right shoulder improvement since her last visit and continuing pain at a 7/10 level. Dr. Cummins performed a subacromial injection, and at her 1/15/16 follow up, Petitioner reported no significant improvement. At that point, Petitioner opted for subacromial decompression surgery, to include diagnostic arthroscopy. (Px4). Petitioner underwent diagnostic arthroscopic right shoulder surgery on 2/8/16. Dr. Cummins' report notes he performed minimal labral debridement, noting he saw no detachment, chondromalacia or loose bodies. The rotator cuff and bicep were intact with no evidence of tearing. There was moderate bursal thickening, and a bursectomy was performed. There was narrowing of the subacromial space, and acromioplasty was performed. Post-surgery, on 2/24/16, Petitioner was doing well and was to start physical therapy. (Px4; Px8).

The Arbitrator notes the Petitioner was also undergoing treatment for right thumb CMC joint arthritis with Dr. Panchal during this time, and underwent surgery for same on 3/24/16. (Px4).

At Advocate Good Shepherd on 3/7/16, Petitioner reported falling and tripping down one step, landing on her knees and elbows and then hitting her head. She complained of headache and blurred vision, but she and her husband indicated they didn't feel the head trauma was significant. She started "going in and out", so her husband called 911 because it looked like another seizure. Petitioner was noted to have had an episode of jaw clenching at the hospital, and that she closes her eyes and seems to sleep but will intermittently wake to answer one question. She was admitted. (Rx2).

On 4/5/16, she reported 6/10 pain and was taking Norco, and Dr. Cummins indicated she was advancing appropriately. On 4/20/16, Petitioner reported reinjuring her shoulder when she tripped over her dog and slammed her right shoulder into a wall, reporting 9/10 to 10/10 pain. Dr. Cummins did not believe she did any damage, noting she "still" had excellent strength and motion. Therapy was to continue, including hand therapy following her thumb surgery. On 5/27/16, Petitioner reported slight improvement but still continued 6/10 right shoulder pain. The Petitioner began to complain of left thumb CMC pain. The right shoulder and left thumb were injected, and therapy was continued. Despite being advised to follow up in 6 weeks, she returned on 6/10/16 with complaints that she fell the week prior with her right arm extended, catching herself on a nightstand with increased right shoulder and thumb pain. As to the shoulder, Dr. Cummins advised rest and to hold off on therapy for two weeks, and she was to follow up with Dr. Panchal for her thumb, and Dr. Brebach for her ongoing back pain and lower extremity weakness. (Px4).

Noting about a year since her last visit, Dr. Brebach's 6/16/16 report states Petitioner reported ongoing difficulty with her right leg since her May "2015" injury. She reported that her cervical pain improved significantly with RFA with Dr. Yu. As to the leg, she reported falling without warning and generalized weakness. A new lumbar MRI was obtained on 6/24/16, which noted mild degenerative changes with facet hypertrophy and a disc osteophyte formation at T12/L1. On 7/1/16, Dr. Brebach reported that films again looked good and he saw nothing that would be causing the reported problem. Petitioner indicated Dr. Yu's lumbar epidurals were not effective, and he had no further recommendations for her, as there was no surgical answer. (Px4 & Rx2).

Petitioner presented to Advocate Good Shepherd on 7/5/16 with reported seizure activity. She had been undergoing transcranial magnetic stimulation therapy (TMS) via Dr. Yu, her psychiatrist. She indicated she felt TMS was helping, and her desire was to decrease her anti-anxiety medications. She had decreased her Clonazepam dose, and once it got to a certain level she reported feeling shaky, tired, heart racing, nauseous and anxious. The ER report of Dr. Greenberg noted she has been diagnosed with pseudoseizures lasting 1-2 minutes as a result of anxiety that presents as curling up and shaking. While it was believed her seizure/pseudoseizure was triggered by anxiety as opposed to medication withdrawal, it was recommended that her Clonazepam dose be increased, and she was to follow up with Dr. Yu. (Px8).

On 7/13/16, PA Baruch noted Petitioner reported overall improvement after right shoulder surgery, with pain at 2/10 and no difficulties with the activities she previously described trouble performing. The note indicated she should continue to improve for up to a year post-surgery, and she was released to return as needed with a home exercise program. (Px4).

A lower extremity EMG/NCV was in the records in Px4, and the study was reported as normal, negative as to radiculopathy. (Px4).

On 7/24/16, Petitioner went to the ER for head pain, dizziness and nausea, noting she fell the prior Friday and had slurred speech on 7/23/16. She noted low back and neck pain, and stated she fell backwards Friday while getting ready, tripped on a piece of furniture, now has progression of symptoms. She had confusion and difficulty staying awake. A separate note indicated she was putting make up on at a closet mirror, attempted to open the closet, lost her balance and hit back of her head on a tray table. Petitioner noted multiple prior concussions. She appeared to have symptoms consistent with concussion, but there were no acute cervical or head findings on CT scan. The diagnosis was acute cervical strain. (Rx2).

Petitioner sought treatment at the Advocate Good Shepherd Hospital ER on 2/7/17 due to seizures. She was discharged with a diagnosis of nonepileptic seizures. She was noted to have been off "benzos", with her last dose taken 1.5 months prior. (Px8).

Records were presented into evidence by both parties which predate the alleged accident date. The records of Lake-Cook Orthopedics were presented as Px4. Records from late 2008 and early 2009 indicate Petitioner's cervical fusion on 3/25/08 had resolved her arm pain and loss of cervical range of motion. The report also notes a syrinx at the C6/7 level had not been exacerbated by the surgery, as this would have resulted in an exacerbation of left arm pain. Dr. Cummins evaluated the right shoulder at that time prior to surgery, and noted no indication that the shoulder was causing her symptoms. An 11/5/07 report of Dr. Brebach also indicated Petitioner reported left leg and arm weakness and numbness. On 1/17/12, Petitioner visited for a second opinion regarding a left ankle sprain occurring 10 weeks prior. Dr. Young indicated she had pain post-sprain, which "is not unexpected", but he had no surgical resolution to offer, recommending continued bracing, exercise and medication. Intake forms also note Petitioner had undergone brain surgery for cavernous hemangioma in September 2005, neck surgery in 2007 or 2008, and gallbladder surgery in December 2010. (Px4).

Records were also submitted from Advocate Good Shepherd Hospital by Respondent which predate the alleged accident. (Rx2). On 3/25/08, Petitioner sought treatment with complaints of horrible neck and right shoulder / arm pain and paresthesias that had been accelerating. On 5/20/12, Petitioner complained of 3 or 4 days of headache and discomfort behind the left eye with sudden onset of weakness to the left upper extremity after becoming less responsive at a firehouse when a friend was taking her to the ER. She was noted to be somnolent at times but easily arousable. It appears that a stroke was ruled out, and a seizure was questioned. On 10/16/12, Petitioner was brought to the hospital via ambulance, and her daughter reported she'd had multiple seizures.

Petitioner's husband indicated she'd had more seizures in the last 48 hours than she'd had in many weeks, and believed it was because she was under lots of stress. However, he noted it was hard to distinguish between a seizure and a pseudoseizure. Petitioner was put into intensive care. Petitioner underwent a brain MRI on 11/10/12 following a head trauma 5 days prior, noting syncope and dizziness. There were no acute findings. A 5/26/13 cervical MRI was performed and compared to one from February 2011, and noted there is now mild central canal stenosis at "this level" (?) with a slight increase in right foraminal narrowing. Two weeks prior to the alleged accident, on 5/13/14, the Petitioner underwent an MRI of her left shoulder at the request of Dr. Cummins following a "sprain/strain injury of the left shoulder." This study revealed findings consistent with a partial thickness tear of the rotator cuff and "a developmental sublabral recess." (Rx2).

A number of records were introduced into evidence regarding Petitioner's psychological treatment, both before and after 5/27/14. With regard to psychological treatment, the Petitioner testified she first had such treatment around 2004 or 2005, after which she treated regularly, including various prescription medications. In 2011, she testified she treated psychiatrically with psychiatrist Dr. Didenko and therapist Lidia Dekhytar-Gerdov. She also treated with chiropractor Dr. Gerdov, the husband of Lidia Dekhytar-Gerdov, at the recommendation of either Dr. Brebach or Dr. Yu. She continues to see Dekhytar-Gerdov weekly, but in the spring of 2016 Dr. Didenko referred her to Alexian Brothers Behavioral Health for more comprehensive treatment, and she treated there with Dr. Yu. She generally now sees Dr. Yu's assistant, Vincent Donelon, but sees Dr. Yu when needed. With regard to psychological treatment, the Petitioner testified she first had such treatment around 2004 or 2005, after which she treated regularly, including various prescription medications. In 2011, she testified she treated psychiatrically with psychiatrist Dr. Didenko and therapist Lidia Dekhytar-Gerdov. She also treated with chiropractor Dr. Gerdov, the husband of Lidia Dekhytar-Gerdov, at the recommendation of either Dr. Brebach or Dr. Yu. She continues to see Dekhytar-Gerdov weekly, but in the spring of 2016 Dr. Didenko referred her to Alexian Brothers Behavioral Health for more comprehensive treatment, and she treated there with Dr. Yu. She generally now sees Dr. Yu's assistant, Vincent Donelon, but sees Dr. Yu when needed. The records clearly show that Petitioner has been actively treating for depression and anxiety for more than a decade, and the evidence in the case reflects that she's had psychological treatment going back to her teens, when she had bulimia. The records of the Dr. Wagner, from Barrington Family Institute, indicate treatment going back to April 2002. His records are handwritten and difficult to read, but it appears that the diagnosis was depression and anxiety. It appears she had treated for these conditions previously as she reported developing hives from using Prozac and Paxil. She was placed on Effexor and continued to follow up with Dr. Wagner throughout 2002. In 2003, the claimant's visits appear to have been more infrequent, with only five visits noted, but it appears Petitioner was kept on Effexor until 12/1/03, when she was transitioned to Lexapro. On 3/15/04, the Petitioner reported complaints of job stress and short-term memory problems. She noted on 4/5/04 that she obtained a new job with the Respondent, and she was switched from Lexapro to Wellbutrin. She continued to follow up with Dr. Wagner throughout 2004, during which time she went off the Wellbutrin to a combination of Elavil and Effexor due to sleep issues. She was subsequently taken off of Elavil secondary to side effects while Effexor was continued. (Rx1). She started treating with Dr. Didenko after her 2011 admission at Alexian Brothers Behavioral Health. She testified that Dr. Wagner was a sole practitioner with his own health issues, and when she couldn't reach him, her primary provider and Dr. Didenko met with her at the hospital and she continued to treat with Dr. Didenko.

On 12/10/07, Dr. Anderson noted the cervical syrinx was known as longstanding. The Petitioner said she fell and complained of right shoulder pain that was worse with head movement. On 9/25/09, the Petitioner reported global weakness on her left side, neck pain and headaches. She was referred to a neurosurgeon. Dr. Anderson noted Petitioner had a motor vehicle accident on 10/23/09 and reported the left side of her face went numb immediately, and by the time she got to the ER her entire left side was numb and weak. On 6/23/10, Dr. Anderson noted Petitioner had four ambulance trips to the ER over 6 days with 2 hospital stays related to

breathing problems followed by panic attacks and seizures and "shaking all over". Petitioner also complained of headaches and memory loss. On 8/16/10, Dr. Bikshorn noted no clear evidence that Petitioner's shaking, panic, shortness of breath or tachycardia was related to any neurologic disease. (Px6).

The Petitioner continued under Dr. Wagner's care through 6/8/11. Again, his notes are very difficult to read, but the Arbitrator notes that Dr. Goldstein appears to have done a very good job of deciphering these in her report. (see Rx5). By 2007 and 2008, it appears the claimant presented to Dr. Wagner two times per year, suggesting her condition had stabilized on the medications she was taking, which were Effexor and Provigil, as indicated by Dr. Didenko. In 2009, it appears that Cymbalta was added and Effexor discontinued. In 2010, she was transitioned back to Effexor and off Cymbalta. (Rx1).

On 7/21/11, Petitioner was admitted to Alexian Brothers Behavioral Health Hospital for psychiatric care secondary to complaints of severe depression, an inability to cope, and suicidal thoughts. She reported she worked in the claims department for Respondent, and had a 14 year history of depression. She was admitted through the ER after her primary care physician had called 911 from his office secondary to the passive suicidal thoughts, so she was admitted through the emergency room. The Petitioner identified multiple stressors in her life, including work, her son leaving for school in three weeks, and "some issue at home." In addition to Effexor and Provigil, Petitioner reported she was also taking Ativan. She reported a prior inpatient psychiatric admission at Advocate Good Shepherd Hospital about 9 years earlier for medication adjustment. Petitioner also reported a history of an eating disorder when she was 28 years old, as well as prior brain surgery, prior neck surgery, surgery for removal of a skin cancer, and gallbladder surgery. Per the testimony of Petitioner and Dr. Didenko, this was when she initially began treatment with Dr. Aleksandr Dekhtyar. He diagnosed recurrent and severe major depression, rule out bipolar II, with severe stressors. He recommended that she be hospitalized for stabilization and treatment. (Px5)

While hospitalized, the Petitioner reported to Dr. Bhargava that she had been feeling overwhelmed, had tension headaches and had suicidal thoughts. She also reported a history of gastritis, hypertension and hyperlipidemia for which she was also on medication. She reported allergies to penicillin, Paxil, Prozac, and Lexapro. Dr. Bhargava assessed the Petitioner with hypertension, controlled, hyperlipidemia, history of a fatty liver and mildly elevated liver function tests, gastritis, asthma, and mood disorder. The Petitioner was ultimately discharged on 7/27/11. She was discharged with the same medications at the same levels as she had coming into the facility. (Px5).

The Petitioner first presented to psychiatrist Dr. Didenko, who was associated with Dr. Dekhytar, for follow-up on 8/4/11. Dr. Didenko assessed the Petitioner with mood depressive disorder and suggested that they rule out bipolar disorder. As was the case with Dr. Wagner, some of Dr. Didenko's handwriting is difficult to read, however his deposition was obtained (see Px12, below). Petitioner continued to follow up with Dr. Didenko on a more or less monthly basis through December 2011, during which time the petitioner's condition remained stable, and she continued on the same medications. She saw Dr. Didenko again in March, April and May of 2012, and at her 6/29/12 visit, she reported that she had self-suspended Provigil, which had been increased to 200 mg per day at the April appointment. Through the end of 2012, it appears that she continued to take Effexor. At her 8/30/12 appointment, the Petitioner reported suffering a pseudoseizure, so Dr. Didenko added Clonazepam to her medications. On 10/12/12, Dr. Didenko indicated the Petitioner could return to full duty employment, though it was unclear when she had been taken off work. On 10/18/12, the Petitioner reported continuing to experience episodes of pseudoseizures, the last one 2 days before. On 11/29/12, it appears that the Petitioner complained of increased depression, and Dr. Didenko at that point began to wean her from Effexor to Prestiq. (Px1).

On 1/29/13, Petitioner presented to mental health counselor Liana Dekhytar (later Liana Gerdov), the daughter of Dr. Aleksandr Dekhytar. While this appears to have been a follow up visit, this is the initial report contained in Px2. These records run through 11/18/14. Forty eight visits were documented between 1/29/13 and 4/7/14, with general intervals of a week to two weeks. No specific diagnoses are indicated, but the Petitioner is noted to have anxiety/depressed mood and triggers, and much of the focus was on Petitioner's issues regarding her health and medical concerns. There are also issues noted regarding grief over past loss. On 2/19/13 and 7/3/13, hospitalizations were noted, but it is unclear if these were medical or psychological hospitalizations. Other noted issues include: becoming an empty nester with kids moving out, unresolved grief, multiple seizures (on 3/6/13 she noted having four such seizures in one day), oversleeping, feelings of helplessness and hopelessness, low energy and motivation, stress at the workplace, worry over how her condition was impacted others, isolating herself, suicide of a neighbor. On 4/30/13, she expressed concern and anxiety about "probability of having another seizure at work", and mentioned on 5/15/13 having an additional seizure. On 5/28/13, she indicated increased stress following a car accident the weekend prior, and due to a fear of continuing to get hurt, was afraid to drive. On 8/12/13, it was noted that the Petitioner was adjusting to returning to the workplace and the stressors and expectations therein. She subsequently reported feeling overwhelmed at work and that she had sought a new position there. On 10/29/13, Petitioner reported difficulty after losing a family friend. On 11/12 and 11/18/13, she reported dealing with several medical issues/concerns, including her stomach, vision and headaches and possible surgery, along with stress at work. On 12/16/13, she reported she fell and hit her head, and during panic had a seizure and went to the ER, and she noted anxiety with the medical staff and conflict with her husband. On 1/7/14, Petitioner reported she was looking for bigger job opportunities ("excess claims"). On 1/13/14 she was noted to have expressed fears and irrational beliefs, and a couple of weeks later noted to Liana that the job she sought was very demanding, self-sufficient and involved lots of travel due to mediations. She noted on 2/3/14 that she did not get the job she sought, as well as that she "isolates, doesn't want to leave 'safety zone'." On 3/3/14, Petitioner reported stomach issues/exhaustion and that she had slept all weekend. On 3/10/14, one month prior to her right ankle injury, the Petitioner expressed recurrent suicidal ideations over the past week, and Liana had her sign a contract regarding same, as well as advised Petitioner to seek emergency care and/or hospitalization. On 3/19/14, Petitioner reported lack of energy and social withdrawal, and it appeared that she had been hospitalized again. On 3/24/14, Petitioner discussed that she would be traveling alone to a mediation in New York and expressed fear and anxiety about it, and Liana discussed the importance of socializing with co-workers. It appears she began to take Adderall around this time and felt better. On 4/7/14, she expressed difficulty with time management and stress at work, as well as family stressors. (Px2).

During the months leading up to the alleged work accident, Liana continued to note ongoing care for the claimant's depression, anxiety, lack of energy and lowered appetite. They discussed coping skills to better handle her stressors. On 4/28/14, the Petitioner indicated she was overwhelmed and burned out at work with an increased workload, as well as conflict with her manager. On 5/19/14, she began to express she was stressed about her father's cancer condition, which resulted in his death shortly thereafter, and after which she again reported issues with grief. Petitioner also continued to report issues of pain and pain management. (Px2).

On 8/11/14, she expressed anxiety about a pending return to work on 11/2/14. Sciatica was noted. The last note of 11/18/14 noted she only slept an hour at night due to pain, and was waiting to get an epidural. Additionally, she noted her recent hospitalization, with "10 ECT's – loss of memory, persisting pain, financial issues. Discussed work stressors that led to recent suicide attempt and assessed client for any suicide ideation/plan." (Px2).

The Petitioner last saw Dr. Didenko on 5/1/14 before her alleged work accident. At that time she complained that she was severely depressed dealing "with much stress related to dying father, has been having fleeting

suicidal thoughts, denies any plans or intent." However, the petitioner's diagnosis remained unchanged as did the medications. (Px1).

At the first post-accident session with Liana on 6/3/14, there was nothing noted in the report about the work accident, but Petitioner did complain of increased alertness and anxiety. Pain management concerns were discussed, as well as continued discussions about coping with work-related stress. On 6/25/14, the Petitioner informed Liana that she had increased fear and anxiety with her father being diagnosed with cancer and undergoing chemotherapy. She again reported increased anxiety at her 8/11/14 session after he had passed away. (Px2)

When she saw Dr. Didenko initially after the accident date on 6/9/14, the report does not mention anything about the incident. The petitioner's presentation remained unchanged from her prior visits and was in fact described by Dr. Didenko as "mood stable, denies any discomforts." (Px1).

At her August 20, 2014 session with Liana, the petitioner indicated that she had "sciatic nerve damage" and that she had been unable to sleep due to shoulder and back pain. (Px2) The arbitrator notes that none of the treating physicians had up to this point diagnosed the claimant with "sciatic nerve damage."

When the Petitioner returned to Dr. Didenko on 8/21/14, she again made no mention at all of a work accident or an increase in symptoms following a work accident. The diagnosis remained unchanged, and Dr. Didenko started the Petitioner on Seroquel 100 mg. (Px1).

Liana noted the Petitioner reported increased stress over her job, workers' compensation and doctors' visits, so these were addressed in the 9/8/14 session. (Px2). When the Petitioner returned to Dr. Didenko on 9/18/14, 2014, she reported that she had been dealing with high level of anxiety. However, there was no mention of the Petitioner's May 2014 elevator incident or of any physical injuries or complaints that the Petitioner may have been experiencing at that time. Her diagnosis and presentation remained unchanged as did the recommended course of treatment. (Px1).

On 9/22/14, Dr. Didenko noted complaints of depression and being tearful with low energy levels and anhedonia. Her presentation and the diagnosis remained unchanged, but Dr. Didenko decided to wean Petitioner from Pristiq and onto Fatzima. On 9/29/14, Petitioner returned to Dr. Didenko and reported feeling very tired, complaining of vivid dreams and stated she had been seen in the emergency department the day before. Petitioner reported having an appointment scheduled to see a neurologist due to tingling sensations. Dr. Didenko's diagnosis again remained unchanged as did the recommendations for treatment. On 10/2/14, Petitioner reported that she was very depressed, having panic attacks and suicidal ideation, and Dr. Didenko referred her to the emergency room for admission. (Px1).

Following her admission at Alexian Brothers Behavioral Health, the Petitioner returned to Dr. Didenko on 11/3/14 and reported feeling better. Dr. Didenko noted her mood was improved, her diagnoses remained unchanged, and Petitioner had been weaned from Pristiq and was to continue Effexor. In an 11/10/14 note, Dr. Didenko indicated Petitioner was unable to return to work. (Px1).

When Petitioner returned to see Liana Dekhytar-Gerdov on 11/18/14, they discussed what led to her suicide attempt, and "work stressors" were listed as the cause. She continued to have suicidal ideation, but without plan, per the 11/23/14 visit. (Px2). The Petitioner returned to Dr. Didenko on 11/24/14 complaining of problems with concentration, but improved since her last visit. He increased her dose of Effexor and restarted her on Provigil. (Px1). On 12/1/14, Petitioner complained to Liana about difficulty with the amount of physical pain

she was experiencing, but also reported that she was sleeping better. The Petitioner expressed guilt for not being able to work "due to her medical condition" on 12/8/14. The Petitioner then missed the next two follow up sessions due to "side effects from epidural." (Px2).

On 12/2/14, the Petitioner returned to Dr. Didenko, again reporting problems with concentration and short-term memory. She was still very depressed but indicated her mood was improved. On 12/29/14, the Petitioner reported increased anxiety, oversleeping and having experienced approximately 3-4 pseudoseizures since her last visit. Dr. Didenko recommended she start taking Vyvanse. (Px1). On 12/29/14, Liana reported that Petitioner appeared "fixated on her inability to go back to work." (Px2). The petitioner returned to Dr. Didenko on 1/12/15, with the same complaints she had on 12/29/14. (Px1). On 1/12/15, Liana noted Petitioner was anxious and guilty about becoming unemployed. On 2/2/15, Liana noted: "Client disclosed feeling less anxiety after learning more about the workers comp process & health related options from her lawyer." (Px2). At her last visit with Dr. Didenko on 1/26/15, Petitioner complained of feeling severely depressed with fleeting suicidal thoughts. (Px1). At this point, Petitioner and Dr. Didenko testified that he referred Petitioner to Alexian Brothers Behavioral Health (ABBH) to find another psychiatrist because he was a sole practitioner and was unable to keep up with the demands of Petitioner's workers compensation/disability providers.

After initially met with a nurse at ABBH on 3/22/16 to set up a transfer of care, the Petitioner presented to Dr. Xiaohong Yu on 4/20/16, and he noted a long history of depression and panic attacks and PTSD (trauma from the injury at workplace), and that she was on "disability leave." He noted chronic depression and pain and referred her for transcranial magnetic stimulation therapy (TMS). The Arbitrator notes that, from what the Arbitrator can tell, these records indicate the first time anyone used the diagnosis of PTSD. (Px9).

On 4/25/14, Petitioner was seen by Dr. Kim to discuss eligibility for TMS. Dr. Kim noted that "this episode of depression began after 5/2014 in the context of a work related accident," and that stress, depression and anxiety worsened and she had a suicide attempt. He noted she was "currently on long term disability for mental health reasons." The Petitioner reported pain issues with the right shoulder, lower back and neck. The Petitioner underwent 34 sessions of TMS from 5/26 to 7/21/16, while also following up with Dr. Yu. On 5/18/16, Dr. Yu noted that Petitioner "has not been able to function at her baseline level. She has frequent crying spells." On 6/29/16, Petitioner stated she felt better but continued to have back pain. Dr. Yu continued her medication and told her to return in 3 or 4 months. Petitioner continued to treat regularly with Dr. Yu. (Px9).

Petitioner testified that the electro convulsion therapy (EGT) she underwent was "horrible," noting she had never undergone such treatment before the 5/27/14 accident, and would not go through it again. When she came under Dr. Yu's care, he continued her off work, and she testified that no psychiatric treater has released her to return to work.

Currently, Petitioner testified she still has daily neck pain. As a result, she avoids walking and riding in the car, noting it hurts to move her neck in any direction. Her low back remains sore, and she has intermittent pain. It is worse with prolonged sitting, lifting and prolonged walking. If she bends forward she can get a "zinger", which she described as a zap of pain in her back like an electric shock. She avoids housework, "I don't really do much of anything. I don't want it to start hurting again". Her right shoulder gets sore, and gets pain mainly when she tries to sleep. She feels it is more the neck radiating to the inner right shoulder versus the outside of the shoulder where she got hit. To reduce her pain, Petitioner testified she takes muscle relaxers, left over hydrocodone from her surgeries that she takes sparingly, and Aleve. She also uses a heating pad, ice at time on her neck, and sometimes alcohol. She sits with her feet up to alleviate her low back pain.

Psychologically, Petitioner testified she feels useless, alone, and often that "it would be easier to be gone". She testified, "I don't know what broke" after the accident, but that she doesn't feel like who she was. She loved to work, working since age 16 and sometimes working multiple jobs, and now she doesn't leave the house and her husband does everything. When she eats, she generally eats in her bed, as it hurt to sit at the kitchen table. When people come over, she has panic attacks and stays in her room.

On cross examination, Petitioner agreed she had been voluntarily trying to move up to higher levels with Respondent to improve herself, it was not a requirement. However, she testified the job didn't really change as she moved up.

Petitioner agreed she had been hospitalized for psychological problems twice prior to 2014. She also agreed she was off work for varying periods of time on short term disability in 2012 and 2013, but could not say if it was a total of 40 weeks off between 6/12 and 7/13. She agreed she treated with Dr. Wagner from 2002 to around 2010. She has been to Advocate Good Shepherd multiple times over the years between 2004 and 2017. She did undergo an evaluation with Dr. Renteria in 7/13 following a head injury in a 5/13 car accident, with testing similar to Dr. Goldstein's evaluation. As to the car accident, she was on her way to work when the car in front of her hit a deer, causing a chain reaction where she hit the car in front of her and got hit from behind. She testified that she had a brain bruise and concussion, so was kept overnight, after which the blood had resorbed and CT/MRI testing that morning showed the blood had resorbed and she was sent home. She returned to work after a couple of days, believes she may have passed out and went back to the hospital and was asked who let her return to work because she had a severe concussion. She had vestibular therapy to get her vision and balance back.

Petitioner agreed some of her TTD and some of her bills were paid by Respondent.

Prior to the accident she had a brain surgery in 9/05 for a cavernous hemangioma, which was a congenital deep cluster of blood vessels. At some point the vessels can leak, and when it does blood on the brain can cause a problem. She passed out at one of her kids ball games, and eventually craniotomy surgery was performed and 4 weeks later she was back to work. Testing revealed no seizures. She had no residual effects.

Her father was diagnosed with brain cancer after he fell at home right before she got injured at work. He previously had colon / intestinal cancer, had treatment and was all clear for two years. As it got towards the end, he wasn't making any sense and, following a scan, it was over and he was put into hospice the first week of July and passed away on 7/16/14. She was close to her father, so she was really sad. She hadn't been able to visit him due to being at home in pain. She missed his last Father's day, noting she was crawling to the bathroom due to pain, and they were still saying he would be okay.

Upon the rejection of a piece of evidence in this case, Px14, the Petitioner indicated, with no dispute from Respondent, that Petitioner was awarded Social Security Disability benefits with a date of disability of 9/26/14, and she began receiving the benefits in March of 2015.

Petitioner's husband, Joseph Pistorius, testified that he and Petitioner have been married for 27 years and have three children, all over 21 years of age. He has worked as a Rolling Meadows policeman for 32 years. Prior to the work accident, he testified that the Petitioner was very competent and smart, outgoing and personable, energetic and dedicated. She was energetic and fun to be around. She worked hard and loved her job. He did agree, however, that the Petitioner had issues with depression prior to the alleged May 2014 accident. He testified she would have bouts of sadness and crying that would last a week or two, and she would confine herself to some degree when this would occur, staying home and avoiding socializing.

Mr. Pistorius testified that after the 5/27/14 incident at work, she complained of significant shoulder and back pain. She attempted to return to work for a short period of time in September 2014, but she would be emotional , upset and crying when she would come home, indicating it was because of what was going on at work or how she was being treated. The Petitioner also complained that she had neck, back and shoulder pain that was so severe that it was causing pain in her leg to go numb and made walking difficult. She also indicated it was hard for her to physically sit at a desk and to get back into working. He testified Petitioner did not attempt to return to work again after September 2014.

The day of or the day after her last attempt to work, Mr. Pistorius testified the Petitioner had a meltdown of some sort and called Dr. Brebach's office. His nurse contacted Mr. Pistorius, stating she reported taking a bunch of pills and drinking alcohol. He left work to check on her at home and when he got there, she was on their deck and drinking, crying and emotional. The Petitioner agreed to see the doctor the next day, at which time Dr. Didenko admitted her to Alexian Brothers as an inpatient.

Mr. Pistorius testified that after her release, she became more reserved, was crying and upset all the time, and appeared to be severely depressed compared to what she was before. He testified she continues to be severely depressed with a lot of highs and lows. She basically sits in the garage, watching TV and smoking to calm herself down, and doesn't leave the house much other than to see her therapist twice a week. Prior to the accident, he testified they used to go out about twice a week.

According to Mr. Pistorius' testimony, they used to both be very outgoing and social people, but since the accident the Petitioner now has a significant fear of being around people, even friends, and going out in public. He testified the Petitioner hid when he had people over for the Super Bowl. He cooks, cleans, does laundry and other housework, and takes care of things for their son who still lives at home. He testified that the Petitioner sleeps a lot. He did testify that the Petitioner has been better at committing to do things when she sees her therapist, Liana Dekhytar-Gerdov.

On cross examination, Mr. Pistorius agreed Petitioner had been seeing a therapist for depression for about a decade prior to the accident. She had also been admitted to the hospital for depression/anxiety prior to the accident. She had been evaluated for epilepsy for seizures before, but this turned out to be "pseudoseizures." He wasn't sure exactly how long before May 2014 that the pseudoseizures started.

On 7/20/16, psychiatrist Dr. Didenko testified by way of evidence deposition. (Px12). He confirmed that he had been the claimant's treating psychiatrist from December 2012 through January 2016, taking over for a prior associate, Dr. Dekhytar, who had been seeing Petitioner since 7/21/11. He testified that Petitioner was looking for someone who could prescribe her psychotropic medications, Effexor and Provigil. Dr. Didenko testified that the Petitioner had a long history of depression and anxiety, and that her treatment prior to May 2014 included two inpatient psychiatric hospitalizations for suicidal ideation and severe depression in July 2011 and March 2014. Dr. Didenko testified that she was hospitalized again, twice, in October 2014. He testified that her condition from 2012 to April 2014 "significantly deteriorated." She had been one of his more stable patients initially, but ultimately became a difficult case. Asked if she remained stable until her work accident, Dr. Didenko testified: "I think even prior to the accident she started to deteriorate", around March of 2014, but that the accident definitely contributed to her decline, to where she became completely incapacitated. He noted she had worked all her life and had an abrupt change to where she wasn't working, was home alone and the pace of her life changed. He testified the May 2014 accident was probably the "last straw" of her stressors at the time, which included being depressed and suicidal to start with, and she was struggling with menopause, pseudoseizures (Px12).

Dr. Didenko testified he did not make any recommendations as to her ability to work after the May 2014 work accident, but agreed it was appropriate for her to be off work from the accident until he stopped seeing her. He did complete disability paperwork on her behalf as well. As to what changed after the accident, Dr. Didenko testified she was more depressed and suicidal, she was more disheveled, and she was back and forth to the hospital, not functioning well at all. Following the second post-accident admission, ECT treatments, which are a last resort, were instituted. The ECT treatments adversely impacted Petitioner's concentration and short term memory, which was a contributing factor to her inability to return to full work. However, he also testified that problems with concentration and memory are "cardinal symptoms of depression." When she tried to return to work, she had pseudoseizures, which he documented on 12/5/14. He testified that pseudoseizures present like a regular seizure, but involve "a purely psychiatric condition," not a physical condition, though the Petitioner cannot control it. Dr. Didenko testified he stopped seeing the Petitioner because, as a sole practitioner, he could not keep up with the demands of her disability providers. When he stopped, Petitioner had still not returned to her baseline condition. He could not comment on her current functional status or future functional status because he had not seen her since January 2016. (Px12).

On cross-examination, Dr. Didenko could not say why the Petitioner had been admitted to the hospital in July 2011 beyond anxiety, but believed it may have been depression and suicidal thoughts. At some point, Petitioner's neurologist took her off of Effexor and Provigil due to the pseudoseizures, because they are treated the same way as epileptic seizures until confirmed to be pseudoseizures. When she had problems with other medications, Dr. Didenko obtained authority from her neurologist in October 2015, Dr. Balabanov, to restart Effexor and Provigil, as the Petitioner had been stable for a long time on these and it had been determined at that point that her seizures were pseudoseizures. He agreed his understanding is the Petitioner developed pseudoseizures after her brain surgery, well prior to when he first saw Petitioner. There is no treatment for these other than psychotherapy. (Px12).

Dr. Didenko agreed that the Petitioner's loss of her father was a significant impact to Petitioner. She was very close to him and became extremely depressed, and actually had to be admitted to the hospital because she was suicidal; "I mean she was – she was probably the worst I've seen her." Her pseudoseizures also increased, and her husband then wouldn't let her drive and had to drive her to appointments. Dr. Didenko testified that it was exactly at that time that they had to start ECT, because it was her worst level of depression by far. (Px12).

Dr. Didenko testified that all he knew about Petitioner's work accident was an elevator door closed on her shoulder and she injured her clavicle, noting it wasn't discussed in further detail and "she was just very depressed at that time." Around that time, Dr. Didenko was generally seeing Petitioner monthly, increasing to every other week "when she was in bad shape." On 5/1/14, he noted Petitioner was severely depressed with significant stress related to her dying father, as well as suicidal thoughts ("So definitely her condition deteriorated, you know, as time went by."). On 7/17/14, Petitioner indicated her father passed away the day before, "and then like once he passed way, things definitely got worse." When queried regarding the 5/1/14 note indicating a significant worsening and 6/9/14 not indicating such worsening, Dr. Didenko testified that her condition "was kind of waxing and waning", with good and bad days. He testified that every visit she would come in with an unpredictable kind of presentation. (Px12).

On redirect, Dr. Didenko testified that the TMC treatment that was performed by Dr. Yu is significantly expensive, and noted that insurance often will not cover it "because there's no evidence if its helpful or not." He didn't feel it was important that he knew how the Petitioner was injured on 5/27/14, because she became almost incapacitated at that time and her depression escalated: "I mean she worked there for over 20 years I believe, and her lifestyle completely changed." His testimony was uncertain to some degree, but he believed she was

doing somewhat better when she left Respondent's employ, and then her dad passed away right around the same time, she started having pseudoseizures, and everything happened at once: "I mean all these things combined together just kind of spiraled her out of control." Her downfall was multifactorial. (Px12).

Dr. Graf, Respondent's Section 12 orthopedic examiner, testified on 10/21/15. (Rx4). A board certified spinal surgeon, he testified that he examined the Petitioner on 2/23/15. She reported her job involved desk work. She reported a prior work injury to her ankle due to uneven sidewalk. She reported that on 5/27/14, she was entering an elevator with a "Ricoh document man" who had a cart. She stated that she was about 2/3 of the way across the elevator threshold when the right door "broke free" (her quotes) from its track and slammed into her right shoulder and upper back. She indicated she then fell on top of the cart, pushing on her right hip, after which she twisted and landed against the elevator wall. She also indicated the document man told her she had a workers' compensation claim. She said her spine felt shaky, and when she came back inside the building, she asked a security guard for ice before going back up to her office and notifying her supervisor before going home to bed. She said the following morning her back again felt funny, and she had pain in the middle and low back into her right leg with right leg numbness, as well as right shoulder and upper back pain. She went to work, came in to fill out workers' compensation information, and noted that when she went to her cubicle her leg fell out, she fell, and she was taken by ambulance to Alexian Brothers. She indicated she was diagnosed with bulging discs, and was prescribed therapy and off work. She noted that at an independent evaluation with Dr. Jacker, she alleged he "assaulted" her during the examination. (Rx4).

Petitioner reported she initially had 10/10 right shoulder pain and 8/10 low back pain, and at the time of the evaluation 10/10 right shoulder and 8-9/10 low back pain. She also noted pain in the dorsal and radial side of the thumb into the wrist and forearm and occasional paresthesias in the fingers. She noted right buttock pain into the buttocks and posterior thigh and ankle. She noted she had tried to kill herself. She asked to see Dr. Graf's file, which he shared with her, to see what he was reviewing. Multiple abnormalities were noted on exam, but they were all subjective and not supported by the objective findings. Neurologic exam was essentially normal. Dr. Graf noted Petitioner displayed eight different non-organic pain signs, including nonanatomic distribution symptoms and pain out of proportion to findings, and the pain questionnaire she completed from the AMA guide rated her in the extreme disability category. He noted Petitioner's initial complaints of shoulder and back pain had morphed into essentially her whole body. As such, he indicated he was unable to objectively substantiate her subjective complaints, and felt she could be malingering. He opined she was at maximum medical improvement regarding her spine, needed no further treatment and was capable of returning to full duty work. He questioned causation given the mechanism of injury, how her symptoms changed, and given her psychological condition and inpatient admission. He really had no diagnosis to support Petitioner's complaints, noting even treating Dr. Brebach really couldn't come up with a diagnosis other than subjective pain complaints. (Rx4).

Following a review of a video of the elevator incident (Rx3), Dr. Graf issued an addendum report on 6/6/15, noting she was shown going into the elevator when the door was closing, making minimal contact with the right shoulder with the door opening up and she took a step back, and walked into the elevator. This was significantly different than the description of the incident she previously gave him, and he opined that this further supported his opinions in this case. (Rx4).

On cross examination, Dr. Graf agreed that he had no opinions regarding Petitioner's psychological condition, as it was outside his area of expertise. He testified that he does treat shoulder injuries, as they overlap significantly with the neck sometimes, but if conservative treatment fails he doesn't perform shoulder surgery and refers such patients out. Agreeing that pain is subjective, Dr. Graf testified that the elevator door did contact Petitioner, but did not produce any anatomic changes. He agreed it could have caused some discomfort,

but not to the level Petitioner complained of. While it is possible she could have had pain from it that warranted medical attention, based on the video this was unlikely: "objectively, I can't substantiate those complaints based upon the injury that I viewed on the video." (Rx4).

Dr. Graf agreed he did not review any of Petitioner's pre-accident medical records and didn't know if she had any similar prior physical complaints. He was aware of the 2007 cervical fusion with Dr. Brebach, and that Brebach indicated she had a good recovery. He agreed he hasn't seen Petitioner since he examined her, and has no opinions regarding her current condition. He personally reviewed the 10/23/14 cervical MRI, and it showed a well-healed fusion and a small C6/7 syrinx, which appeared to be old. He noted that the C5 nerve root is the highest level that goes to the shoulder, and then lower down the cervical spine the nerves impact more and more of the arm. He did not see the epidurogram from December 2014, but testified that this is not a significant diagnostic film. He agreed that cervical x-rays showed multi-level degenerative facet joint disease, which can be painful and could possibly be aggravated by trauma. The "tethered cord" noted in his review of the 6/13/14 lumbar MRI indicates a congenital problem that can cause neurologic problems, but would not present at the Petitioner's age. It's possible it could be aggravated by trauma, but he has never seen such a case. Again, he opined Petitioner may be malingering, but he agreed it's possible it isn't necessarily being done intentionally on her part, and that psychological issues can exacerbate an injury. He had no opinion whether Petitioner's psychological issues exacerbated her condition. Again, he agreed her shoulder contacted the elevator door, and that she did appear to look at her shoulder, but he couldn't recall if she lifted her sleeve to do so or rubbed her shoulder. He agreed it's possible that someone can have more pain the day after a trauma than the day of. Dr. Graf agreed he tends to take a conservative approach to spine care. (Rx4). On redirect exam, Dr. Graf testified that the cervical syrinx was preexisting, and opined that he couldn't support the elevator incident as something that aggravated Petitioner's cervical facet joints. (Rx4).

Petitioner was examined at Respondent's request pursuant to Section 12 of the Act by clinical psychologist Dr. Goldstein. She testified that her specialties are in neuropsychology and forensic psychology. She met Petitioner on 4/8/15, at which time a battery of psychological testing was performed over eight plus hours. On 4/10/15, Dr. Goldstein interviewed the Petitioner over an approximate 4 hour period. She indicated she reviewed the vast majority of records that are in evidence in this case through the time of her evaluation, with the exception of the records of Liana Dekhytar-Gerdov. At the evaluation, Petitioner complained of neck pain radiating to her right arm and hand, reduced neck motion, low back pain shooting into the right leg, headaches and motor coordination difficulties. She noted pain with everyday activities, such as doing dishes, lifting anything that wasn't very light and washing and drying her hair. Emotionally, she complained of a history of depression, which was as bad as it had ever been. (Rx5).

During the evaluation, Petitioner was slow: gait, working on testing, speech. She was tearful several times in discussing history. She was intense when discussing her resentment towards the Respondent, both based on her perception of how her workers compensation claim had gone as well as some longstanding tensions with her boss, Julie, from whom she felt great pressure. Her presentation of her perceptions were often dramatic. There was significant disconnect and lack of insight between her descriptions of her psychological symptoms and her physical symptoms. For example, she discussed her pseudoseizures as real seizures even though she essentially understood they were psychological. She testified: "(Petitioner) just had no ability to connect stressors in her life to her poor coping and tendency to somaticize every time she became stressed." Dr. Goldstein also noted Petitioner was a poor historian regarding her psychological background with a lot of contradictions (both within her own stated history, as well as her history versus the reviewed records), though she did not feel this was intentional on Petitioner's part. (Rx5).

Historically, per the records, Petitioner has had mental health issues since she was a teen, which included bulimia at that time, as well as depression throughout her life. She generally had been able to function, but would have very recurrent major severe depression episodes. The records reflected a lot of medication regimen changes and therapy approaches, and multiple hospitalizations. Generalized anxiety disorder was also part of the picture, as well as off and on suicidality. In Dr. Goldstein's opinion, the Petitioner has a somatization or conversion disorder. This explains the findings of Dr. Graf and Dr. Jacker that Petitioner's subjective complaints were not consistent with their objective findings. (Rx5).

It appeared Petitioner initially had pseudoseizures following brain surgery in 2005, then redeveloped them in 2012. This could be related to conversion disorder, as can voluntary motor and sensory problems, which matches the Petitioner's complaints. Dr. Goldstein testified that Petitioner's stated history of the elevator accident and her review of video of the incident were not consistent, as there is no indication of the immediate pain she described. (Rx5).

With regard to the neuropsychological; testing Petitioner underwent, it indicated Petitioner wasn't particularly defensive or over-endorsing of anything. She was straightforward and cooperative, so there was a valid profile. She was endorsing depression and anxiety and somatic symptoms, and a tendency to convert psychological symptoms into physical symptoms: the test results "looked like someone with a somatoform disorder," which was consistent with her clinical picture. There were no appreciable cognitive impairments – the Petitioner gave good effort, and was happy about the results, as prior neuropsychological testing in 2013 with Dr. Renteria had indicated mild to moderate attention problems, and she had current concerns and complaints about her concentration and memory. Again, she was not a good historian regarding her prior psychological issues, and this was described by Dr. Goldstein on pages 30 to 32 of her deposition. Of significance, there were things from her social and work histories where there have been a number of stressors in her life to which she has not reacted well, including her father being diagnosed with cancer and dying very shortly thereafter. She indicated she had been drinking heavily in the year prior to her injury in response to stress with working with Julie. Her description indicated "again, a big disconnect, talking about how much she hated it, it was terrible pressure, how it literally drew her to suicide one time because of the pressure being unable to work quickly enough to learn Dragon and, yet, saying I loved my job so much." She had a number of stressors where there was a clear pattern of decompensating psychiatrically and developing pseudoseizures, etc., in response to conflicts and stressors, whether happy or sad, and this is something her psychiatrist commented on repeatedly. She felt pressure to keep working because she had made a decision with her husband that he could retire after 30 years on the force and she would continue to work after that and be the breadwinner. (Rx5).

Dr. Goldstein diagnosed longstanding recurrent major depressive disorder, severe in nature without psychotic features, as well as a specific somatoform disorder, conversion disorder. Conversion disorder is the presence of physical symptoms that cannot be explained by any organic or medical condition – subjective complaints with no objective findings to back them up. Again, such disorder specifically affects voluntary motor and sensory functions, essentially perception without sensation. Dr. Goldstein agreed Dr. Didenko also has diagnosed a borderline personality disorder. She noted such diagnosis is better made by someone who sees a patient over time and can see symptoms wax and wane and see situations that lead to eruptions and disintegrations and psychiatric instability, versus once, like herself, but that this was not inconsistent with her findings. Such disorder involves longstanding patters of interpreting, perceiving and interacting with the world in very maladaptive ways, and this causes dysfunction. This would include moodiness, crying, unstable affect, identity problems, poor coping skills and stress tolerance. These are things that are seen in the Petitioner. (Rx5).

Dr. Goldstein opined that there is no mental health condition of the Petitioner that is directly or indirectly caused by the 5/27/14 accident. Her prior psychiatric treater, Dr. Wagner, going back to 2002, noted no change in the

diagnosis of major recurrent depressive disorder with multiple remissions, and global assessment function ratings (GAF) which, even during remissions, were dysfunctional. Dr. Didenko, starting in 2011, indicated GAF ratings even more severe than Dr. Wagner had, and this lasted through and after the 5/27/14 incident. She noted there was even an entry after the noted accident where Petitioner indicated she felt better. Dr. Goldstein testified: "The bottom line is we don't see any evidence, objective evidence, in treating notes of any change. There's no exacerbation, there's no new onset disorder, etc." She has had a somatoform disorder since approximately 2012, when she began to have seizures. She began to decompensate psychiatrically in the weeks prior to 5/27/14 in association with her father's illness, which happened fast and she became suicidal at that time. Dr. Goldstein further testified:

"I just don't see the manner in which this thing that happened in the elevator caused any of her issues. They were well established or well documented already. And the fact that she describes during the interview here I was doing so well up until the moment that this happened and I never had these problems before, again, its this amazing remarkable disconnect from fact and from objective findings. In her own mind in her perception she was okay prior to this but for this incident happening in the elevator, she would have been fine when all of the evidence is she absolutely was not fine. And that is the – That's somatoform disorder and poor coping." (Rx5).

Dr. Goldstein opined that the Petitioner is capable of working without restrictions. She testified that the Petitioner has worked throughout her life with success, and had opened her own business at one point, so she has shown she can do so and has become accustomed to her disorders. However, it's predictable that she doesn't respond well to stressors. Her anger towards the Respondent in this case leaves Dr. Goldstein with the opinion that it's unlikely that a return to work with Respondent would go well. However, were she to return to the same type of job with a different employer, Dr. Goldstein thinks she would be fine doing so. (Rx5).

On cross examination, Dr. Goldstein agreed that while her opinion is that Petitioner was not affected psychologically from the 5/27/14 incident, the Petitioner's perception is that she had been. In her opinion, the Petitioner is not intentionally malingering, but she also could not reasonably rule this out as a possibility. Somatoform conversion is not intentional. She didn't believe that Petitioner's inconsistent stated history was intentional, but again could not say so with certainty. While the Petitioner did report work being a stressor, she also reported loving her job. She testified that it's fair to say Petitioner's perception is that both the physical accident and her difficulty in returning to work are stressors. (Rx5).

Dr. Goldstein testified that Petitioner underwent neuropsychological testing with Dr. Renteria in 2013 following a motor vehicle accident. She used FMLA time after that, after her prior brain surgery in 2005, neck surgery in 2007, pseudoseizures in 2012, a purported concussion in the 2013 accident and after the 5/27/14 injury. The car accident was one of the situations where Petitioner described it dramatically, indicating she had blood on the brain when testing clearly indicated she did not. Dr. Renteria did find some cognitive problems in the 2013 testing, but also diagnosed a conversion disorder at that time. Dr. Goldstein agreed that ECT is a more aggressive type of depression treatment which Petitioner never underwent prior to 5/27/14. (Rx5).

Petitioner presented her alleged causally related medical expenses as Petitioner's Exhibit 13.

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 Petitioner alleges that she sustained a physical injury when the elevator door hit her on 5/27/14. She also alleges that she sustained a psychological injury as a result of this alleged accident, based on a "physical-mental" theory of accident. For the reasons indicated below, the Arbitrator finds that the Petitioner has failed to prove an accidental injury which arose out of the Petitioner's employment with Respondent on 5/27/14.

At the time of the alleged accident, Petitioner was taking a break from her work duties to go and stretch her legs. There is no testimony or other evidence to refute that fact. Under the "personal comfort doctrine," it is well-accepted in Illinois that an employee taking a short break from daily work activities to perform some act of personal comfort is deemed to still be "in the course" of her employment so long as the actions of the employee are not an unforeseen or impermissible deviation from the employment activities. In this case, the Arbitrator finds that Petitioner was still within the course of her employment when she went to board the elevator to go downstairs to take a break. However, the issue remains with regard to whether an accident occurred which arose out of the employment.

As noted by the Supreme Court in *Caterpillar Tractor Co. v. Industrial Comm'n*:

> "For an injury to "arise out of" the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. (*Jewel Cos. v. Industrial Comm'n* (1974), 57 Ill.2d 38, 40; *Chmelik v. Vana* (1964), 31 Ill.2d 272, 277.) Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. (*Howell Tractor & Equipment Co. v. Industrial Comm'n* (1980), 78 Ill.2d 567, 573.) A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Orsini v. Industrial Comm'n* (1987), 117 Ill.2d 38, 45; *Fisher Body Division, General Motors Corp. v. Industrial Comm'n* (1968), 40 Ill.2d 514, 516; see, e.g., *Peel v. Industrial Comm'n* (1977), 66 Ill.2d 257 (claimant injured while pushing vehicle which was blocking entrance to parking lot); *Union Starch, Division of Miles Laboratories, Inc. v. Industrial Comm'n* (1974), 56 Ill.2d 272 (claimant injured during break on employer's roof).
>
> If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. (*Orsini v. Industrial Comm'n* (1987), 117 Ill.2d 38, 45; see, e.g., *Chmelik v. Vana* (1964), 31 Ill.2d 272, 59*59 278 (claimant injured during a mass exodus of vehicles at quitting time); *DeHoyos v. Industrial Comm'n* (1962), 26 Ill.2d 110 (claimant fell on ice in employer's parking lot).) However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable. *Material Services Corp. v. Industrial Comm'n* (1973), 53 Ill.2d 429, 433; see, e.g., *Orsini v. Industrial Comm'n* (1987), 117 Ill.2d 38 (claimant's automobile lurched forward, injuring claimant); *Branch v. Industrial Comm'n* (1983), 95 Ill.2d 268 (claimant injured while removing his coat after arriving at work); *Greene v. Industrial Comm'n* (1981), 87 Ill.2d 1 (claimant assaulted on employer's premises by unidentified assailant); *Jones v. Industrial Comm'n* (1980), 78 Ill.2d 284 (claimant closed car door on his hand); *Fisher Body Division, General Motors Corp. v. Industrial Comm'n* (1968), 40 Ill.2d 514 (claimant's car battery exploded)." *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 541 N.E.2d 665 (1989).

For an injury to arise out of the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury.

Metropolitan Water Reclamation Dist. Of Greater Chicago v. Workers' Compensation Comm'n, 407 Ill.App.3d 1010 (2011). There are three types of risks to which an employee can be exposed: 1) risks distinctly associated with the employment; 2) risks that are personal to the employee and 3) risks that do not have any particular employment or personal characteristics and thus are neutral in nature. If a risk is neutral in nature, in order to recover the employee must demonstrate she was exposed to the risk to a greater degree than the general public. An increased risk can either be qualitative or quantitative, "such as when the employee is exposed to a common risk more frequently than the general public." Id. The Arbitrator believes that this case would fall under category 3, as a neutral risk.

As noted above, it is clear to the Arbitrator that the Petitioner's injury occurred in the course of her employment. While she was on her way to take a break, such break would fall under the personal comfort doctrine, and she also remained on her own floor in her building when she went to enter the elevator. However, the Arbitrator finds the Petitioner has failed to prove that she sustained an accidental injury which arose out of her employment. The Petitioner fulfilled the first prong noted by the Supreme Court in that an act of personal comfort is an act that is incidental to the employment, and thus the Petitioner's act of going outside to get some air and walk around would fall into this category. However, there is nothing about the act of walking into an elevator that the Arbitrator can see which subjected the Petitioner to an increased risk of injury over that of the general public.

In the Arbitrator's view, the Petitioner was simply walking into an elevator. This is an activity performed by a large number of people within the general public, often on a daily basis, going to and coming from work. There was no evidence presented in this case that would indicate that the risk involved for Petitioner in this basic activity was increased over that of the general public. There is no evidence the Petitioner was in a hurry, due to her employment or otherwise. While she testified that she was busy at work at this point in time, she was headed out for a break at the time of the injury. There was no evidence presented that the Petitioner was carrying anything, or that there were any visual obstructions, which would have increased the risk of injury to her in entering the elevator. Video of the incident was presented as well, and the Arbitrator saw no evidence of the elevator behaving in an unusual or defective manner. Petitioner did not testify to any such defect. While there are medical histories in which it appears she reports the elevator acting in a defective manner, this is just not depicted in the video. Instead, it appears to the Arbitrator that the video shows the Petitioner basically walking into the closing elevator door, the door immediately opening upon contact with the Petitioner, and the Petitioner then entering the elevator. It looked very similar to someone walking into the corner of a wall. The elevator doors are closing fairly slowly, and the Petitioner essentially walked into it, striking her right arm.

The *Caterpillar Tractor Co.* case involved the court finding that the act of stepping off a curb was not something the claimant was exposed to at a degree above that of the general public. While it appears the claimant in that case argued that he regularly traversed the curb, and that this increased his risk of injury, the Court stated: "While it is true that he regularly crossed this curb to reach his car, there is nothing in the record to distinguish this curb from any other curb." *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 541 N.E.2d 665 (1989). The Arbitrator finds this statement to be equally applicable in this case: while the Petitioner regularly used the elevator, there was no evidence presented to indicate the elevator in question was distinguishable from any other elevator the general public uses on a daily basis.

As the Arbitrator has determined that there is no compensable accident when the Petitioner ran into the elevator door, the physical injury to the Petitioner is not compensable. Thus, an argument for a physical-mental case also fails without the physical component of such a claim.

The Arbitrator finds that the Petitioner has failed to prove that she sustained accidental injuries arising out of her employment with Respondent on 5/27/14.

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 finding that the Petitioner failed to prove a compensable accidental injury, this issue is moot.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

The parties dispute the Petitioner's average weekly wage in the year prior to the accident. Respondent submitted payroll records for Petitioner into evidence. (Rx9). However, there was no substantial testimony by any witness as to the various types of earnings set forth in those payroll records. This includes regular compensation, PTO, bonus, "other income" and STD, presumably short term disability. The Petitioner testified that she earned more money based on certain levels of production, but this was really not fleshed out in any detail which would indicate if it is the type of bonus that would or would not be includable in the AWW calculation. Generally, under Section 10 a bonus would not be includable.

Overall, the preponderance of the evidence indicates the Petitioner has failed to prove the alleged AWW, and this the Arbitrator finds that the Petitioner's AWW is the figure stipulated to by the Respondent, $1,294.42.

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 finding that the Petitioner failed to prove a compensable accidental injury, 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 finding that the Petitioner failed to prove a compensable accidental injury, this issue is moot.

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:

Based on the Arbitrator's finding that the Petitioner failed to prove a compensable accidental injury, this issue is moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

☒ 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

Marcy Ferone,

Petitioner,

vs.

NO: 14WC 8776
15WC 41704
15WC 41705
16WC 6939

Chrysler UFCA-UC-LLC,

Respondent.

18IWCC0493

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 30, 2017, 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.

18IWCC0493

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 $29,200.00. 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 8 - 2018
o072618
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FERONE, MARCY
Employee/Petitioner

Case# **14WC008776**

15WC041704
15WC041705
16WC006939

CHRYSLER LLC
Employer/Respondent

18IWCC0493

On 11/30/2017, 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 1.43% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
JASON CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
BRIAN J HINDMAN
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARCY FERONE
Employee/Petitioner

v.

CHRYSLER, LLC
Employer/Respondent

Case # 14 WC 08776

Consolidated cases: 15 WC 041704, 15 WC 041075 & 16 WC 06939

18IWCC0493

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 **Rockford**, on **August 16, 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 **08/29/2012; 01/23/2013; 01/09/2014; & 04/16/2014**, 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 **08/29/2012**, Petitioner *did* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$34,916.96**; the average weekly wage was **$671.48**.

On the date of accident, Petitioner was **33** years of age, *single* with **2** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$6,680.55** for other benefits, for a total credit of **$6,680.55**.

Respondent is entitled to a credit of **$All medical bills paid** under Section 8(j) of the Act 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.

ORDER

Respondent shall pay Petitioner **temporary total disability benefits of $447.65/week for 20 weeks commencing July 14, 2014 through September 7, 2014 and from September 21, 2014 through December 15, 2014, as provided in Section 8(b) of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits of $402.89/week for 66.5 weeks, because the injuries sustained caused the 15% loss of use of the left hand and 20% loss of use of the right hand, as provided in Section 8(e) of the Act.**

Respondent shall pay Petitioner all compensation benefits that have accrued from 8/29/2012 through 8/16/2017 in a lump sum and shall pay the remainder of the Award, if any, in weekly benefits.

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

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

Signature of Arbitrator

November 30, 2017
Date

NOV 30 2017

INTRODUCTION

Petitioner had five pending cases against Respondent on the date of trial, August 16, 2017. Upon Petitioner's Motion for a Voluntary Order of Dismissal, Case Number 14 WC 8777 (involving a disputed back injury claim) was dismissed by the Arbitrator.

The matter proceeded to trial regarding the remaining cases: 14 WC 08776 (claimed accident date: 8/29/2012), 15 WC 041074 (d/a: 1/23/2013), 15 WC 041075 (d/a: 1/9/2014), and 16 WC 06939 (d/a: 4/16/2014). These cases involved claims for disputed injuries to Petitioner's hands, under a cumulative trauma theory.

Given the proofs in these matters and the nature of cumulative trauma cases, the decision in Case Number 14 WC 08776 encompasses the three other consolidated cases.

FINDINGS OF FACT

Petitioner, Marcy Ferone, began working for Respondent, Chrysler, LLC, in May of 2012. She started as a part time employee before becoming a full time employee in July of 2012. Prior to working for Respondent, she worked for Frito-Lay, in Beloit, Wisconsin, for approximately fourteen years. During the first year at Frito-Lay, she was a packer and she then worked the last thirteen years in sanitation. Her job duties in sanitation at Frito-Lay included using chemicals and various tools to clean up equipment, as well as sweeping and mopping floors.

Petitioner is right handed. At the time of trial, she was 38 years old. She was 5'3" tall and weighed 140 pounds (essentially normal habitus, per Dr. Coe).

In July and August of 2012, Petitioner was on the "B Crew" at Respondent, which meant she started work at 6:00 p.m. and normally worked until 4:30 a.m. She had a thirty minute lunch break, two fifteen minute breaks, and one twenty minute break. As of August of 2012, her position at Respondent was a floater. A floater covers various assembly positions at Respondent on an as needed basis. When an employee acquires seniority, they may bid into a permanent position.

In August of 2012, Petitioner was assigned to the corner mod job. In this job, she used a hoist to move parts. She testified that approximately forty-percent of her work on the corner job was moving and assembling a part called a module. A module is similar to a rotor but has other parts attached to it, which makes it heavier than a simple rotor. She began the module job by pulling the hoist up to her head level. Once the hoist was in place, she hit the "lower button" and attached the hoist to the module. She then hit the lift button and pulled it back, which required her to grip "pretty hard." The module, which weighed about ten pounds, would then be transported to her work station by manually pulling the hoist along the wire on which it hangs. Once the module was in place, she repeated the process with the hoist to transport the strut to the work station, so that it could be attached to the module. The strut was a spiral shaped part that she attached to the module using a four inch screw. She started inserting the screw using her left hand then completed the job using a drill. She testified she held the drill tightly with both hands to torque the bolt into place and secure the two parts together. She testified that the drill vibrated while performing this job.

Once the module and strut had been assembled, which was then called the "strut assembly," she connected it to the hoist. She then used the hoist to drag the forty pound strut assembly to a rack, where it was then disconnected and left there. The process would then be repeated on the next module to complete another strut assembly.

Petitioner also performed a second job on the corner mod line. Some cars did not require the module and strut to be assembled. She testified some cars only required her to pick up a ten pound part called a knuckle and carry it from one rack to another rack. During her time on the corner mod job, the plant was assembling between 670 and 680 cars per day. She testified she produced the same amount of strut assemblies and knuckles combined per day as well. Petitioner estimated forty percent of the cars required the strut assembly and sixty percent required the knuckle.

While performing the corner mod job in August of 2012, Petitioner began waking up in the middle of the night with numbness and tingling in both of her hands. She testified she was working on the corner mod job for Respondent on August 29, 2012, the first claimed accident date. On September 5, 2012, she presented to Respondent's Plant Medical with complaints of worsening numbness and tingling in both hands. She testified her symptoms were becoming more frequent and that the pain and duration of the numbness was becoming longer. She completed an accident report that day. It was noted that Petitioner did not rotate on the corner mod job. (PX1, p. 47)

Petitioner testified the September 5, 2012 accident report was completed by Darren Baie, her supervisor at the time. The date of injury was identified as August 29, 2012. (PX1, p. 47) The description of the accident stated: "I work on corner mods and do not rotate so I'm gripping, squeezing, pushing + pulling hoists all shift (10 hrs). Now both my hands and wrists hurt to use them." (PX1, p. 47) Petitioner testified the report was not written in her handwriting but she agreed it was an accurate summary of what was occurring at the time. Petitioner identified her signature on the bottom right hand side of the accident report and confirmed that she provided Mr. Baie with the August 29, 2012 date of accident.

At that initial visit to Plant Medical, she was provided with wrist supports for both the left and right hands. The physical exam revealed no edema or ecchymosis. Over the next four months, Petitioner wore the wrist supports as she continued to work at Respondent. The plant medical records indicated this was an occupational incident. (PX1, p. 5)

On January 23, 2013, Petitioner returned to Plant Medical due to ongoing complaints of pain in both wrists. (PX1, p. 6). She filled out a second accident report that day as well. (PX1, p. 46A-46B) She testified she personally filled out this two-page accident report. The description of accident stated:

> " A few months ago while working on corner mods, I started experiencing numbness and tingling in my fingers (both hands) while sleeping. Several fingers would also be stuck in a bent position and was painful to straighten them. After being taken off of the corner module job (and sleeping with braces on) my hands/fingers gradually got better. I was put on a new line on 1-14-13 and on 1/19/13 while sleeping I woke up several times with pain in my wrists and numb fingers. 1/20/13 and 1/21/13 I slept w/braces on but my fingers were still numb all night and took 20 mins after I got out of bed for sensation to come back. My hands also go numb if I hold my phone to my face for more then 5 min." (PX1, p. 46A-46B).

Petitioner testified that she was working on the prop shaft job at the time she went to Plant Mv vedical on January 23, 2013, which is the second claimed accident date. Although she did not remember whether she was working on the B shift at that time, she testified she was worked the same hours as she did while on the corner mods job but it may have been a morning start rather than an afternoon start. She worked the same amount of hours with the same length of breaks during the workday.

On the prop shaft job, Petitioner worked on the assembly line and cars came to her station. Each prop shaft was approximately eight feet long, round, with an octagon shape on one end. She installed the prop shaft into each car by sliding the octagon shaped onto four bolts onto a piece on the car. She then used a drill to tighten the nuts onto the four bolts to attach the prop shaft to each car. She testified she used her right hand to hold the drill and her left hand to hold the prop shaft and nuts that she was installing onto the car. She explained the drill she used on the prop shaft line had "an extreme amount of vibration, and it's part of the reason I had to use two hands." Petitioner performed this job on approximately seventy-four cars per hour for two hours before rotating to a different job. She performed the prop shaft rotation twice per shift, for a total of four hours. Petitioner performed various other jobs when she rotated off the prop shaft line during her workdays.

Petitioner returned to Plant Medical on January 29, 2013 and requested an appointment with Dr. Deepak Mehta, the plant doctor. (PX1, p. 6). She treated with Dr. Mehta at Respondent's plant medical on February 1, 2013. (PX1, p. 6) At that visit, Dr. Mehta summarized her history of right and left hand symptoms beginning in July of 2012 through her current work on the shaft line. Dr. Mehta noted Tinel's test, median nerve roll, and Phalen's tests were all negative. He advised Petitioner to wear the wrist braces while working and his office notes indicated this involved an occupational incident.

Petitioner continued to seek medical care at Plant Medical for her bilateral hand pain on March 19, April 19, 23, 26, and October 8, 2013. (PX1, p. 7, 8, 10).

Petitioner next sought treatment with Nurse Practitioner Sue Ipsen at Mercy Health System on October 21, 2013. This is Petitioner's PCP facility. Nurse Ipsen noted Petitioner's repetitive use of her hands at work with increasing bilateral hand pain. Petitioner complained of numbness and tingling in both hands that was waking her up at night. Nurse Ipsen provided Petitioner with thumb spica splints, 600 mg Ibuprofen, and recommended she begin occupational therapy. She would refer Petitioner to neurology for an EMG, if therapy did not alleviate her symptoms. Petitioner began a course of occupational therapy at Mercy Health System on November 18, 2013. (PX1)

Petitioner returned to Plant Medical with ongoing complaints of bilateral wrist pain on January 9, 2014. (PX1 p. 12) This is the third claimed date of accident. In late 2013 and early 2014, Petitioner had begun working on the banjo build line at Respondent. Her work hours were the same as the prior two jobs, including the same basic breaks schedule. The banjo bolt job involved installing parts of the cars in the wheel well area of each vehicle that came down the line. The first task on the banjo build job was to hand start three bolts. Once the three bolts were started, she used a large drill, similar to the one she used in the prop shaft job. She testified she operated the drill with her left hand and held the three screws with her right hand. She then completed the work on each car by inserting some plastic pieces before the next car came down the line and the job was repeated. She testified she performed this job for two hours at a time and twice per day, for a total of four hours. When not performing the banjo build job, Petitioner rotated to several other jobs on the line.

Some of the other jobs she performed while rotating such as using a "long thing with a hook on the end. And you have to stick it up in there and pull back and that was one of the jobs – you had to use a lot of strength and

force to do that to be able to pull that." She testified to other various jobs during her rotations which all involved using a drill to torque down screws. During her days on the banjo build line, 670-680 cars came down the line during her average shift.

Throughout January, February, and March of 2014, Petitioner continued to receive treatment at Plant Medical for her ongoing bilateral wrist pain. (PX1, p. 12-17) At her April 16, 2014 Plant Medical visit, it was noted that she had an appointment scheduled with Dr. Ajmal Matloob on May 6 in order to discuss surgery. This is Petitioner's fourth claimed date of accident, (PX1, p.17).

On May 6, 2014, Petitioner began treatment with Dr. Matloob, an orthopedic surgeon at the Beloit Clinic. (PX2, p. 4) Dr. Matloob noted Petitioner worked at Chrysler and was there that day due to bilateral numbness and tingling in her hands that started around one year ago. He noted the symptoms mainly affected her long, ring, and little fingers. He noted that the patient had completed nerve conduction studies in January that year which showed mild bilateral carpal tunnel syndrome. He recommended proceeding with bilateral carpal tunnel release surgeries. He concluded, "In my opinion, her carpal tunnel is work related." (PX2)

On July 14, 2014, Petitioner underwent right hand carpal tunnel release surgery performed by Dr. Matloob at Beloit Memorial Hospital. At surgery, it was noted that the ligament over the median nerve was thickened. (PX2, p. 70) At her August 13, 2014 follow up visit, Dr. Matloob indicated she was able to return to work with restrictions as of September 8, 2014. (PX2, p. 117) Petitioner testified she did return to work for Respondent with restrictions as of that date. She worked for Respondent with restrictions until September 20, 2014. She was off work again as of September 21, 2014.

Petitioner underwent left hand carpal tunnel release surgery performed by Dr. Matloob on September 22, 2014. At surgery, it was noted that the ligament over the median nerve was thickened. (PX2, p. 172) She followed up with Dr. Matloob again on October 28, 2014 and he once again charted that her carpal tunnel syndrome is work related. (PX2 at 223). On December 15, 2014, Dr. Matloob released Petitioner to full duty work the next day. (PX2, p. 253). Petitioner returned to work for Respondent, without restrictions, as of December 16, 2014. She was completely off work from September 21, 2014 through December 15, 2014.

Petitioner returned to work for Respondent, as of December 16, 2014, performing her regular work duties. Approximately one month later, however, on January 14, 2015, Petitioner returned to Plant Medical with complaints of painful numbness and swelling in both hands due to gripping, squeezing, pushing and pulling hoists all shift. She was advised to return to Plant Medical after she followed up with Dr. Matloob. (PX1, p. 21)

Petitioner returned to Dr. Matloob on January 27, 2015. (PX4, p. 3). He noted she was having pain in her left wrist area that started after regular use of her hands at work for Respondent. He provided her with light duty restrictions for the next four weeks of "no tight squeeze and no more than 2 pounds lifting with left hand." Petitioner returned to work for Respondent within these restrictions, at that time. Her symptoms decreased while performing light duty but her hands were still going numb, tingling, and waking her up at night.

Petitioner returned to Dr. Matloob again on February 17, 2015 with ongoing complaints in both hands. Dr. Matloob noted her symptoms had improved and agreed with the plant physician's recommendation to continue her light duty restrictions for another four months. Petitioner testified she continued working at Respondent over the next four months within those restrictions. Her hands continued to go numb but her symptoms were much better than when she was performing her regular full duty work. Petitioner returned to Dr. Matloob again

on May 26, 2015 and he continued her light duty restrictions for one year. Dr. Matloob charted that she had "reached the end of her healing" at that visit. (PX4, p. 40)

Petitioner continued working for Respondent within the restrictions provided to her by Dr. Matloob following her May 26, 2015 visit. She testified her symptoms continued to improve over the next year as she worked within her restrictions. On August 16, 2016, she had her final visit with Dr. Matloob. (PX5, p. 39). He noted she had been on light duty restrictions on a yearly basis and was hoping to have them put on permanently. He indicated she was tolerating restrictions of four pounds lifting with each hand as was her employer. He concluded, "It is reasonable to put her on these restrictions on a regular basis permanently to allow her to continue her job." (PX5) Petitioner testified that the Plant Medical doctor had suggested to her that she speak with Dr. Matloob about making her restrictions permanent rather than being reconsidered yearly.

Petitioner testified that she was still working for Respondent as of the date of the hearing. She testified she works on the QVS job, which she stated is a quality inspection position. She explained that she visually inspects parts and marks them with a pencil if they are broken or missing. When she inspects for bumps, scratches and dents, she sometimes has to polish and sand. She still notices some numbness and tingling in her hands while performing this job toward the end of her workweek. She performs this same or similar jobs in various parts of the plant. She would like to stay at this job. At present, Petitioner is still a floater.

Petitioner takes Ibuprofen or anti-inflammatory medication approximately every other day due to symptoms with her hands. She testified that she has not sustained any other injuries to her hands since August of 2012, other than the subsequent symptoms, complaints and treatment she had testified about on Direct. There was no evidence of any prior hand complaints or treatment.

On an average day, Petitioner wakes and notices that her hands are numb and she has to "shake them out." On mornings that her hands feel "tight," she takes Ibuprofen. She wakes up with numbness or tingling every day. As she progresses through her normal workday, her hands get tight and she has to stretch them out. During the night while sleeping, she is sometimes awakened with numbness and tingling in her hands and she has to shake them or change positions. Overall, her symptoms are much milder than before she had the surgeries.

Respondent submitted the testimony of Brian Jones. Mr. Jones is currently the lead supervisor for the body shop at Respondent and has been in that position for four months. Previously, he was in the trim, chassis, and final department for twenty-three years. From 2012 through 2016, his position in the trim, chassis, and final department was "Planner."

Mr. Jones is familiar with the corner mod job performed by Petitioner. He testified he has never performed this job but it involves assembling the strut, knuckle, disc, and brake pad parts for installation onto the frame of the cars. Jones' description of the job was similar to that of Petitioner. He did not feel that the levers used on the hoist required significant forceful grasping. He was not aware whether a torque wrench was used on the corner mod job. The operating switches on the hoist are toggle switches.

Mr. Jones testified that the corner mod assembly was done on approximately thirty-three-percent of the 651 cars they built each day. He did not explain what the employees did while the other two-thirds of the cars came down the line, however, the Arbitrator notes that Petitioner explained this during her testimony. The employee carries the knuckle part from one rack to another.

Jones also testified he was aware of the prop shaft or half shaft job. He explained the installers took the shaft out of a rack, lined it up, and then "jam" it in there. He explained prop shafts are longer than half shafts and only were installed on all-wheel drive vehicles. He was not aware whether Petitioner performed the prop shaft or half shaft job. He has never performed the prop shaft job or the half shaft job.

Mr. Jones also explained the basic job duties of the banjo bolt job. He explained the workers hand start bolts into a bracket that hooks onto the strut. They then use a tool that hangs down to tighten the bolts. He testified the tool has a pistol grip and he did not believe it vibrated when it torqued down bolts. He stated the tool was designed to hang in a position so the installers did not have to lift it. Specifically, he stated the tool was designed to hang in place for a person around 5'6" to 5'7" tall and it was not adjustable for height. Mr. Jones testified the height of the tool would not be ideal for someone of that height. He has never performed the banjo bolt job.

Jones testified that every job at the plant goes through an ergonomic study prior to be set up for production. Plant ergo people and union ergo people participate in the study, along with the planner, safety people and the supervisor from Respondent and the union committeeman and steward. If a problem is identified, they attempt to make a temporary fix and then institute a permanent change if necessary. No changes were made to the corner mod job, the banjo bolt job, or the prop shaft job. Jones did not believe that the use of the drill involved much vibration, as these tools are set to a specific torque, and they release when the nut is tightened to specification.

According to Jones, a "floater" acts as a substitute for absent employees. There is no designated time that a floater would stay on a specific job. Jones did not comment on Petitioner's testimony that she did not rotate when she was performing the corner mod job and as is set forth in the Plant Medical records.

At the request of Respondent, Petitioner was examined by Dr. Stephen Weiss on July 16, 2015, pursuant to §12. (RX1 Dep. Ex. 2) Dr. Weiss is a board certified orthopedic surgeon. He no longer performs surgery and he no longer has an active patient practice. Dr. Weiss drafted a nine page report dated that same day. Dr. Weiss indicated he was asked to evaluate Petitioner for injuries involving her hands and lower back. Petitioner voluntarily dismissed her back claim at the start of the trial.

Dr. Weiss noted Petitioner took birth control medication from 2009-2014. He noted she began working for Respondent in 2012 and was employed as a floater. He summarized her job activities within his July 16, 2015 report. He noted while working on a job involving rotors, she had to move the hoist forcefully with both hands, which is when she began noticing symptomatology in her hands. She noted some improvement when she was taken off of that job. Dr. Weiss recorded that her symptoms increased when she began working on the "banjo bolt" job sometime in late 2013 or 2014. Petitioner also advised Dr. Weiss that grabbing the gun on the "banjo bolt" job required forceful gripping with her left hand. Dr. Weiss summarized Petitioner's medical treatment for her hands within his 2015 report.

Dr. Weiss also noted that he personally viewed the job involving the making of rotors called "corner mods." He stated he was informed this job was done on thirty-percent of the cars. He felt this job was slow paced. He also stated that he viewed the "banjo bolt" job. He noted it involved using a torque gun to insert three bolts and was completed on two out of every three cars.

After his examination of Petitioner and his review of the medical records, Dr. Weiss diagnosed Petitioner with post bilateral carpal tunnel releases, use of birth control medications, probable hyperthyroidism, and post

thoracolumbar scoliosis surgery. He concluded that her work at Respondent did not contribute or cause her bilateral carpal tunnel syndrome condition. He did not believe her work activities involved highly repetitive forceful gripping or prolonged exposure to vibration. He noted that Petitioner was taking oral birth control medications during the period of time which she became symptomatic and "this is a well known cause of carpal tunnel syndrome." The Arbitrator notes Petitioner was on birth control for approximately three years from 2009 through 2012 before she began working at Respondent with no symptoms in her bilateral hands. Dr. Weiss thought that edema associated with the birth control medication could lead to carpal tunnel syndrome. He did not comment on the lack of any wrist edema being noted in the medical records.

Dr. Weiss did not believe Petitioner required any work restrictions related to her hands. (RX1)

Dr. Weiss also drafted an addendum report dated January 27, 2016 at the request of Respondent. (RX2) He reviewed his own deposition transcript from December 10, 2015 as well as the independent medical examination report of Dr. Jeffrey Coe dated September 29, 2015. He set forth his disagreements with Dr. Coe's opinions. He noted Dr. Coe did not state the "force required" in Petitioner's work duties or the frequency and number of seconds in which the activities were performed. Dr. Weiss did not believe that posture is not considered to be a causative or aggravating factor in most cases of carpal tunnel syndrome. He did agree that Dr. Coe's description of the jobs was consistent with his. They had different opinions regarding the nature of the jobs. (RX2)

Dr. Weiss testified by way of evidence deposition on December 10, 2015. (RX1). He clarified that his diagnosis of "probable hyperthyroidism" was in no way related to or a cause of Petitioner's bilateral carpal tunnel syndrome condition.

Dr. Weiss testified he has been to the Respondent's plant approximately 30-50 times and stated there is at most one job that he has seen that could potentially cause carpal tunnel syndrome, which involved putting two tubes together. (RX1, p. 27-29).

Dr. Weiss testified that 99-percent of his current medical practice is performing independent medical examinations and 90-95-percent of the examinations are for workers' compensation claims. Approximately 99-percent of the worker's compensation examinations he performs are on behalf of the employers. He stopped treating patients in 2008.

At the request of her attorneys, Petitioner was examined by Dr. Jeffrey Coe on September 29, 2015 and he testified by way of evidence deposition on February 26, 2016. (PX3). Dr. Coe is board certified in occupational medicine. He has an active Occ Med practice, instructs in occupational medicine at the University of Illinois and has a forensic/IME practice. The IME practice breaks down as 60% IME's for Respondents and 40% IME's for Petitioners.

Dr. Coe noted Petitioner was employed by Respondent as an assembler. She normally worked forty or more hours per week and worked on 600 or more cars per day. He noted she worked on the corner mods job and half shaft installation in 2012 and 2013. He noted these jobs were performed without job rotation at that time. She advised Dr. Coe that these jobs involved the use of torque guns, gripping hoist controls with repetitive and awkward bending and twisting of her wrists. He was not aware when Petitioner began working at Respondent. He obviously had not viewed the job activities. (PX3)

Dr. Coe noted that as she performed these job duties, Petitioner began to develop pain, numbness, and tingling in both hands. He summarized her medical treatment within the pages of his report. At the time of her examination, Dr. Coe noted Petitioner continued to complain of tightness and stiffness in both wrists. She continued to have occasional bilateral hand tingling and sometimes awakened at night with hand tingling. (PX3)

After reviewing her medical history, job duties, and performing a physical examination, Dr. Coe concluded: "Based on the findings of this examination, it is my opinion that there is a causal relationship between the repetitive bilateral upper extremity strain injury suffered by Ms. Ferone at work for the Chrysler Motor Corporation (Dates of Repetitive Strain Injury: August 29, 2012, November 10, 2012) and her current bilateral hand symptoms and state of impairment." (PX3 Dep. Ex. 2, p. 7) He noted her repetitive strain injuries in her work as an assembler at Respondent were a factor in causing the development of symptomatic bilateral carpal tunnel syndrome. Dr. Coe appears to have considered only the corner mods job and the half shaft job that was described to him by Petitioner. (PX3)

Dr. Coe also testified by way of evidence deposition on February 26, 2016. (PX3). He testified consistently with the contents of his report. He testified there is a relationship between repetitive forceful activities and carpal tunnel syndrome, which he further noted is a standard teaching in his area of occupational medicine at the University of Illinois Medical Center in Chicago. (PX3, p. 7, 23)

Dr. Coe testified he reviewed both operative reports regarding Petitioner's carpal tunnel releases. (PX3 p. 26) The reports were of significance based on Dr. Matloob's description of what he saw during the surgeries. He noted Dr. Matloob described the compression of the median nerve in both wrists was due to a thickened and tight transverse carpal ligament. Dr. Matloob did not describe any sort of anatomic abnormality. Dr. Coe explained that the thickening of her transverse carpal ligament with its associated tightness is typical of what is seen in repetitive microtrauma. He explained that the work activities at Respondent that Petitioner described to him and to others were consistent with being a factor in the development of her carpal tunnel syndrome.

Dr. Coe testified Petitioner had no other risk factors for carpal tunnel syndrome. He explained his opinion specifically regarding her use of birth control medications. (Id. at 36). He stated:

> Birth control pills may, in some women, mimic certain elements of pregnancy due to hormonal fluctuation. And that is in individuals who develop significant fluid retention. Fluid retention causes a generalized edema. This is generalized swelling, swelling in the upper extremities, swelling in the lower extremities. It's fluid retention.

Dr. Coe noted the absence of any discussion of generalized edema within Petitioner's medical records. With the absence of generalized edema, her use of birth control medication was not a cause of her bilateral carpal tunnel syndrome. It is a possibility that taking birth control medication could be a causative factor.

Dr. Coe's diagnosis as to Petitioner's upper extremity condition was bilateral carpal tunnel syndrome, status post successful carpal tunnel release surgery. He did not know if Petitioner had permanent restrictions regarding her hands at the time that he examined her. Dr. Coe assessed an AMA impairment rating of 2% of each upper extremity. (PX3)

CONCLUSIONS OF LAW

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

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(b)3(d). To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of her claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between the employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003)

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)

AS TO ISSUE C., DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? and ISSUE F., IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY? THE ARBITRATOR FINDS:

The issues of accident and causation are often intertwined in cumulative trauma cases, as they are in this case. The evidence supporting both Parties' positions is compelling. After a thorough review and careful consideration of all of the evidence adduced, including the testimony of Petitioner, Brian Jones and Drs. Weiss and Coe, the Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on August 29, 2012 and that her current condition of ill-being (to wit: bilateral carpal tunnel syndrome, status post successful bilateral carpal tunnel release) is causally related to the injury.

In coming to this conclusion, the Arbitrator finds Petitioner's testimony regarding her job activities on the corner mod job, the half shaft and prop shaft jobs and the banjo bolt job to be credible.

Significantly, Petitioner did not rotate when she performed the corner mod job at the time that she developed CTS symptoms in August of 2012. This factor was considered by Dr. Coe in rendering his causation opinion. Dr. Weiss appears not to have considered the lack of job rotation in rendering his no causal opinion. Plant medical records and the accident reports document lack of job rotation. While there may be some production/efficiency values in having auto assembly workers rotate tasks during the work day (avoiding fatigue, burn out, boredom, etc. leading to quality issues), there are obviously ergonomic factors to be considered in rotating job tasks. The ergonomic factors are not addressed if the employee does not rotate.

The factors considered in favor of compensability are as follows. Petitioner was 33 years old. There was no evidence of prior hand injuries or cumulative trauma injuries. She had no co-morbidities. There were no systemic risk factors. She was of normal body habitus. Rotation was not followed. Her description of her job tasks is credible. Her hand complaints and symptoms were associated with a couple of jobs. When she was not doing those jobs, the symptoms decreased. The job set up was for a person of the height of 5'6" or 5'7", Petitioner was 5'3". Dr. Matloob endorsed causation. Plant Medical did not document any dispute as to

causation. Dr. Coe endorsed causation, at least as to a factor, regarding Petitioner's job tasks of repetitive gripping, twisting and lifting, along with her positioning in performing the job tasks. Petitioner had entrapment of the median nerve by the transverse carpal ligament, as noted by Dr. Matloob at surgery. Dr. Weiss' theory on causation regarding birth control medication is not persuasive here, where no edema was ever noted in the medical records. Plant Medical documented that Petitioner's hand complaints were due to an "occupational incident". This is likely due to the patient stating that her complaints are due to work activities and is not any kind of admission to be construed against Respondent.

Factors considered in favor of denying the claim are Dr. Weiss' opinion that Petitioner's job tasks did not require forceful gripping or grasping or prolonged exposure to vibration. Dr. Weiss saw the job tasks that Petitioner claimed aggravated her CTS condition (albeit not being done by Petitioner) and formulated his opinion that the tasks were not sufficiently forceful or vibratory. The drills had a torque regulator to shut them down when the correct torque for a nut is reached. The jobs were subject to ergonomic review and there were no changes for the corner mod and banjo bolt jobs. Petitioner's testimony as to the number of cars that she performed the corner mod job is not necessarily accurate. At the first visit with Dr. Matloob, Petitioner's complaints were charted as involving the long, ring and little fingers (ulnar nerve?). It is noted that the NP charted that Petitioner's complaints involved the first 3 fingers (more consistent with CTS). Jones' testimony supports that there is less force and vibration on the jobs, but he did not perform any of the jobs, the jobs are set up for a taller employee, and he did not consider that Petitioner did not rotate in some of the jobs.

Considering the above, the entirety of the evidence adduced and the relevant caselaw, Petitioner's bilateral carpal tunnel condition manifested itself on August 29, 2012, the date that Petitioner identified when she first sought treatment at Plant Medical on September 5, 2012. Durand v. Industrial Comm'n, 224 Ill. 2d 53 (2006)

Dr. Coe's causation opinion is more persuasive than that of Dr. Weiss and best comports with the evidence, as is explained above. Petitioner's work activities (especially in light of the failure to have her rotate tasks) were a causative factor in the development of her bilateral carpal tunnel syndrome condition. The job activities need not be the sole or principal cause, as long as it was one of the causes of Petitioner's current condition of ill-being. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193 (2003)

AS TO ISSUE J., WHETHER THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER WERE REASONABLE AND NECESSARY?, THE ARBITRATOR FINDS:

As Petitioner's present condition of ill-being as it relates to bilateral carpal tunnel syndrome is causally related to her repetitive-trauma work accident of August 29, 2012. the Arbitrator finds that the medical services provided to Petitioner as they relate to her bilateral hands were reasonable and necessary and causally related to her accident of August 29, 2012.

The bills have been paid, per the Parties stipulation, with the exception of a $71.41 balance owed to Beloit Health System (PX 6). PX 6 consists of 19 pages and includes charges for services not related to Petitioner's hands. Without an explanation as to what the claimed unpaid bill is for, the Arbitrator declines to award this claimed medical expense.

AS TO ISSUE K., WHETHER PETITIONER IS DUE COMPENSATION FOR TEMPORARY TOTAL DISABILITY PAYMENTS?, THE ARBITRATOR FINDS:

Based upon the Arbitrator's finding regarding accident and causation above, Petitioner is entitled to TTD benefits from July 14, 2014 through September 7, 2014 and September 21, 2014 through December 15, 2014, a period of 20 weeks.

Respondent shall be given a credit of $6,680.55 for non-occupational indemnity 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 §8(j) of the Act.

AS TO ISSUE L, WHAT IS THE NATURE AND EXTENT OF THE INJURY?, THE ARBITRATOR FINDS:

As the accident occurred after September 1, 2011, the Arbitrator must consider the factors set forth in §8.1b of the Act in determining an award of PPD.

With regard to subsection (i) of §8.1b(b) of the Act, the AMA Impairment Rating, the Arbitrator places some weight on this factor. Dr. Coe provided the impairment rating of 2% loss of each upper extremity. The Arbitrator notes that the AMA does not provide for an increase based on work restrictions caused by one's injury. Further, impairment is not disability.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner's occupation is a laborer and her job involved working with her hands upwards of ten hours or more per day. She testified clearly and convincingly that her bilateral hand injuries affect her daily – especially those days in which she works and develops pain and tightness. Petitioner, as a result of her injuries and permanent restrictions, has been unable to perform her prior work duties as a floater on the prop shaft, banjo build, and corner mod lines. She is no longer able to perform her usual and customary employment although she does remain employed by Respondent. Because of her ongoing symptomatology and inability to perform her usual and customary work duties, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was only 38 years old on the date of arbitration. She was 33 on the date of the injury. As a younger person, she is required to live with this disability for many years going forward. The Arbitrator gives greater weight to this factor because Petitioner will have to work with and live with her symptoms for much of her work life expectancy.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner's earning capacity may be affected as a result of her injuries. Her testimony and the corroborating medical records provide clear and convincing evidence that her injuries interfere with her daily activities, especially after working all day. This is likely to impede her ability to work longer hours later into life. The Arbitrator therefore gives some weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes there is a significant amount of evidence within the medical records of her ongoing disability. Her difficulties with regular duty work was well-documented by Dr. Matloob as well as the plant

medical records. On August 16, 2016, she had her final visit with Dr. Matloob and he confirmed she was tolerating restrictions of four pounds lifting with each hand. He advised her that these restrictions would become permanent at that visit. This factor is given great weight in determining PPD.

Section 8(e) of the Act provides that a PPD award for injury to a hand occurring after June 28, 2011, involving carpal tunnel syndrome due to repetitive or cumulative trauma, is based on 190 weeks value for the hand and shall not exceed 15% loss of use of the hand, except for cause shown by clear and convincing evidence and in which case the award shall not exceed 30% loss of use of the hand.

Here, Petitioner's date of accident was August 29, 2012 and PPD is therefore limited to a fifteen-percent permanent partial disability cap on each of her hands unless there is cause shown by clear and convincing evidence that her disability is higher. The Arbitrator finds clear and convincing evidence to increase her disability above the fifteen-percent threshold, based upon her complaints and the permanent restrictions endorsed by Plant Medical and Dr. Matloob. The Arbitrator has also considered Dr. Coe's opinion that the release surgeries were successful and Dr. Weiss' opinion that Petitioner was capable of full duty work. The permanent restrictions convince the Arbitrator that the correct award for PPD, given the above, including the 5 factors to be considered under §8.1b and all of the evidence adduced is: 20% loss of use of petitioner's right (dominant) hand and 15% loss of use of Petitioner's left hand.

The award for PPD is therefore 66.5 weeks of compensation at the PPD rate of $402.89.

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

James Simpson,
Petitioner,

vs. NO: 17 WC 7679

Custom Staffing Industrial Services, LLC,
Respondent.

18IWCC0494

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2018, 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 - 2018
o080218
DLG/mw
O45

David L. Gore

Stephen Mathis

Deborah Simpson

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

SIMPSON, JAMES
Employee/Petitioner

Case# **17WC007679**

CUSTOM STAFFING
Employer/Respondent

18IWCC0494

On 1/8/2018, 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 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC, LTD
MICAHEL N FOLGA
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

5990 LITCHFIELD CAVO LLP
GREGORY S KELTNER
222 S CENTRAL AVE SUITE 200
ST LOUIS, MO 63105

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)

JAMES SIMPSON
Employee/Petitioner

v.

CUSTOM STAFFING
Employer/Respondent

Case # **17** WC **7679**

Consolidated cases: _____

18IWCC0494

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 **Herrin**, on **July 13, 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. ☒ 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 _____

18IWCC0494

FINDINGS

On the date of accident, **Feburary 17, 2017**, 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.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent children.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on February 17, 2017. All benefits are hereby denied. All other issues are moot and the Arbitrator makes no conclusions as to those issues.

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 3, 2018
Date

ICArbDec19(b)

JAN 8 - 2018

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JAMES SIMPSON
Employee/Petitioner

v.

Case #: 17 WC 7679

CUSTOM STAFFING
Employer/Respondent

18IWCC0494

MEMORANDUM OF DECISION OF ARBITRATOR

Testimony of Petitioner James Simpson

On February 17, 2017, Petitioner was 46 years old, married, and had one dependent child. He was employed by Respondent as a coal miner and had been so employed since December 2016. He was assigned to work for Knight Hawk Coal. He testified he earned $18.00 per hour and worked twelve-hour shifts four days per week, for a total of 48 hours per week. He further testified that overtime hours in excess of 40 hours per week were mandatory by Knight Hawk. His job duties included cleaning machinery and running heavy equipment such as a low dozer, which is an end loader fitted with a dozer blade. The low dozer is used to push gob, which is rejection from the coal and consists of things such as clay, mud, and rock. He was also required to shovel coal and to lift up to 75 pounds on a frequent basis.

On February 17, 2017, Petitioner was assigned by the lead man to run a low dozer. He testified that between 1:45 and 2:00 a.m. he had to fuel the low dozer. He stepped up onto the dozer's step rail, with the fuel hose in his left hand and his right hand grasping a bar to pull himself onto the dozer. The step rail was two to three feet high. Petitioner testified there was mud on the step rail and as he was loosening the gas cap off, his right foot went forward and he lost his footing. He fell backwards onto the ground and landed on his tailbone and buttocks and then rolled to the right. He testified he experienced immediate pain "like a shock wave", which went from his tailbone down his right leg to the top of his foot. He continued working until the end of his shift at 6:00 a.m. He testified that he continued working because he was embarrassed and was afraid he might lose his job if he left early, due to his status as a contractor. He testified that his supervisor Brock Gale, a Knight Hawk employee, was working approximately two miles away from him at the time of the accident. Another Knight Hawk employee, Joe Tindall, was working approximately a quarter of a mile away from him.

Petitioner testified that after his shift he went home, took Tylenol and an Epsom salt bath, and slept for about three hours. When he woke up he had severe pain in his low back and right leg and decided to go to the emergency room at Pinckneyville Community Hospital. While in the emergency room he called Heather at Custom Staffing and advised her of the accident. His understanding was that Heather took down the information into some type of incident report.

Petitioner testified that he followed up with his primary care physician, Dr. Alex Zambrano, who ordered a lumbar MRI and physical therapy and took him off work. Following the MRI, Dr. Zambrano referred him to Dr. Kyle Colle. However, he did not see Dr. Colle, as it was denied by workers' compensation. Instead he saw Dr. Richard Kube. Petitioner testified he took his recent MRI film to Dr. Kube, as well as films from prior MRIs. He was diagnosed with an L5-S1 herniation. Dr. Kube recommended physical therapy and steroid injections, which Petitioner has not undergone because his claim was disputed.

Petitioner testified that he sustained a prior back injury in December 2015. He could not recall specifically when his treatment ended, but testified that it was at least three months prior to February 17, 2017. He denied any medical treatment or use of pain medication in the three months prior to the current alleged accident. He testified that his current symptoms differ from his symptoms following the December 2015 incident, in that he now has tailbone pain and did not have such pain prior to February 17, 2017. He testified that he constantly experiences low back pain and almost constant numbness radiating down his right leg and across the top of his right foot. He takes Norco, prescribed by Dr. Zambrano, twice a day.

Petitioner testified that as a result of his pain he has difficulty dressing and is unable to perform simple household chores such as vacuuming or taking out the trash. He is unable to bend over to tie his shoes. He estimated he could sit and stand for 20 to 25 minutes before he experiences pain. He can no longer go fishing or mow his yard. He testified he has not received any medical treatment since his May 3, 3017, visit with Dr. Kube. He has not received any funds from Respondent except for an advance of $2,824.20, and he has several unpaid medical bills.

On cross-examination Petitioner testified that he may have spoken with one of Respondent's employees about a return to work after the alleged accident, but that he did not remember such a conversation.

Petitioner testified that prior to working for Respondent he worked mining related jobs with S Coal, Strata Mining Services, American Coal Company, Frontier-Kemper, Prairie State Generating Campus and Peabody Gateway Mine. He agreed that prior to working for each mine employer he underwent safety training. He could not recall whether he was ever instructed by any of his employers of the necessity of immediately reporting an injury after its occurrence nor could he recall being told during retraining after he was hired of the necessity of immediately reporting an accident.

Petitioner confirmed that when he previously went to work for Custom Staffing in October 2012 he signed a document, identified as part of Respondent's Exhibit 4, acknowledging that if he sustained an injury on the job he would inform the client and Custom Staffing immediately after the accident. He conceded that he was aware at that time that he was to report accidents

immediately after they occurred. He also acknowledged that he signed another document on October 14, 2012, also a part of Respondent's Exhibit 4, acknowledging that he would report an injury, no matter how minor, to his employer/supervisor. Petitioner agreed that while working at Knight Hawk he was under the supervision of Knight Hawk employees, as there were no Custom Staffing employees onsite, and that if he had an injury or work issue he would speak to a Knight Hawk employee.

Continuing on cross-examination, Petitioner confirmed that when he returned to work for Respondent in 2016 he again filled out and signed documents acknowledging that he needed to immediately report accidents to his onsite supervisor. He acknowledged that the documents also indicated that all injuries were to be reported regardless of the extent of the injury. He claimed he did not understand what the document meant when he signed it and that he thought he was to contact Custom Staffing to report an accident. He then acknowledged that Brock Gale would have been the person to whom he would report an accident since Mr. Gale was his direct supervisor.

Petitioner testified that in December 2015 he injured his low back when the haulage truck he was driving at a rock quarry hit a bump or hole in the road and bounced him around the cabin. He ended up seeing Dr. Colle at Regional Brain and Spine and he underwent a lumbar facet injection on June 17, 2016. Petitioner told Dr. Colle on July 5, 2016, that the injection did not help and that he felt worse after the injection. He also reported on July 5 that his back pain continued and had not improved. He advised Dr. Colle that his pain was worsening and he rated it at 8/10. Petitioner admitted that he also told Dr. Colle on July 5, 2016, that he was experiencing right leg pain. Dr. Colle ordered a functional capacity evaluation at that time.

Petitioner testified that he was unable to complete the functional capacity evaluation secondary to pain. He returned to Dr. Colle on August 16, 2016, and reported low back pain with radicular symptoms to the right leg and buttock, and right leg pain. Petitioner admitted that he told Dr. Colle on August 16 that his pain was worse with standing, walking, bending, or twisting, or with any exertional activity. He admitted that on August 16, 2016, he also requested pain medication and reported a pain level of 8/10.

Petitioner confirmed that on August 16, 2016, Dr. Colle imposed permanent restrictions of no lifting greater than 25 pounds, no repetitive bending, stooping or twisting, no overhead work, and no extension or flexion of the spine. He admitted that sometime following the August 16, 2016, encounter with Dr. Colle he applied for Social Security Disability.

Petitioner admitted that, although he told Dr. Kube on April 5, 2017, that his tailbone pain was new, he actually did have tailbone pain following the December 2015 accident. He also admitted that he told Dr. Kube that his condition following the December 2015 accident had improved with therapy, that he required no additional treatment and that he was given a full duty release, which was not accurate. He admitted that he never returned to Dr. Colle after the August 16, 2016, visit and that Dr. Colle never removed the restrictions. He admitted that he did not tell Dr. Kube about the permanent restrictions imposed by Dr. Colle, nor did he tell him that he was unable to complete the functional capacity evaluation secondary to pain. Petitioner admitted that he filed a claim for Social Security Disability benefits following the February 17, 2017, accident.

On redirect examination, Petitioner testified that he underwent an independent medical examination with Dr. Crane following the December 2015 accident, and that Dr. Crane released him to return to work. For that reason, he told Dr. Kube that he had been given a full duty release. Petitioner testified that he told Brock Gale of the alleged accident after the emergency room visit on February 17, 2017.

On re-cross examination Petitioner acknowledged that he left the mine property on February 17 without telling anyone at Knight Hawk about his injury and that the first report of injury was made to Heather after he was discharged from the emergency room on February 17.

Petitioner's Exhibit 7 is an Injured Employee's Report completed and signed by Petitioner. The report indicates that the accident occurred when Petitioner was fueling the load dozer, lost his footing, and fell down on the ground on his butt. The Arbitrator notes that the report is undated.

Testimony of Joe Tindall

Joe Tindall testified by way of deposition on June 16, 2017. He has worked for Knight Hawk Coal for nine years and has been a supervisor for seven of those years. He testified that Brock Gale was Petitioner's supervisor. He testified that he had worked with Petitioner on approximately a dozen occasions prior to working with him on February 17, 2017. He testified that on that date he and Petitioner rode to the work site together. He did not notice anything unusual about Petitioner's demeanor, presentation, appearance, or conduct, and Petitioner did not appear to be in any pain. He testified that Petitioner was operating the loader dozer that day. There was little talk between him and Petitioner during the shift. He testified that he had no recollection of Petitioner reporting an accident during the shift, and that if Petitioner had reported an accident, a report would have been completed immediately. Mr. Tindall testified that if Petitioner had an accident or problem on the job he could have contacted Mr. Gale or himself via CB radio or cell phone, both of which are carried by the employees. He testified that had Petitioner reported an injury, it would have been documented. Mr. Tindall testified that he and Petitioner left the job site together. He noticed nothing unusual about Petitioner's demeanor, appearance, or conduct at the end of the shift, and Petitioner did not appear to be in any pain or discomfort at the end of the shift. He testified that Petitioner's mood was typical for the end of the shift.

On cross-examination, Mr. Tindall testified that he was not an eyewitness to the alleged accident and was not within eye contact of the Petitioner when the accident occurred. He has no medical training to ascertain medical symptoms. He testified he was contacted by Knight Hawk to give a statement within one week of Petitioner's accident. He agreed that the area where Petitioner was working could contain mud and sludge, depending on the weather, but he did not recall any on that particular evening. He noted it was quite cold but there was no precipitation at the time. He testified he was the closest Knight Hawk employee to Petitioner, but could not see him at the time that the accident allegedly occurred.

Testimony of Brock Gale

Brock Gale testified by way of deposition on June 16, 2017. He testified that he was employed by Knight Hawk Coal as a Lead Man and was Petitioner's supervisor. He testified that

when Custom Staffing employees are brought onto the mine property to work they receive safety training and are also instructed on accident reporting.

Mr. Gale testified that he worked with Petitioner on several occasions prior to and including February 17, 2017. He did not notice anything unusual about Petitioner's appearance or conduct prior to the shift the day and testified that Petitioner did not appear to be in pain. He testified that he was approximately a mile away from the alleged accident site. He testified that if there was a work injury or an equipment problem the employee could contact his lead man or someone else from Knight Hawk during the shift by way of CB radio. Mr. Gale testified that Petitioner did not say anything to him about an alleged incident any time prior to the end of the shift on February 17, 2017. He testified that if an accident had been reported during the middle of the shift an incident report would have been completed or the employee would have received immediate medical treatment, depending upon the severity of the injury.

Mr. Gale testified that he saw Petitioner at the end of the shift on February 17, 2017. He saw nothing about Petitioner's appearance or conduct that was different from the encounter prior to the beginning of the shift 12 hours earlier. He testified that at the end of the shift Petitioner did not appear to be in any pain and was not limping. He asked Petitioner how things went during the shift and Petitioner responded "good". He testified that Petitioner's mood was typically "happy go lucky" and that Petitioner was in his normal mood at the end of the shift.

On cross-examination, Mr. Gale testified that he was not an eyewitness to the alleged accident. He was advised of Petitioner's accident on the same date that the accident occurred. He confirmed that he has no medical training to ascertain medical symptoms. He agreed that the area where Petitioner was working could contain mud and sludge. Mr. Gale testified that he was informed by J.P. Loos of Knight Hawk Coal that Petitioner called and was in the emergency room. He had no reason to disagree with Joe Tindall's statement that Mr. Tindall was "not within eye contact" of Petitioner when the accident occurred.

Pre-accident medical records

Respondent proffered medical records from Dr. Kyle Colle with Regional Brain & Spine. Dr. Colle's records contain a lumbar MRI report and lumbar x-ray report from Signature Medical Group dated March 10, 2016. The reports reflect that Dr. Benjamin Crane ordered the studies. The lumbar MRI showed mild disc desiccation at L5-S1 with a possible annular tear, minimal diffuse annular disc bulge and a broad based central disc protrusion with no central canal stenosis. Mild lateral recess stenosis which encroached on the exiting nerve root was noted on the right at S1, as was minimal bilateral neural foraminal exit stenosis. RX3.

At Petitioner's first visit with Dr. Colle on May 31, 2016, he reported he was injured at work on December 18, 2015, when he was riding in a truck that hit a pothole, and he felt a "bolt of lightning" in his back. Dr. Colle noted that Petitioner complained of an L5 distribution pattern of right leg tingling and dysesthesia, and increased pain with sitting, standing, bending, lifting and decreased pain with lying down. He interpreted the March 10, 2016, MRI as showing mild degenerative disc disease at L5-S1 with a small annular tear and a mild central disc bulge with possible contact of the right greater than left S1 nerve root. Dr. Colle diagnosed lumbosacral

spondylosis with radiculopathy. He recommended electrodiagnostic testing, utilization of a lumbar corset, and bilateral S1 facet blocks. RX3.

On June 2, 2016, Dr. Colle/PA Patrick Hammond authored a letter wherein he summarized Petitioner's first examination. He also noted, "Additionally, he has complaints that appear somewhat exaggerated to include increased low back pain with light axial loading, upper extremity resistance testing, light palpation to the lower back, and passive trunk range of motion." RX3.

On June 16, 2016, Petitioner underwent an EMG of the bilateral lower extremities. He reported numbness and tingling into his right lower extremity with burning into the top of his right foot, as well as pain into his tailbone that radiated into his right lower extremity. The EMG revealed no evidence of any focal nerve entrapment or a lumbar radiculopathy in the right lower extremity. On June 17, 2016, Petitioner underwent an intraarticular facet injection at L5-S1. RX3.

On July 5, 2016, Petitioner was evaluated by Dr. Colle and reported that the injection did not help and actually increased his pain. He reported that his ongoing lumbosacral pain continued and had not improved. Sensory exam in the lower extremities was normal to light touch and pinprick, from L1 through S1 bilaterally. Straight leg raise test was negative bilaterally. Diagnosis was right leg pain, lumbago and lumbosacral spondylosis. Dr. Colle advised Petitioner that he had degenerative changes at L5-S1 with degenerative disc disease and facet arthropathy. Dr. Colle opined that the work injury caused an acute exacerbation of pain at the degenerative level. He recommended a functional capacity evaluation to evaluate for permanent work restrictions. He opined that Petitioner's symptoms and the need for diagnostic work out were related to the December 2015 accident. RX3.

Petitioner returned to Dr. Colle for a final visit on August 16, 2016. Dr. Colle noted, "According to the functional capacity exam paperwork and according to Mr. Simpson he was unable to complete functional capacity exam due to pain." Petitioner complained of low back pain, right radicular symptoms, right buttock pain, and right leg pain. He reported increased pain with standing and walking for long periods of time, bending, twisting, or any exertional activity. Petitioner requested pain medication, reported that his pain was worsening, and rated his pain at 8/10. Diagnosis was right leg pain and numbness, lumbago, and lumbosacral spondylosis with radiculopathy. Dr. Colle placed Petitioner at maximum medical improvement and released him to return to work with restrictions of no lifting greater than 25 pounds, no highly repetitive bending, stooping or twisting, no overhead work and no flexion or extension of the spine. Dr. Colle opined that these restrictions were permanent. RX3.

Post-accident medical records

Following the accident, Petitioner presented to the emergency room at Pinckneyville Community Hospital at approximately 2:40 p.m. on February 17, 2017. The initial Nursing Note indicates Petitioner had complaints of lower back pain with no radiation and that he stated, "I've had low back pain since early this AM since working on the mine equipment machine." A later Nursing Note from approximately 5:44 p.m. states, "Patient tells this author at this time that he remembers that he fell off a dozer 3 feet off the ground. At first he didn't think anything of it, but now that's what he thinks it's from." The Physician Chart notes Petitioner was working with

machinery at a coal mine and fell in the sitting position. It further notes, "There is a history of chronic back pain…There is a history of having had a similar problem in the past." Examination showed tenderness on the left side. Lumbar x-rays were negative for acute fracture or spondylolisthesis. Petitioner was diagnosed with a lumbosacral strain. He was excused from work through February 20, 2017, and was instructed to follow up with his family physician to obtain a release to return to work. PX1.

On February 21, 2017, Petitioner presented to Dr. Alex Zambrano and reported he had fallen off machinery onto his bottom from about three feet high and hurt his back in the process. He reported his pain was moderate to severe, was located in his lower back and radiated to the right thigh. The record does not contain any specifics as to a detailed physical examination or testing. Assessment was lumbar radiculopathy. Dr. Zambrano kept Petitioner off work, referred him to physical therapy, prescribed Norco and Prednisone, and ordered an MRI. PX2.

On February 28, 2017, Petitioner underwent a lumbar MRI. It revealed (1) modest relatively nonfocal degenerative changes most apparent at L5-S1, with fairly advanced disc degenerative change and an annular fissure; and (2) moderate left L5 lateral recess stenosis. PX3.

Petitioner returned to Dr. Zambrano on March 7, 2017, and reported that the pain medication was not working. He was referred to neurosurgeon Dr. Kyle Colle and excused from work through June 21, 2017. He was instructed not to lift, push, pull, or perform any strenuous activity. PX2. The Arbitrator notes this is the final treatment record from Dr. Zambrano. The Arbitrator further notes that Petitioner testified he did not attend an appointment with Dr. Colle, as it was denied by worker's compensation.

On April 5, 2017, Petitioner presented to Dr. Richard Kube of Prairie Spine & Pain Institute. He provided a detailed account of climbing on a land dozer with a fuel line in hand when he fell a couple of feet, hit his tailbone, and went to the right side. The Arbitrator notes this was the first mention in the medical records of Petitioner having a fuel line in his hand. Petitioner reported that the pain started within several minutes but he finished his shift and then went to the emergency room. Petitioner advised Dr. Kube that the right-sided leg pain began the next day and that the tailbone pain was new. He further advised that he had a low back injury in 2015 which involved back pain and right leg pain, that it improved with injections and therapy, that he required no additional treatment beyond the injections and therapy, and that he was given a full duty release. Dr. Kube reviewed Petitioner's lumbar MRI films from 2015, 2016, and 2017. He noted that the 2015 MRI showed degenerative changes at L5-S1 with a grade 3 disc and spondylolisthesis, minimal stenosis, and a small annular tear. He commented that the 2016 film was similar with no change in the size of the annular tear. In contrast, he noted that the 2017 MRI showed edema in the posterior annulus. Although the stenosis was unchanged, Dr. Kube opined that the annular tear appeared to have increased substantially in size. He recommended physical therapy and an epidural steroid injection, and restricted Petitioner to sedentary work. PX4.

On May 3, 2017, Dr. Kube completed a Work Status Form indicating that Petitioner was to continue on sedentary work. There is no corresponding office note and it is unclear whether Petitioner was actually examined on this date. PX4. The Arbitrator notes this is the final record from Dr. Kube.

On April 20, 2017, Petitioner was evaluated by Dr. James Coyle, Respondent's Section 12 examiner. Dr. Coyle reviewed records from Dr. Crane, Dr. Kube, and Dr. Zambrano, as well as Petitioner's lumbar MRI films from December 19, 2015, March 10, 2016 and February 28, 2017. Dr. Coyle's report reflects that on April 18, 2016, Dr. Crane discussed the possibility of a discectomy at L5-S1 on the right and a fusion type operation at L5-S1. Dr. Crane indicated that he was leaning toward a right L5-S1 discectomy which might result in Petitioner having life-long back pain. At that time, Petitioner elected to consider his options and indicated that he would follow-up with Dr. Crane thereafter. RX1.

Petitioner reported to Dr. Coyle that his back pain was not as severe as it was following the December 2015 injury, but that his tailbone pain was new. Dr. Coyle noted, however, that Dr. Crane documented tailbone pain in the course of his examination. Petitioner also reported that his leg pain was not as bad as it was previously but that his back pain was worse. RX1.

Dr. Coyle noted that the MRI of February 28, 2017, revealed increased facet and ligament hypertrophy at L5-S1 and increased disc desiccation, which was evidence of progressive degenerative changes. He further noted that the increased disc desiccation and facet and ligament hypertrophy at L4-5 was a degenerative condition. Dr. Coyle opined that there was abundant objective evidence that Petitioner's imaging studies showed progressive degenerative changes at multiple lumbar levels and that the essential pathology was unchanged and consisted of discogenic low back pain with radiculopathy due to an L5-S1 disc prolapse and annular fissure. He opined that this progression was not altered by Petitioner's activities on February 17, 2017. Dr. Coyle advised Petitioner that Dr. Crane's diagnosis was essentially correct when he suggested the possibility of discectomy that would leave Petitioner with ongoing low back pain. RX1.

On May 11, 2017, Dr. Coyle issued a supplemental report following review of records from Pinckneyville Community Hospital emergency room and Dr. Zambrano. Dr. Coyle commented that on September 12, 2016, Dr. Zambrano referred Petitioner to Physical Medicine and Rehabilitation for chronic back pain. He noted that Dr. Zambrano gave Petitioner a work slip which, based on musculoskeletal screening and the functional capacity test of August 2, 2016, restricted Petitioner from sitting or standing longer than five to ten minutes and from lifting more than ten pounds. He further noted that Dr. Zambrano provided Petitioner with a temporary parking permit. Dr. Coyle commented that Dr. Zambrano's note of September 27, 2016, indicated that Petitioner was referred to a neurosurgeon in St. Louis for chronic back pain and a lumbar disc herniation. Dr. Coyle opined that having reviewed the additional records, the opinions expressed in his April 20, 2017, report were unchanged. RX1.

On May 22, 2017, Dr. Coyle issued an additional report following review of records from Dr. Robert Bernardi, Dr. Colle, and APEX Physical Therapy. Dr. Coyle noted that the records from the aborted functional capacity evaluation at APEX on August 2, 2016, reflected that when asked to forward bend and reach overhead within his tolerances, Petitioner refused to perform any movement screens, decided he was done, and the FCE test was stopped. The report indicated that Petitioner completed 10 out of 16 performance criteria and that six of the performance criteria were abnormal including a perceived disability of being crippled, elevated somatic perception score, poor score on work related recovery expectations and inappropriate symptoms. RX1.

Dr. Coyle also noted that on October 5, 2016, Dr. Bernardi performed an independent medical examination which included a pain disability questionnaire, on which Petitioner answered questions on a zero to 10 scale with zero indicating no problems and 10 indicating maximum score for disability. Petitioner marked most questions at level 10 and he had a total disability score of 138 out of 150. Dr. Bernardi noted that Petitioner was taking Norco. Petitioner advised Dr. Bernardi that his pain was 7 out of 10 on a pain scale. In his report, Dr. Bernardi opined that numerous findings suggested non-organic factors contributing to Petitioner's ongoing complaints and perceived sense of disability. Dr. Coyle noted that Dr. Bernardi indicated that the weakness noted on neurologic examination was not compatible with ambulating and that the weakness was not genuine. Dr. Bernardi also noted that Petitioner exhibited numerous Waddell signs and concluded that the possibility of malingering could not be excluded. Dr. Coyle concluded that, based on the review of the additional records, there was no change in his previous assessment that Petitioner's symptoms substantially predated the February 2017 injury claim and that his symptoms were not causally related to the February 2017 accident. RX1.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a 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:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accidental injury on February 17, 2017, that arose out of and in the course of his employment with Respondent. In so concluding, the Arbitrator finds Petitioner's testimony regarding the alleged accident to not be credible, particularly when viewed in conjunction with the evidence in total.

Petitioner's personnel file indicates that on two occasions he signed virtually identical forms before beginning work with Respondent acknowledging that any accident, regardless of its magnitude, was to be reported immediately to the employer to whom he was assigned *and* to Respondent. Petitioner agreed that he signed these documents on two occasions. He testified that immediately after the alleged accident he experienced pain "like a shock wave" in his tailbone and down his right leg to the top of his right foot. Yet he left the Knight Hawk property without reporting the alleged injury to anyone. While he testified that he did not report the accident before he left the mine because he was concerned that he might lose his job, he offered no evidence to

indicate that this was a reasonable belief. Moreover, and more significantly, given the severity of the immediate post-accident symptoms to which he testified, the Arbitrator does not find Petitioner's explanation for not reporting the accident to be tenable.

The Arbitrator finds the testimony of Knight Hawk employees Brock Gale and Joe Tindall significant in terms of assessing Petitioner's credibility. Both Mr. Gale and Mr. Tindall observed Petitioner before and after the shift. They both testified that Petitioner's demeanor and appearance before and after the shift were identical, with Petitioner exhibiting no behavior indicative of injury or pain. Particularly significant is Petitioner's response of "good" to Mr. Gale's inquiry at the end of the shift as to how things went during the shift, and his failure to mention anything about the alleged accident. Given Petitioner's testimony as to the "shock wave" of pain following the accident, and given his documented knowledge of the need to report all accidents immediately, the Arbitrator finds it implausible that, had Petitioner been injured as claimed, he would not have told Mr. Gale about the accident when he inquired as to how things went during the shift.

Petitioner's veracity is further questioned when looking at circumstances which occurred prior to him beginning work for Respondent. Specifically, when treating for his prior work accident, Dr. Colle noted on June 2, 2016, "Additionally, he has complaints that appear somewhat exaggerated to include increased low back pain with light axial loading, upper extremity resistance testing, light palpation to the lower back, and passive trunk range of motion." Dr. Coyle noted in his report of May 22, 2017, that review of APEX records from Petitioner's aborted FCE on August 2, 2016, reflected that Petitioner "refused to perform any movement screens, and then decided he was done with the FCE, and the test was stopped".

Dr. Coyle further noted that review of Dr. Bernardi's IME report of October 5, 2016, reflected that Petitioner reported significant disability and was under permanent restrictions from Dr. Colle at that time (as of August 16, 2016). However, on November 15, 2016, Petitioner completed and signed an Essential Job Functions form for Respondent, wherein he indicated he was able to perform activities which Dr. Colle had permanently restricted him from. Specifically, he wrote that he was able to safely climb ladders, bend, stoop, perform forceful exertions, push, twist, kneel, crawl, perform overhead work, reach, shovel, and lift up to 50 pounds. Further, Petitioner reported to Dr. Kube that he had been released to return to work from his prior work accident. After being confronted about these inconsistencies on cross-examination, Petitioner testified on re-direct that, with regard to his prior work accident, he saw IME physician Dr. Crane, who released him to return to work, and that was why he reported to Dr. Kube that he had been able to return to work following the 2015 accident. Dr. Crane's records were not offered into evidence. However, Dr. Coyle reviewed the records and noted that on April 18, 2016, Dr. Crane actually recommended a right L5-S1 discectomy. There is nothing in the record reflecting that Dr. Crane ever released Petitioner to return to work.

In addition, Petitioner reported to Dr. Coyle that he saw Dr. Bernardi in December 2016 and was released to return to work. Dr. Coyle's report of May 22, 2017, reflects that Petitioner actually saw Dr. Bernardi in October 2016. There is no indication in Dr. Coyle's report as to whether Dr. Bernardi opined that Petitioner could return to work, with or without restrictions, but Dr. Coyle did note that Dr. Bernardi did suggest that Petitioner might be malingering and that

numerous findings suggested non-organic factors contributing to his complaints and perceived sense of disability.

Petitioner's veracity is also called into question by virtue of his reporting to Dr. Kube that following the 2015 accident his low back and leg pain improved with injections and therapy and that he received a full duty release. Even if Dr. Bernardi gave Petitioner a full duty release (and as noted above, there is nothing in the record which indicates that to be the case), Petitioner scored 138 out of 150 on a disability scale, which clearly indicated that he did not improve with injections and therapy as he reported to Dr. Kube. Moreover, Petitioner neglected to advise Dr. Kube that his own treating physician, Dr. Colle, had imposed permanent restrictions nine months prior and that he was unable to complete a Functional Capacity Evaluation ordered by Dr. Colle secondary to pain.

The Arbitrator has considered Petitioner's testimony that he did not report the accident to Brock Gale before he left the mine property because he thought he was to report any accidents to Respondent. The Arbitrator does not find this explanation to be persuasive, in light of Petitioner's testimony that he clearly understood that Mr. Gale was his onsite supervisor and that there were no representatives of Respondent at the mine. In addition, the Arbitrator notes that Petitioner signed the *Workers' Compensation Policy and Procedure* form, on which he acknowledged that all injuries must be reported immediately to the **onsite** supervisor regardless of the extent of the injury, and that Respondent was to be informed of any accident immediately after it was reported to the onsite supervisor. While the record is clear that Petitioner did in fact report the accident to Respondent later that day, the issue is not one of notice. Rather, the issue is whether an accident occurred at all. To that point and that issue, the Arbitrator finds the testimony of Brock Gale and Joe Tindall to be more credible and persuasive than that of Petitioner.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment. All benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

Eduardo Hernandez,
Petitioner,
vs.

NO: 15 WC 33787

Komatsu America Corp,
Respondent.

18IWCC0495

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2017, 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 - 2018
o080218
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HERNANDEZ, EDUARDO
Employee/Petitioner

Case# **15WC033787**

KOMATSU AMERICA CORP
Employer/Respondent

18IWCC0495

On 11/28/2017, 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 1.43% 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:

0640 KINGERY DURREE WAKEMAN & RYAN
ARTHUR R KINGERY
416 MAIN ST SUITE 915
PEORIA, IL 61602

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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

Eduardo Hernandez
Employee/Petitioner

v.

Komatsu America Corp.
Employer/Respondent

Case # **15** WC **33787**

Consolidated cases: **N/A**

18IWCC0495

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 **Peoria**, on **12/21/16**. 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 _____

18IWCC0495

FINDINGS

On **6/24/15**, 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 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 **$60,559.43**; the average weekly wage was **$1,235.91**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$16,729.18** for other benefits, for a total credit of **$16,729.18**.

Respondent is entitled to a credit of **$22,726.67** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment, benefits are denied.

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

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

Michael K. Nowak, Arbitrator

11/22/17
Date

NOV 28 2017

FINDINGS OF FACT

Petitioner, a 35 year old welder, alleges that he sustained an accidental injury to his right knee that arose out of and in the course of his employment by Respondent on June 24, 2015. Petitioner testified at trial that he was cleaning up his work area and in the process of emptying a garbage can twisted his leg and felt pain in his knee. He went to report his injury to his supervisor, but having found that he was gone, he reported it to safety.

Petitioner completed an accident report form on June 25, 2015 in which he described the mechanism of injury as "[a]fter dumping a garbage can and setting it down, right knee quit working." (RX 6)

On June 25, 2015, Petitioner presented to OSF Saint Francis Center for Occupational Health and Dr. Edward Moody. He reported that at the end of his shift yesterday his right knee suddenly gave out on him while emptying a trash can. He denied any specific mechanism of injury. There was no specific incident or accident associated with symptom onset. Dr. Moody opines that sometimes combinations of position, weight bearing and normal movements can result in a knee injury, especially if there is an underlying abnormality. (PX 3)

Petitioner gave a recorded statement on June 26, 2015. (RX 1) Petitioner testified that the transcription of the recorded statement was true and accurate. During his recorded statement, Petitioner was asked about his work injury and mechanism of injury. The colloquy, in pertinent part, was as follows:

> Question: "Okay, and then, umm, you put it down, you went to walk away, and as you walked away, your knee, your right knee gave out on you?"
>
> Answer: "Correct, correct. I wasn't turning or anything just going straight."
>
> Question: "Alright. No turn. So you really don't have any idea, you know, cause some people say, you know, I twisted or I fell or anything along those lines you…"
>
> Answer: "Yeah, exactly and I was gonna say nothing that I, well I think could have caused it you know, there's no step, no twist, no turn, no uhh, anything." (RX 1)

On June 30, 2015, Petitioner presented to UnityPoint Health and Dr. Jay Harms. Petitioner presented to obtain a letter to return to work. He reported he hurt his knee on Wednesday June 24, 2015. Petitioner reported that his knee gave out. He reported his knee was feeling more or less normal. He denied any pain. Dr. Harms diagnosed acute right knee pain and released Petitioner to return to work. (PX 2)

On August 13, 2015, Petitioner presented to St. Clare Family Health Center and Jessica Garceau, CNP, complaining of one month of right knee pain and swelling. He denied any known injury. He reported being a welder and going up and down ladders all day long. He reported that one day at work he was just walking and his right knee gave out and he almost fell. He reported having consistent pain after that. He reported it pops if he turns wrong. A right knee MRI was ordered. (PX 1)

On August 28, 2015, Petitioner underwent a MRI of the right knee at OSF Healthcare. The radiologist's impression was: (1) injury pattern consistent with a pivot shift type injury with full-thickness tear of the ACL; and (2) full thickness radial tear of the posterior horn of the medial meniscus. (PX 1)

On September 21, 2015, Petitioner sought care with Dr. Steven Olevitch at Great Plains Orthopaedics. He reported that his right knee gave out after he emptied the garbage. He reported he turned around to walk and his knee gave out. There was no wet floor, oil slick or oil spill. He reported he was just merely turning to walk away from the garbage area and his knee gave out. Dr. Ortlevitch noted that Petitioner had an MRI which revealed an ACL tear. Dr. Orlevitch also noted a complex tear of the posterior horn of the medial meniscus and arthritis under the patella. Dr. Orlevitch opined that Petitioner's low energy injury to his ACL was slightly atypical. Dr. Orlevitch recommended an ACL reconstruction with Achilles allograft, partial medial meniscectomy and possible microfracture of the medial femoral condyle. (PX1 & 3)

On October 2, 2015, Dr. Orlevitch authored an off work slip indicating that Petitioner could return to light-duty work until his scheduled surgery on November 4, 2014. The slip indicates that Petitioner would be out of work from November 4, 2015, through November 13, 2015. (PX1 & 3)

On November 3, 2015, Petitioner sought pre-surgery clearance. Dr. Orlevitch noted Petitioner's history of emptying a garbage can and having his right knee give out at that time. Dr. Orlevitch noted that Petitioner's low-energy ACL injury was slightly atypical. Dr. Orlevitch continued to recommend surgery. (PX1 & 3)

On November 4, 2015, Dr. Orlevitch performed a: (1) right knee arthroscopy assistant ACL reconstruction with Achilles allograft; (2) right knee arthroscopic partial medial meniscectomy; (3) right knee arthroscopic extensive chrondroplasty patella and medial compartment; and (4) right knee arthroscopic excision multiple loose bodies randing from 1 cm to 4 mm in diameter, the largest being removed with a grasping forceps. (PX1 & 3)

On November 16, 2015 Dr. Orlevitch continued Petitioner off of work for next three weeks. (PX1 & 3)

On December 8, 2015 Petitioner followed up Dr. Orlevitch. He reported feeling better. Dr. Orlevitch noted that Petitioner had degenerative changes in the medial and patellofemoral compartments grade 3 and a tear of the posterior horn of the medial meniscus. Dr. Orlevitch continued to keep Petitioner off of work for one month. (PX1 & 3)

On January 5, 2016 Dr. Orlevitch noted that Petitioner had degenerative changes, medial and patellofemoral, grade 3, of a significant nature. Petitioner reported improving with physical therapy. Dr. Orlevitch recommended Petitioner continue with therapy and follow up in 4 weeks regarding a potential release to work. (PX1)

On February 2, 2016 Dr. Orlevitch noted his right knee ACL reconstruction was improving. Petitioner complained of pain with kneeling and squatting. Dr. Orlevitch recommended Petitioner continue with physical therapy. (PX1 & 3)

On March 4, 2016 Petitioner returned to Dr. Orlevitch. He reported having right knee pain while kneeling at church. Dr. Orlevitch opined this was due to his degenerative changes in the patella. Dr. Orlevitch

noted that Petitioner has severe arthritis of the patella with significant flaps and fibrillations of advanced grade 3 changes. Dr. Orlevitch opined that Petitioner's crepitation in the plantar flexion joint was arthritic and pre-existing. Dr. Orlevitch recommended Petitioner continue with physical therapy. Dr. Orlevitch continued to keep Petitioner off of work due to his job duties being very active and requiring kneeling and rigorous physical activity. (PX1 & 3)

On April 1, 2016 Dr. Orlevitch noted that Petitioner was doing well. However, Petitioner was continued off of work for the next five weeks. Petitioner was to continue with his regular therapy until work conditioning was authorized. (PX1 & 3)

On April 4, 2016, Respondent obtained a records review report from Dr. Bryan Neal at Arlington Orthopedic & Hand Surgery Specialists, LTD. Dr. Neal opined that Petitioner may have suffered a right knee soft tissue strain following a buckling incident due to preexisting intrinsic anterior cruciate ligament deficiency which was temporarily symptomatic following the June 24, 2015, incident. Dr. Neal opined that no work condition contributed to Petitioner's injury. He opined that the fact that the events were sudden in onset is not surprising since he described a sudden intrinsic giving way of his knee. (RX 4)

On June 17, 2016, Dr. Orlevitch testified via evidence deposition. Dr. Orlevitch testified that he first saw Petitioner on September 21, 2015. Petitioner reported to him that his right knee gave out after emptying a garbage can and turning to walk away. Dr. Orlevtich testified that following his exam and review of Petitioner's MRI films, he diagnosed him with an ACL tear, medial meniscus tear and osteoarthritis. Dr. Orlevtich testified that Petitioner likely suffered a "pivot shift" injury. Dr. Orlevitch testified that Petitioner's pivot shift injury was the cause of his need for surgery on November 4, 2015. (PX 5)

On cross-examination, Dr. Orlevitch testified that he believed Petitioner sustained a pivot shift injury while emptying a garbage can. When questioned whether the fact that Petitioner reported during a recorded statement on June 26, 2015, two days after his alleged injury, that he was walking straight, not turning, twisting or stepping, would change any of his causation opinions, Dr. Orlevitch testified that if Petitioner did not have any twisting or pivot shift type injury, that would tend to support that his work was not a cause of his injury. Dr. Orlevitch admitted that he would expect that Petitioner would have felt pain while turning. Dr. Orlevitch admitted this was an atypical, low energy injury, but that he did not have any information suggesting Petitioner sustained an ACL and meniscus tear at some other time, so he believes this work activity was the cause of his injury. Dr. Orlevitch testified that Petitioner reported his employer did not have any light-duty, so Dr. Orlevitch did not believe it needed to be addressed. Dr. Orlevitch testified he was not aware this was an alleged workers' compensation injury since there were no case nurses or other indication from Petitioner that it was. Dr. Orlevitch testified if he had known Petitioner could have worked light-duty, he would have allowed him to return to such much earlier. He testified that Petitioner could have likely returned to office type work within 8 weeks of his surgery, or approximately January 4, 2016. (PX 5)

On August 2, 2016, Dr. Neal testified via evidence deposition. Dr. Neal testified, consistent with his report, that Petitioner may have suffered a right knee soft tissue strain following a buckling incident due to preexisting intrinsic anterior cruciate ligament deficiency which was temporarily symptomatic following the June 24, 2015, incident. He testified that no work condition contributed to Petitioner's injury. He testified that

an intrinsic giving away is an internal occurrence that does not have any relationship to Petitioner walking after setting down the garbage can. He also testified that Petitioner could have likely been performing some sedentary light-duty within 7-10 days and should have been able to return to work full-duty much sooner than he did. (RX 4)

Petitioner testified he worked light-duty for several days after his work accident before being told by Mr. Wayne Adams that his injury was not work-related and he had to go home. He followed up with the company doctor who would not release him back to full-duty so he went to a prompt care and was released to full-duty. He then continued to work his regular job duties through the remainder of the summer.

Petitioner testified that following his surgery he was released to full-duty on June 20, 2016, and has continued to work his regular job duties since his return to work.

At trial, Petitioner testified he twisted his right knee while emptying a garbage can. He testified that he suffered a pivot shift injury and tore his ACL. He testified that his orthopedic surgeon opined that he must have twisted his knee since he tore his ACL. He testified that it was not until Dr. Orlevitch advised him of this that he believed that he twisted his knee. The first time that Petitioner reported twisting his knee while emptying a garbage can was at the December 21, 2016, arbitration hearing.

Respondent called Mr. Chris DuBois to testify on its behalf. Mr. DuBois is the human resource manager at Respondent. He is familiar with Petitioner and his workers' compensation claim. Mr. DuBois testified that Respondent could have accommodated Petitioner's light-duty restrictions if he had been released back to work with restrictions. He testified that Respondent has a policy of accommodating light-duty restrictions, regardless of whether an employee is claiming a workers' compensation injury. He testified Respondent would not have accommodated light-duty if the restrictions were so severe such that there was nothing for Petitioner to do. Mr. DuBois testified that Respondent accommodated Petitioner's light-duty restrictions in May 2016 after it was made aware of Petitioner having been released back to light-duty. He testified Respondent could have accommodated light-duty restrictions sooner if Petitioner had not continued to be taken completely off of work by Dr. Orlevitch.

CONCLUSIONS

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

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 348 Ill. Dec. 559 (2011). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989).

Injuries sustained at a place where a claimant might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. *Caterpillar Tractor Co. v. Industrial*

Comm'n, 129 Ill. 2d 52, 57, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In this case, it is undisputed that the Petitioner's injuries were sustained in the course of his employment. The only legitimate issue for analysis in this case is whether the claimant's injuries arose out of his employment.

For an injury to "arise out of" the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. There are three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment: (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007) (citing *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000)).

In this case, the Petitioner testified at trial that he twisted his leg while emptying a garbage can resulting in a pivot shift injury but that he did not realize that twisting was the cause until many months later when Dr. Orlevtich indicated that this is what caused his injury.

The Arbitrator finds it significant that immediately following the accident Petitioner made no mention of twisting his leg or knee. He completed an accident report form on June 25, 2015 in which he described the mechanism of injury as "[a]fter dumping a garbage can and setting it down, right knee quit working." (RX 6) On June 25, 2015, when seeing Dr. Moody, he reported that at the end of his shift yesterday his right knee suddenly gave out on him while emptying a trash can. The doctor noted that he denied any specific mechanism of injury and there was no specific incident or accident associated with symptom onset. Even more significantly Petitioner gave a recorded statement on June 26, 2015 in which he unequivocally denied having twisted his knee. He stated "...I wasn't turning or anything just going straight. ... [T]here's no step, no twist, no turn, no uhh, anything." (RX 1) On June 30, 2015, Petitioner reported to Dr. Harms that his knee gave out. When he saw Jessica Garceau, CNP on August 13, 2015, He denied any known injury and reported that one day at work he was just walking and his right knee gave out and he almost fell. It was not until Petitioner came under the care and treatment of Dr. Orlevitch in September 2015 that there was any mention of a twisting or pivot-shift injury. (PX 1)

Dr. Neal's opinions are consistent with the plethora of descriptions of his injury provided by Petitioner immediately following the incident. Dr. Neal opined that Petitioner may have suffered a right knee soft tissue strain following a buckling incident due to preexisting intrinsic anterior cruciate ligament deficiency which was temporarily symptomatic following the June 24, 2015, incident. He testified that no work condition contributed to Petitioner's injury. He testified that an intrinsic giving away is an internal occurrence that does not have any relationship to Petitioner walking after setting down the garbage can. Dr. Neal's opinions support there not being any increased risk of injury as a result of Petitioner walking away from the garbage area after emptying a garbage can.

The Arbitrator finds the histories Petitioner provided prior to his first visit with Dr. Orlevitch in September 2015 more persuasive than his trial testimony regarding the mechanism of injury. The Arbitrator further finds Dr. Neal's opinions that there was an intrinsic giving away which is an internal occurrence that

does not have any relationship to Petitioner walking after setting down the garbage can to be consistent with Petitioner's initial reported accident history.

Even assuming arguendo that the onset of pain was not the result of an intrinsic giving away of the knee due to a preexisting anterior cruciate ligament deficiency, a risk that would be personal to Petitioner, under the facts of this case Petitioner's claim cannot survive a neutral risk analysis. Injuries resulting from a neutral risk do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d at 163. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Petitioner indicated in his statement that the trash can weighed 10 pounds or less. From the record it appears he was required to dump the trash only once per day at the end of his shift. Simply walking does not establish an increased risk caused by the employment. *See. Id.* citing *Oldham v. Industrial Commission*, 139 Ill.App.3d 594, 487 N.E.2d 693 (1985). Likewise, turning away from a trash dumpster or turning to go around a corner does not expose one to a risk greater than that encountered by the general public.

Based upon the foregoing and the record taken as a whole, the Arbnitrator finds Petitioner has failed to meet his burden of establishing that he sustained an accidental injury which arose out of and in the course of his employment. Benefits are therefore denied. All other issues are moot.

16WC23770
Page 1 of 2

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

Carol Bennett,

Petitioner,

vs. NO: 16 WC 23770

State of Illinois IEPA,

Respondent.

18IWCC0496

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, 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 February 7, 2018, 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.

18IWCC0496

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

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

DATED: AUG 8 - 2018
o080218
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

BENNETT, CAROL
Employee/Petitioner

Case# **16WC023770**

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY
Employer/Respondent

18IWCC0496

On 2/7/2018, 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 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1157 DELANO LAW OFFICES LLC
PATRICK JAMES SMITH
1 S E OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

4993 ASSISTANT ATTORNEY GENERAL
CHELSEA GRUBB
500 S SECOND ST
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
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2101 S VETERANS PARKWAY
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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

FEB 7 - 2018

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

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CAROL BENNETT,
Employee/Petitioner

v.

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY,
Employer/Respondent

Case # **16** WC **23770**

Consolidated cases: _____

18IWCC0496

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/17/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. [x] 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, **12/10/14**, 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 **$55,764.00**; the average weekly wage was **$1,072.38**.

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 all reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 related to the arthroscopic evaluation of petitioner's shoulder recommended by Dr. Herrin.

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

2/5/18
Date

ICArbDec19(b)

FEB 7 - 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 58 year old Office Administrator II, alleges she sustained an accidental injury to her right shoulder, that arose out of and in the course of his employment by respondent on 12/10/14.

On 12/10/14 one of petitioner's duties was moving files from one 5 foot filing cabinet to another. The weight of each file was 3-5 pounds. While petitioner was holding the folder and turning from the cabinet in front of her to the cabinet in back of her she felt a sharp pain through her right shoulder. Petitioner stopped right away, and went back and sat at her desk and put ice on her right shoulder. Petitioner reported the incident to her supervisor and completed an accident report. She provided a consistent history of the accident.

On 1/26/15 petitioner first presented for treatment to Dr. Rodney Herrin at Orthopedic Center of Illinois. Petitioner testified that she waited to seek treatment because she thought her right shoulder would get better. When it did not, she sought treatment from Dr. Herrin. Petitioner gave a history of injuring her right shoulder in December while pulling files out of a filing cabinet and placing them behind her. She reported prior problems that included surgery to her cervical spine. Dr. Herrin examined petitioner and reviewed some x-rays. He assessed pain in the right shoulder. He was of the opinion that some of petitioner's symptoms appeared to be related to the posterior joint, with a possible injury to the posterior labrum, possible injury to the scapular stabilizers, and some myofascial type symptoms. He felt it was less likely that she had a rotator cuff injury based on her symptoms. Dr. Herrin recommended some physical therapy. Petitioner underwent physical therapy at Carlinville Hospital through 5/13/15.

On 5/4/15 petitioner returned to Dr. Herrin. She reported that she did not notice much improvement with physical therapy. She continued to complain of pain more along the posterior aspect of the right shoulder. Dr. Herrin performed a corticosteroid injection into the right shoulder. Dr. Herrin was of the opinion that petitioner's problems with her right shoulder appeared to be more related to an injury to the posterior labrum. An MR arthrogram was ordered.

On 10/7/15 petitioner returned to Dr. Herrin and reported that her right shoulder still remained bothersome. She reported significant temporary improvement from the previous injection. She also reported that her pain was primarily in the posterior portion of the right shoulder. Dr. Herrin's assessments included work related injury, impingement syndrome of the right shoulder, injury caused by pulling, rotator cuff tendonitis, and right shoulder pain. Dr. Herrin noted that the fact that the injection provided her relief lead him to believe that petitioner could have a problem with the posterior labrum. He ordered an MR arthrogram of the right shoulder.

On 1/29/16 the petitioner underwent an MR arthrography of the right shoulder that showed no evidence of a rotator cuff tear; medial attachment of the anterior joint capsule in the glenoid of the scapula which could indicate anterior capsular stripping; some distal extension of contrast along the fascial planes in the proximal forearm from the tendon sheath of the tendon of the long head of the biceps which could be due to microperforation of the tendon sheath due to overdistention or could indicate and incompetent transverse ligament; no definite slap tear; and subcortical cysts or small Hill-Sachs lesion posterior to the lateral aspect humeral head neck junction.

On 3/8/16 petitioner followed-up with Dr. Herrin after undergoing the MR arthrogram. He noted that the MR arthrogram of the right shoulder showed no evidence of rotator cuff tear; no tendonitis or tear; no signs of impingement; normal superior, posterior and inferior labrum; and a full thickness tear of the anterior labrum, or some labral foramen. He assessed impingement syndrome of the right shoulder, right rotator cuff tendonitis, and right shoulder pain. Dr. Herrin noted that petitioner continued to have problems with the right shoulder primarily along the posterior aspect of the shoulder. He noted that the MR arthrogram did not note a labral tear. Dr. Herrin wanted the radiologist to further evaluate the posterior labrum on the MR arthrogram.

On 7/25/16 petitioner returned to Dr. Herrin. Petitioner reported that she was still having difficulties with the right shoulder and the pain was primarily along the posterior aspect. Dr. Herrin performed a repeat injection. He was of the opinion that petitioner's pain may in part be related to an intra-articular problem such as a posterior labral tear, although her MR arthrogram did not necessarily show that.

On 8/31/16 petitioner followed-up with Dr. Herrin. She again noted improvement after the injection, and stated that it was still giving her some benefit. The position of her pain complaints remained the same. Dr. Herrin was of the opinion that it appeared most likely that petitioner had an intra-articular problem such as possibly a posterior labral injury to the chondral surface of the posterior aspect of the glenoid or humeral head. He was of the opinion that the MR arthrogram could have been a false negative.

On 10/17/16 petitioner returned to Dr. Herrin. Her complaints remained the same. Petitioner reported that when she reaches forward she notes pain in the posterior shoulder. Dr. Herrin was of the opinion that one consideration would be a posterior labral injury versus a chondral injury to the posterior aspect of the right shoulder. Dr. Herrin recommended that they proceed with an examination of the right shoulder under anesthesia followed by arthroscopic evaluation if she does have a labral pathology that would be addressed as indicated, including either repair or debridement.

On 4/26/17 petitioner underwent a Section 12 examination performed by Dr. Michael Nogalski at the request of the respondent. Petitioner provided a consistent history of the accident on 12/10/14 and treatment to date. Petitioner reported immediate pain in her right shoulder at that the time of the accident. She reported that she still has pain and soreness in the right shoulder, difficulty lying on the shoulder, inability to mow her yard easily due to pain on the top of the shoulder, and radiating pain that goes down her arm and up in the trapezial area. She noted that most of her pain was in the back of the shoulder, with additional pains around the front and top of the shoulder. She gave a history of cervical surgery performed by Dr. Freitag.

Following an examination and record review, that included no records prior to the date of injury, Dr. Nogalski was of the opinion that petitioner had undergone a previous cervical decompression, and more likely than not some form of anterior glenohumeral dislocation. His diagnosis was a possible old glenohumeral dislocation with solid shoulder stability findings, and possible chondromalacia and/or glenoid labral tear of the posterior shoulder that probably contributes to the superior shoulder pain due to cervical radiculopathy. Dr. Nagolski was of the opinion that there is no causal connection between petitioner's current objective findings and her reported accident. He believed she reasonably had some chondromalacia or abnormalities in the shoulder that pre-date the claimed event that had been established over time and made symptomatic during her handling of the files, but he did not believe she had specific documentation of an objective injury to the shoulder relative to the claimed 12/10/14 injury. He was of the opinion that medical treatment to date was reasonable and necessary with respect to her subjective complaints, and additional medical treatment could be considered. He was also of the opinion that it was reasonable to consider an arthroscopy and possible glenoid labral debridement since petitioner could possibly have an anterior glenoid labral complex issue and this may well be the cause of her symptoms. He did not believe petitioner had specific shoulder instability as a result of her claimed injury, nor did she have a specific need for surgery relative to her claimed 12/10/14 event. His prognosis of petitioner was somewhat guarded because her symptoms appeared to be somewhat out of proportion to his objective findings. Dr. Noglaski was of the opinion that petitioner had reached MMI with respect to her claimed accident.

On 7/10/17 petitioner returned to Dr. Herrin with complaints of continued posterior shoulder pain. He again discussed the option of an arthroscopic evaluation of the right shoulder. Dr. Herrin performed a third corticosteroid injection into petitioner's right shoulder.

On 8/17/17 petitioner last followed-up with Dr. Herrin. She again noted some improvement from the previous injection. However, she continued to complain of posterior right shoulder pain. Petitioner

also noted that she was having problems with her cervical spine and was going to see Dr. Graves for that. Dr. Herrin again discussed the arthroscopic evaluation, and noted that there was a chance he may not determine any specific etiology of petitioner's pain.

On 9/19/17 Dr. Herrin drafted a letter to petitioner's attorney in response to his specific questions. Dr. Herrin noted that petitioner denied any prior surgery to her right shoulder. Dr. Herrin was of the opinion that petitioner injured her right shoulder and has had continued posterior shoulder pain. He also noted that she appeared to have an intraarticular problem of the shoulder based on the fact that she does get temporary improvement from the intraarticular injections. He thought it could be a posterior labral problem or an injury to the articular surface of the posterior aspect of the glenohumeral joint. He was of the opinion that petitioner's cervical spine problem appeared to be a separate issue from her right shoulder. Based on petitioner's failed conservative measures, and the fact that it appears petitioner has an intraarticular problem, Dr. Herrin was of the opinion that the best option is an arthroscopic evaluation of the right shoulder. He noted that he was waiting for approval.

Dr. Herrin also noted that he reviewed Dr. Nogalski's Section 12 examination. He noted that even Dr. Nogalski was of the opinion that it would reasonable to consider an arthrosocopy and possible glenoid labral debridement. He disagreed with Dr. Noglaski's finding that there is no causal relationship between the need for surgery and petitioner's claimed injury. His problem with Dr. Noglaski's opinion was that if petitioner was asymptomatic regarding her right shoulder before the injury and symptomatic after the injury, he believes her condition is related to the injury. Dr. Herrin related the need for surgery to either causing, or aggravating a problem with petitioner's posterior aspect of the genohumeral joint.

Respondent offered into evidence records of Dr. Beth Bergman, petitioner's plastic surgeon. Petitioner presented to Dr. Bergman approximately 7 times before 12/10/14. On 9/20/12 Dr. Bergman noted a history of adhesive capsulitis of the right shoulder. No other history of any right shoulder problems were identified in Dr. Bergman's Patient History Reports prior to 12/10/14.

Petitioner denied that she had problems with her right shoulder before 12/10/14 like she had after the injury and still has today. Petitioner testified that she wants to undergo the surgery Dr. Herrin is recommending. Petitioner admitted that she had surgery to her neck years ago, and still has pain in her neck that his unrelated to the pain in her right shoulder she has had since the injury on 12/10/14. Petitioner testified that her neck surgery was before she started treating with Dr. Bergman in 2012.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges she sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 12/10/14. Petitioner provided unrebutted testimony that on 12/10/14, while she was holding a 3-5 pound file folder and turned from the cabinet in front of her to the cabinet in back of her, she felt a sharp pain through her right shoulder. Following the injury petitioner reported the incident to her supervisor and completed an accident report. Respondent offered no evidence to rebut petitioner's claim. For this reason, the arbitrator finds the petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 12/10/14.

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

Petitioner alleges her current condition of ill-being, as it relates to her right shoulder, is causally related to the injury she sustained on 12/10/14. Petitioner testified that although she had some right shoulder symptoms prior to the injury on 12/10/14, her symptomatology after the injury on 12/10/14 was far worse than any prior right shoulder problems she had.

With respect to petitioner's prior right shoulder problems, the only evidence offered was one reference in Dr. Bergman's records. Although petitioner sought treatment with Dr. Bergman, a plastic surgeon, for an unrelated condition, the only reference to specific right shoulder problems identified in Dr. Bergman's Patient History Reports was a reference made on 9/20/12 to a history of adhesive capsulitis of the right shoulder. Dr. Bergman provided petitioner no treatment for her right shoulder, and no credible medical records were offered into evidence that would support a finding that petitioner had any treatment to her right shoulder between 9/21/12 and 12/10/14.

Following the injury on 12/10/14 petitioner had hoped her right shoulder would improve on its own. When it did not, petitioner began treating with Dr. Herrin on 1/26/15. Beginning that day, and throughout her treatment with Dr. Herrin on 9/19/17, Dr. Herrin noted that petitioner continued to complain of pain primarily in the posterior portion of the right shoulder. Dr. Herrin was of the opinion that it appeared most likely that petitioner had an intra-articular problem such as a possible labral injury to the chondral surface of the posterior aspect of the glenoid or humeral head. Dr. Herrin based this opinion on her complaints and relief with intra-articular injections.

Dr. Herrin opined that if petitioner was asymptomatic regarding her right shoulder before the injury and symptomatic after the injury, he believes her current right shoulder condition is related to the injury. He further opined that her cervical spine problem appeared to be a separate issue from her shoulder.

Petitioner testified that she had undergone surgery to her cervical spine in 2012, prior to seeing Dr. Bergman.

Respondent had petitioner examined by Dr. Nogalski. Dr. Noglaski examined petitioner, and performed a record review that only included medical records after 12/10/14. Dr. Noglaski made no mention of reviewing any medical records related to petitioner's cervical spine surgery or any prior right shoulder symptomatology. Despite not having reviewed any prior records related to petitioner's cervical spine or right shoulder, Dr. Nogalski opined that there is no causal connection between petitioner's current condition of ill-being as it relates to her right shoulder, despite the fact that he believed she had some chondromalacia or abnormalities in the right shoulder that pre-dated the claimed event that had been established over time and made symptomatic during her handling of the files. The arbitrator finds this opinion would show that petitioner's right shoulder condition was either aggravated, accelerated or exacerbated by the injury on 12/10/14. Dr. Nagolski was also of the opinion that there is no causal connection between her right shoulder and the injury on 12/10/14 because he did not believe she had specific documentation of an objective injury, despite the fact that she reported the injury on the date it occurred, the fact that she completed an accident report the day it occurred, and the fact that her condition has remained constant since that date of the injury.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Herrin more persuasive than those of Dr. Nogalski, and finds petitioner's current condition of ill-being as it relates to her right shoulder, causally related to the injury on 12/10/14. The arbitrator further finds the opinions of Dr. Nogalski to be speculative at best, and not based on any credible medical evidence that was offered into evidence.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found petitioner sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 12/10/14, and her current condition of ill-being as it relates to her right shoulder is causally related to the injury on 12/10/14, the arbitrator finds the petitioner is entitled the prospective medical care recommended by Dr. Herrin in the form of an arthroscopic evaluation of her right shoulder.

The arbitrator bases this finding on the fact that not only does Dr Herrin find this surgery reasonable and necessary, but Dr. Noglaski was also of the opinion that an arthroscopy and possible glenoid labral debridement would be reasonable and necessary.

The arbitrator finds the respondent shall pay all reasonable and necessary medical expenses pursuant to Sections 8(a) and 8.2 related to the arthroscopic evaluation of petitioner's right shoulder recommended by Dr. Herrin.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

- ☐ 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

STATE OF ILLINOIS – ILLINOIS WORKERS' COMPENSATION COMMISSION,
Petitioner,

18IWCC0497

vs. No: 15 INC 198

MICHAEL HANFELDER, INDIVIDUALLY
& D/B/A HANFELDER TREE SERVICE,
Respondents

DECISION AND OPINION ON PETITION FOR
FINES FOR INSURANCE NON-COMPLAINCE

This matter comes before the Commission on the Commission's Motion for Imposition of Fines for Failure to Maintain Workers' Compensation Insurance. A hearing was held before Commissioner Simpson on July 11, 2018 in Collinsville. Petitioner was represented by the Office of the Attorney General. Neither Respondent nor counsel on behalf of Respondent appeared and the matter was heard *ex parte*.

Michael Cummins testified he works as an investigator for the Insurance Compliance Division of the Workers' Compensation Commission. He began to investigate whether Respondent had workers' compensation insurance after an Application for Adjustment of Claim was filed in 2015 naming Respondent as his employer and the Injured Workers' Benefit Fund as an additional respondent.

Mr. Cummins identified a certified copy of a report from the National Council on Compensation Insurance which indicated Respondent currently did not have workers' compensation insurance. He also identified documents from the Illinois Department of Revenue, Illinois Department of Employment Security, and the United States Occupation Safety and Health Administration all verifying that Respondent had employees. In addition, in a conversation he had with Mr. Hanfelder, he did not dispute the fact that he had employees.

18IWCC0497

Mr. Cummins also testified that Mr. Hanfelder informed him that he acknowledged receipt of the Notice of Hearing and that he was hiring a lawyer. On September 12, 2016, Mr. Cummins received a call from attorney Joe Papa who indicated he represented Respondent and asked for a settlement offer. On March 1, 2018, he called Mr. Papa and informed him that the Office of the Attorney General was ready for trial and the review date was May 2, 2018. On that date, Mr. Cummins received a call from Mr. Papa's office asking that the review date be continued. It was continued to July 11, 2018, and Respondent was properly served with notice of the change of review date. That was the last time Mr. Cummins had contact with Respondent or a lawyer on Respondent's behalf. As noted above neither Respondent or a lawyer on Respondent's behalf appeared at the instant hearing.

Mr. Cummins noted that during his conduct of business, Respondent had workers' compensation insurance intermittently. He noted that Respondent did not have workers' compensation insurance coverage for a total of 2,095 days of operation. The statutory fine for non-compliance with the requirement to maintain workers' compensation insurance is $500.00 a day. Therefore, the statutory fine would be $1,047,500.00. The Commission notes that because Respondent occasionally had workers' compensation insurance, he was aware of the requirement to maintain such insurance and his non-compliance was intentional and willful. Accordingly, the Commission imposes the statutory fine of $1,047,500.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's request for fines for non-compliance with the requirement of maintaining workers' compensation insurance is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Michael Hanfelder, individually and doing business as Hanfelder Tree Service, pay to the Commission $1,047,500.00 for knowingly and intentionally failing to maintain workers' compensation insurance for 2,095 days, pursuant to §4(d) of the Act.

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

DATED: AUG 13 2018

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
R-7/11/18
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tanya Stiger,
Petitioner,

18IWCC0498

vs.

NO: 16 WC 24334

Chicago Park District,
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, permanent disability, 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 May 4, 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.

18IWCC0498

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:
o7/26/18
DLS/rm
046

AUG 13 2018

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the Decision of the majority. The Commission affirmed and adopted the Decision of the Arbitrator who found that Petitioner's current condition of ill-being of her right knee was causally related to a work accident and ordered Respondent to authorize and pay for prospective surgery recommended by Dr. Silver. I would have found that Petitioner did not sustain her burden of proving the alleged work-accident caused a current condition of ill-being of her right knee.

Petitioner is a seasonal laborer for Respondent. She alleges that on July 9, 2016 she suffered an injury to her right knee while either getting into or getting out of a pickup truck. Her accounts varied. She went to the Emergency Department at Mercy Hospital that day and complained of 7/10 pain. X-rays showed mild degenerative changes with suggestion of joint effusion. She was discharged with a knee immobilizer and prescriptions for Naproxen and Tramadol. Two days later she went to MercyWorks. Dr. Anderson noted that she reported 4/10 pain and he took her off work. Petitioner returned to Dr. Anderson on July 18th. She then reported her knee was better with "only occasional 2/10 level of pain." Dr. Anderson diagnosed resolving right-knee pain and recommended she continue to use the brace and Naproxen, as needed. He released her to work with no restrictions as of July 20th and noted she was to return on July 26th.

Petitioner returned to work at full duty on July 20, 2016. Apparently, she was able to perform her work activities without difficulty. She was laid off on July 25th, which was consistent with her seasonal employment. Instead of returning to Dr. Anderson on July 26th as instructed, on July 27th she presented to Dr. Silver, a doctor referred to her by her lawyer. He ordered an MRI which showed a small medial meniscal tear and intact lateral meniscus and

collateral and cruciate ligaments. Dr. Silver recommended arthroscopic surgery. Petitioner presented to Dr. Maday for an examination pursuant to Section 12 of the Act. He diagnosed right-knee medial-based pain, which may be caused by "meniscal pathology versus early degenerative changes" and that the injury temporarily exacerbated her underlying degenerative condition. He also noted that "the underlying degenerative condition may also be responsible for the meniscal pathology noted in the MRI." He was unsure of the etiology of Petitioner's subjective pain. It appears that Petitioner continued in her seasonable employment with Respondent in the seasons following the accident.

The record before us presents serious issues regarding Petitioner's credibility. Her histories of accident were inconsistent and instead of returning to her initial treater, she presented to a doctor referred to her by her lawyer two days after her seasonal lay off. I would have found that Petitioner suffered a temporary exacerbation of an underlying degenerative condition which effectively resolved as of July 20, 2016, when she was released to full duty after reporting only occasional 2/10 pain. I would have denied benefits after that date. Therefore, I respectfully dissent from the majority opinion.

RWW/dw
O-7/26/18

AUG 13 2018

Deborah L. Simpson
Deborah L. Simpson

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

STIGER, TANYA
Employee/Petitioner

Case# **16WC024334**

18IWCC0498

CHICAGO PARK DISTRICT
Employer/Respondent

On 5/4/2017, 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 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
10 S DEARBORN ST SUITE 500
CHICAGO, IL 60602

1946 CHICAGO PARK DIST LAW DEPT
LEON W PAWLYCOWYCZ
541 N FAIRBANKS CT 3RD FL
CHICAGO, IL 60611

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)

TANYA STIGER
Employee/Petitioner

v.

CHICAGO PARK DISTRICT
Employer/Respondent

Case # 16 WC 24334

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 **DOUGLAS S. STEFFENSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JANUARY 26, 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. ☒ 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 _____

18IWCC0498

FINDINGS

On the date of accident, **JULY 9, 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*** 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 $**39,499.20**; the average weekly wage was $**759.60**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**2,025.68** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**2,025.68**.

ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law*;

1) The Respondent shall pay the reasonable and necessary medical services, subject to all necessary adjustments pursuant to the Medical Fee Schedule, of $1,185.65 to MercyWorks, $787.00 to Northshore Orthopedics, $26,953.00 to Athletico Physical Therapy, $1,649.40 to Elmwood Park Same Day Surgery Center, and $3,728.64 to Workers' Compensation Rx Solutions, as provided in Section 8(a) and 8.2 of the Act;
2) The Arbitrator finds the Petitioner entitled to prospective medical care, namely the surgery prescribed by Dr. Silver. Further, all rehabilitation and medication needed to aid the Petitioner in her recovery from such surgery also is reasonable and necessary;
3) The Respondent shall pay the Petitioner TTD benefits at the applicable TTD rate, that being $506.40, for the period from July 11, 2016 through July 18, 2016, and from July 27, 2016 through January 26, 2017, less the stipulated Respondent's credit of $2,025.68.

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

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

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

Signature of Arbitrator

MAY 3, 2017
Date

ICArbDec19(b)

MAY 4 – 2017

TANYA STIGER v. CHICAGO PARK DISTRICT

16 WC 24334

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on January 26, 2017. The issues in dispute were accident, causal connection, medical bills, prospective medical care, and TTD. (*Arbitrator's Exhibit* 1). The case proceeded on the Petitioner's Section 19(b) Petition. (*Transcript* at 5). The parties did agree to the stenographic stipulation, requested a written decision pursuant to Section 19(b), and further agreed to receipt of this decision via e-mail. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

The Petitioner has worked for the Respondent as a seasonal laborer, pulling garbage, cleaning up beaches. (*Transcript* (hereinafter, *T.*) at 15). She has worked in this capacity for the Respondent for the past 15 years. (*T.* at 16). The Petitioner worked from Ohio Street to Montrose Avenue and would be transported to her work locations in a truck. (*T.* at 15). The Petitioner described the trucks as larger than a regular sedan that could seat two or four people. (*T.* at 16).

The Petitioner was working for the Respondent on July 9, 2016, performing her regular work duties, and riding in a truck. (*T.* at 16-17). The Petitioner testified that she attempted to get into a truck by lifting herself up and swinging into the truck when she was unsuccessful, came down and twisted her right knee. (*T.* at 17-18). She experienced immediate pain in her right knee and was unable to get back up into the truck. (*T.* at 18). Two co-workers were working with her on that day but she could not remember their names. (*T.* at 18). The Petitioner reported the accident to her foreman and a report was filed. (*T.* at 19). The incident report was completed on July 9, 2016 and details that the Petitioner was climbing into a truck, lifting herself and twisted her knee. (*Petitioner's Exhibit* 1).

The Petitioner sought treatment that same day at Mercy Hospital. (T. at 20). The intake records from Mercy Hospital indicate that the Petitioner complained of pain in her right knee from stepping up into her truck and twisting it. (*Petitioner's Exhibit* (hereinafter, *PX*) 3). The Petitioner was provided with an immobilizer and crutches. (*PX* 3). The Respondent then sent the Petitioner to MercyWorks on July 11, 2016. (*T.* at 21). The intake from MercyWorks on that

day indicates that the Petitioner injured her right knee when she twisted it while getting into a truck. (*PX* 4). The Petitioner was placed off work. (*PX* 4). The Petitioner followed up at MercyWorks on July 18, 2016, was continued in a brace and related to return to work. (*Id.).* The Petitioner testified that she continued to have pain and tenderness in her right knee. (*T.* at 23-24).

On July 27, 2016 the Petitioner sought a second opinion with Dr. Ronald Silver, an orthopedic surgeon. (*T.* at 24). Dr. Silver noted a history of the Petitioner "getting down" from her truck on July 9, 2016 and twisted her knee. (*PX* 5). He noted that she did not have a history of issue with her right knee, had a positive McMurray test and a limited range of motion. (*PX* 5). Dr. Silver recommended an MRI study and physical therapy. (*Id.).*

The Petitioner underwent physical therapy at Athletico Physical Therapy from August 1, 2016 through the January 26, 2017 hearing date. (*PX* 6). On August 4, 2016 the Petitioner underwent an MRI of her right knee that revealed a tear to the mid-body of her right meniscus. (*PX* 5). The Petitioner followed up with Dr. Silver on August 11, 2016 and surgery was recommended based upon the MRI findings. (*PX* 5). Dr. Silver further noted that that torn meniscus was due to the work injury of July 9, 2016. (*Id.).* The Petitioner continued to follow up with Dr. Silver on a monthly basis since that time and surgery continues to be recommended. (T. at 26 and PX 5).

On October 26, 2016 the Respondent sent the Petitioner for an Independent Medical Evaluation with Dr. Michael Maday at Midland Orthopedics. (T. at 26). Dr. Maday diagnosed the Petitioner with right knee medial based pain that may be due to meniscal pathology or underlying degeneration. (*Respondent's Exhibit* 1 at 2). Dr. Maday noted that there was a discrepancy between whether the Petitioner was stepping up or down from the truck, which he believes to be significant. (*Respondent's Exhibit* (hereinafter, *RX*) 1 at 2). Dr. Maday opined that there is some question as to the cause of her pain and whether the meniscal pathology is pre-existing. (*RX* 1 at 3). Dr. Maday recommended a steroid injection to the knee, the result of which would dictate whether surgery was warranted. (*RX* 1 at 3). He believed that the Petitioner did not require any further physical therapy. (*Id.*).

On November 18, 2016 Dr. Silver reviewed the IME report and drafted a report in response. (PX 5). Dr. Silver stated that a twisting injury is the most common cause of meniscal damage. (PX 5). He further disagreed with Dr. Maday's assessment that the meniscus tear could be degenerative. (*Id.*). Instead, he opined the MRI does not demonstrate any degenerative changes, nor do the x-rays. (*Id.*). Further, he noted the shape of the tear is in a single plane. (*Id.*). Dr. Silver noted that because the Petitioner was asymptomatic prior to the accident, an opinion that the condition is related to degeneration completely distorts the facts of the case. (*Id.*).

The Petitioner testified that, prior to July 9, 2016, she never had any issues with her right knee other than normal bumps and bruises and none of those incidents required medical care. (*T.* at 47-48). She never had any issues performing her full duty job prior to July 9, 2016, but has been unable to do so since. (T. at 27-28). She received partial benefits from the Respondent and her medical bills have not been paid. (T. at 28). The Petitioner indicated her desire to have the recommended surgery and her intention to return to work for the Respondent during the next season. (T. at 29).

CONCLUSIONS OF LAW

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

Issue C: ***Accident***

The Arbitrator finds that the Petitioner was injured in an accident that arose out of and in the course of her employment by the Respondent. To obtain compensation under the Act, a claimant must show by a preponderance of the evidence that he or she has suffered a disabling injury arising out of and in the course of his or her employment. Both elements must be present at the time of the claimant's injury in order to justify compensation. *IL Bell Telephone Co. v. Indust. Comm'n.*, 131 Ill.2d 478, 483 (1989). 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, are generally deemed to have been received "in the course" of the employment. *Caterpillar Tractor Co. v. Indust. Comm'n.*, 129 Ill.2d 52, 57 (1989). The "arising out of" component refers to the origin of 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. *Caterpillar Tractor v. Indust. Comm'n.*, 129 Ill.2d at 58.

The first prong of this legal inquiry is satisfied in the case at hand. The Petitioner was injured while performing her job duties for the Respondent and therefore her injury is "in the course" of her employment. The Respondent provides trucks for their workers in order to get them from location to location to perform their job duties. On July 9, 2016 the Petitioner was working for the Respondent and attempting to pull herself into one of the trucks when she twisted her knee. The fact that the Petitioner was performing work for the Respondent on that day establishes that the accident was "in the course" of her employment. This is further supported by the Petitioner's injury report and medical records.

The "arising out of" prong is also met in this case. As part of her job, the Petitioner was required to climb in and out of trucks. This is an activity that is unique and incidental to the Petitioner's employment and a risk that is created distinctly by her employment. As such, this prong also is satisfied.

Even if this risk is not deemed to be unique to the Petitioner's employment, it was still incidental to the Petitioner's employment by the Respondent. Courts have recognized three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. *Metropolitan Water Reclamation Dist. of Greater Chicago v. IWCC*, 407 Ill.App.3d 1010, 1014 (1st Dist. 2011). Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public. *Metropolitan Water Reclamation Dist. Of Greater Chicago v. IWCC*, 407 Ill.App.3d 1010. Such an increased risk may be qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public. *Id.* In this instance, the Petitioner was exposed to this risk more frequently than the general public. She was required to travel in these trucks in order to perform her work every day. Quantitatively she was exposed to the risk of having to climb into large vehicles more than the general public.

As such, the Arbitrator finds the Petitioner suffered an accident on July 9, 2016 that arose out of and in the course of her employment with the Respondent.

Issue F: ***Causal Connection***

The Arbitrator finds that the Petitioner current condition of ill-being is causally related to her work related accident. Petitioner's credible testimony in conjunction with her contemporaneous medical records establishes Petitioner's work for Respondent as the cause of her right knee condition. Further, proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. *Land and Lakes Co. v. Indust. Comm'n.*, 359 Ill.App.3d 582, 593 (2d Dist. 2005). This is known as the "chain of events" analysis. *Land and Lakes Co. v. Indust. Comm'n.*, 359 Ill.App.3d 582. The Petitioner's testimony and contemporaneous injury report establish conclusively that the Petitioner was injured on July 9, 2016. Since that date the Petitioner has been unable to work and has had the same complaints regarding her right knee. This demonstrates a causal connection between the Petitioner's present condition of ill-being and her July 9, 2016 work accident.

The Arbitrator also adopts Dr. Ronald Silver's medical opinion in regard to causation. Dr. Silver opined the Petitioner's right knee condition is causally related to the July 9, 2016 work accident. (*PX* 5). Further, Dr. Silver indicated a twisting injury is the most common mechanism of injury for meniscal pathology. (*PX* 5). All of the Petitioner's medical records and testimony indicate the Petitioner suffered a twisting injury on July 9, 2016. In contrast, Dr. Maday does not clearly opine as to a definitive cause of the Petitioner's present condition of ill-being. (RX 1).

As such, the Arbitrator finds a causal connection between the Petitioner's current condition of ill-being and her July 9, 2016 work accident.

Issue J: ***Medical Bills***

The Arbitrator finds that the Petitioner's medical care has been reasonable and necessary. As discussed above, the Petitioner's July 9, 2016 work accident resulted in a torn medial meniscus in the Petitioner's right knee. She has required doctor's visits, medication, physical therapy and diagnostic testing. This is a conservative based course of care that is reasonable, necessary, and causally related to the work accident. Furthermore, *Petitioner's Exhibit* 2 itemizes those medical bills incurred by the Petitioner for medical services to her right knee for this incident.

As such, the Arbitrator finds the Respondent liable for those unpaid medical bills listed in Petitioner's Exhibit 2, subject to all necessary adjustments pursuant to the Medical Fee Schedule under Section 8.2 of the Act.

Issue K: ***Prospective Medical***

The Petitioner has demonstrated by the preponderance of credible evidence that her right knee injury is causally related to her work injury. Currently, Dr. Silver is recommending surgical intervention for the Petitioner's right knee situation.

As such, the Arbitrator finds the Petitioner is entitled to prospective medical care in the form of a right knee arthroscopic procedure by Dr. Silver, along with all associated reasonable and necessary post-operative care. (*PX* 5).

Issue L: ***TTD***

The Arbitrator finds that the Petitioner is entitled to TTD benefits from July 11, 2016 through July 18, 2016 and from July 27, 2016 through the hearing date of January 26, 2017. The Petitioner was authorized off of work by MercyWorks for the initial period, and then taken off of work by Dr. Silver for the second period. Even if Dr. Maday's opinion as to the Petitioner's ability to perform light duty work were to be accepted, the Petitioner would still be entitled to TTD benefits under *Interstate Scaffolding v. Ill. Workers' Compensation Comm'n.*,

236 Ill. 2d 132 (2010), as she was laid off by the Respondent at that time and had not reached maximum medical improvement. (*T.* at 48).

Accordingly, the Petitioner is entitled to TTD benefits running from July 11, 2016 through July 18, 2016, and from July 27, 2016 through January 26, 2017.

Issue N: ***Respondent's Credit***

The parties stipulated the Respondent paid $2,025.68 in TTD benefits during the course of the present claim. (*AX* 1). As such, the Respondent is entitled to a credit in the amount of $2,025.68 against the TTD benefits awarded above.

Signature of Arbitrator

MAY 3, 2017
Date

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

MATTHEW JOHNSON,

Petitioner,

vs. NO: 16 WC 26553

STATE OF ILLINOIS,

18IWCC0499

Respondent.

DECISION AND OPINION OF REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission after considering the issues of accident, causal connection, medical expenses, temporary disability, and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

Petitioner was a 43 year old Correctional Officer for Respondent working in the pod of its segregation unit at Shawnee Correctional Center on July 19, 2016. Petitioner's injury occurred when he put a 70-pound dumbbell on the rack pinning his left index finger between the dumbbell and the rack while Petitioner was working out on his lunchbreak.

The accident occurred in a special area of the gym designated for staff that is separate from where the inmates work out. Petitioner testified that he is not permitted to leave Respondent's premises during his lunch break because he must be available to respond to emergencies. Respondent permits Petitioner to utilize the gym during his lunch break and he has done so for six years along with other staff. Employees on break are allowed to go in the Commissary, staff dining room, the gym, and an outdoor area.

Petitioner testified that he utilized the opportunity to work out in the gym on his lunch hour to stay fit so he could "handle himself" during inmate altercations. He acknowledged that the gym equipment was provided as a courtesy. He did not allege that there was any defect in the gym or the equipment. Petitioner sought medical attention and was diagnosed with a laceration of his left index fingernail, nail avulsion, contusion and a comminuted distal phalanx fracture.

18IWCC0499

Petitioner acknowledged in his testimony that he was not ordered, assigned, or otherwise directed to lift weights or work out. He stated that his participation in work out activities was voluntary and that Respondent offered no incentives to work out.

We disagree with the Arbitrator's determination that Petitioner sustained an accident that arose out of and in the course of his employment. Petitioner's participation in weight lifting activity was purely voluntary. The activity occurred during Petitioner's unpaid lunch hour. The Commission finds that Petitioner was engaged in a voluntary recreational activity as outlined in Section 11 of the Act.

Section 11- Voluntary Recreation states as follows:

> Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program. 820 ILCS 305/11.

As Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on July 19, 2016, Petitioner's claim is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 7, 2017 is hereby reversed, and Petitioner's claim is denied.

Pursuant to Section 19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

Stephen J. Mathis

DATED:
o-06/7/18
SM/msb
44

AUG 14 2018

Deborah L. Simpson

Deborah Simpson

DISSENT

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

David Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, MATTHEW
Employee/Petitioner

Case# **16WC026553**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0499

On 12/7/2017, 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 1.45% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

DEC 7 - 2017

Rachel A. Ramirez
RACHEL RAMIREZ, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0499

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Johnson
Employee/Petitioner

v.

State of Illinois / Shawnee Correctional Center
Employer/Respondent

Case # **16** WC **26553**

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 **November 14, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **July 19, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$60,513.76**; the average weekly wage was **$1,163.73**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

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 **$all amounts paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibits 1 and 7** 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. 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 the sum of **$698.24/week** for a further period of **12.9 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **30% loss of use of the left index finger.**

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

12/1/17

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Johnson
Employee/Petitioner

Case # **16** WC **26553**

v.

Consolidated cases: **N/A**

State of Illinois /
Shawnee Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the injury, Petitioner was a 43-year-old Correctional Officer for Respondent working in the pod of its segregation unit. Petitioner's injury occurred during his lunch break on July 19, 2016, when he put a 70-pound dumbbell on the rack and his left index finger was pinned between the dumbbell and the rack.

Petitioner testified that he is not permitted to leave Respondent's premises during his lunch break because he must be able to respond to emergencies. Petitioner testified that Respondent permits him to utilize the gym during his lunch break and that he has done so for over 6 years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. He testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. He testified the while the same facilities are available to inmates, there are separate work out times for staff and inmates.

Respondent`s representative at the time of arbitration, Major Terry Grissom, testified that he worked with Petitioner and stated that he was a good employee. Major Grissom testified that there was nothing incorrect about Petitioner's testimony and confirmed that there was no prohibition against weight lifting and that Respondent acquiesces to this activity.

Petitioner testified that despite the improvement from his surgery, his left index finger is always numb and that he is unable to feel objects he grasps. He also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the Emergency Department on July 19, 2016, at which time it was noted that he was injured at work and that he dropped a 70-pound dumbbell on his left index finger. It was noted that Petitioner had a 2 cm laceration with partial nail avulsion. Petitioner underwent x-rays of the left index which were interpreted as revealing comminuted

fracture of the distal phalanx. A splint was applied. Petitioner was instructed to follow up with Orthopedics. (PX3).

The medical records of Graham Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on July 22, 2016, at which time it was noted that he had sustained injury to the left index finger while at work. It was noted that Petitioner was putting away a dumbbell when it began to roll off the stand, that he went to catch the dumbbell and that it smashed his finger between the dumbbell and the stand frame. It was noted that Petitioner reported that his finger was still sore but tolerable. The assessment was noted to be that of fracture of phalanx of finger and left finger laceration. It was noted that Petitioner already had an appointment set up with Dr. Young's office. (PX4).

The medical records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 25, 2016 for left hand pain. It was noted that Petitioner presented with pain, decreased range of motion, fracture and swelling on the left side and that he stated that the symptoms had been acute, traumatic and began on July 19, 2016. It was noted that Petitioner stated that the symptoms began as the result of smashing his finger under a 70-pound weight. It was noted that Petitioner would be kept in his metal finger splint that was given to him in the Emergency Department and that he was to follow-up with Dr. Golz to have the sutures removed and for continuance of care in 4-8 days. It was noted that Petitioner was to remain off work until his follow-up with Dr. Golz. A work slip was issued on July 25, 2016, taking Petitioner off work until he was reevaluated. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on August 2, 2016, at which time it was noted that the pain was improving, that he denied any paresthesias and that he had been in a long AlumaFoam dorsal and volar splint since the time of his injury. It was noted that Petitioner had a few sutures that were present that were placed in the Emergency Department and that they were removed without difficulty. It was noted that Petitioner had tactile sensation present over both the radial and ulnar aspects of the index finger, that he maintained very good range of motion to the MCP as well as PIP joints and that the DIP was restricted. The assessment was noted to be that of left index finger distal phalanx fracture. Petitioner was placed in a Stax splint so that he could work on range of motion to the PIP and MCP joints. A work slip was issued on that date, allowing Petitioner to return to work on August 3, 2016 with restrictions of no lifting, pushing or pulling of the left upper extremity more than 5 pounds. At the time of the August 30, 2016 visit, it was noted that Petitioner was doing well, that he had been wearing his splint, that he had been light duty at work and that he did not have many complaints of pain and that it still felt a little stiff and swollen. It was noted that Petitioner still had some moderate soft tissue swelling of the distal phalanx of his left index finger and that he was developing a second-generation nail plate. It was noted that Petitioner was slightly restricted in end-range composite flexion at the DIP joint but it was certainly less than a fingerbreadth of composite flexion. It was noted that most problematic for Petitioner was the soft tissue wound on the ulnar aspect of his distal phalanx where he may have had a small neuroma which was quite tender to the touch, but the wound itself was well healed. It was noted that the scar was slightly hypertrophic. It was noted that Petitioner was aware that it could possibly go on to a nonunion but that Dr. Golz did not think it would be clinically significant. Petitioner was instructed to discontinue the splint except for with heavy activities and that he was to continue to be protective of the finger. Petitioner was released to full duty work as of August 31, 2016. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on November 2, 2016, at which time it was noted that he was at work full duty, that overall he was improving and that he was still concerned about the nail plate which was irregular. It was noted that Petitioner stated that he always had the numbness and tingling in the tip of his finger and that this caused him to have trouble with grip. It was noted that Petitioner had to alter how he shot on the range and that he

had trouble with fine tasks such as loading a fishing hook or picking up drywall nails. It was noted that Dr. Golz thought that Petitioner was progressing slowly but satisfactorily and that they talked about the generation of the nail plate. It was noted that Dr. Golz thought that the sensibility would continue to improve but that Petitioner was aware of the potential for permanent dysthesias in the digit. Petitioner was to continue with full unrestricted duties, soft tissue massage and range of motion exercises. It was noted that Petitioner did not feel that he was at a point of maximum medical improvement. At the time of the December 9, 2016 visit, it was noted that Petitioner stated that the left index finger had "popped and had pus coming out of it." It was noted that it felt better since it drained but that he continued to have some tenderness. It was noted that Petitioner had a piece of fingernail that was growing out of the side of the finger, which he felt was the culprit in the recent round of infection. Petitioner was started on antibiotics. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on December 21, 2016, at which time it was noted that the antibiotics that he was placed on cleared up the drainage as well as the erythema and that he was there to discuss excision of the nail fragment as well as ablation of the germinal matrix. It was noted that Petitioner had excellent range of motion and excellent strength, and that he had a small piece of fingernail protruding over the radial aspect of the finger. It was noted that a discussion was had regarding surgical excision of the nail and ablation of the germinal matrix and that Petitioner elected to proceed. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by a nurse on February 9, 2017, at which time it was noted that he was doing well and taking Tylenol for pain. At the time of the February 21, 2017 visit, it was noted that Petitioner stated that his pain was negligible and that he had some mild parethesias. Petitioner was to work on range of motion exercises and keeping his finger clean. A work slip was issued, indicating that Petitioner was off work from February 6, 2017 through February 13, 2017. At the time of the March 24, 2017 visit, it was noted that Petitioner stated that his finger was still very hypersensitive to any touch or bumping it but that he was pleased with the motion. It was noted that Petitioner had concerns about what his nail bed would look like down the road. It was noted that Petitioner's wounds were healing well and that he had hypersensitivity to touch. It was noted that Petitioner's motion and strength were excellent and that his nail was slowly growing out. It was noted that it may take upwards of six months for the nail to be grown back out to full length and that the hypersensitivity to the finger if he worked on desensitization should improve over the next several months as well. It was also noted that Petitioner was not at maximum medical improvement due to the sensitivity of the finger. At the time of the July 18, 2017 visit, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Operative Report dated February 6, 2017 noted that Petitioner underwent partial resection of the left nail bed matrix and reconstruction of the lateral nail fold, left index finger, for a pre- and post-operative diagnosis of status post distal phalanx fracture with nail bed injury, left index finger. (PX6).

The list of Petitioner's Out-of-Pocket Expenses were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

The Arbitrator notes that Petitioner relies on the personal comfort doctrine when claiming that he sustained an accidental injury that arose out of and in the course of his employment with Respondent, while Respondent claims this case invokes the voluntary recreation provision of Section 11 of the Illinois Workers' Compensation Act.

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase 'arising out of the employment' refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. [Citations] The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). The personal comfort doctrine provides that an employee, "while engaged in the work of his or her employer, may do things that are necessary to his or her health or comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Company v. Industrial Commission*, 313 Ill. App.3d 347, 350, 732 N.E.2d 49, 52, 247, Ill. Dec. 333 (5th Dist. 2000). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" applies. *Eagle Discount*, N.E.2d at 496-97. Acts of "personal comfort," including engaging in sports activities, are "incidental to employment" and satisfy the "arising out of" requirement. *Id.* So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. *Id.* Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* N.E.2d at 497.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Id.* N.E.2d at 496. The Commission expressly held in the case of *Campbell v. Taylorville*, 13 I.W.C.C. 0574 (2013), *aff'd*, 2014 IL App (5th) 140010WC-U (R23 Order), that the doctrine set forth in *Eagle Discount*, although rendered prior to the Voluntary Recreation Amendment of § 11 of the Act, stands as law. In *Campbell*, the Commission acknowledged the aforementioned distinction while stipulating the purpose of § 11:

> The mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases as noted in Eagle Discount. . . Section 11 of the Act is intended to apply to situations where there are recreational programs such as employer sport teams or employer picnics where the employer may have organized or contributed to the formation of the teams or events. . . (Emphasis added). *Id.*

The Commission also relied on *Eagle Discount* following the Amendment of Section 11 in *Mary Hatfield v. Washington School Dist. # 50*, 00 I.I.C. 0896 (2001).

In *Eagle Discount*, the claimant was on lunch break without pay when he tripped and was injured on the employer's parking lot while playing Frisbee. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). Additionally, although the employees were not per se restricted to the employer's premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. *Id.* The manager would also turn on the parking lot lights so that the employees would have light in which to play. *Id.*

The employer argued that the claimant's injuries were non-compensable for four reasons: (1) The claimant's "parking lot" injury is non-compensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a non-compensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980). The Supreme Court rejected the employer's arguments.

The Court gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. *Id.* N.E.2d at 496. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* N.E.2d at 496-97. Consequently, the Supreme Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises, the claimant did not expose himself to an unnecessary or unreasonable risk and the employer acquiesced to the activity. *Id.*

The undisputed facts in this case show that Petitioner injured himself while engaged in an act of personal comfort which Respondent permitted. Petitioner testified that he utilizes the gym during his lunch break and that he has done so for over six years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. Petitioner testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. Major Grissom confirmed that there is no prohibition against weight lifting and that Respondent acquiesces to this activity. The Arbitrator finds that Respondent benefits when its Correctional Officers are in shape and are able to handle inmate altercations and emergencies. Based upon the aforementioned law, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident, as he was injured during an act of personal comfort that was incidental to his employment. As a result thereof, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the work accident of July 19, 2016.

The uncontroverted evidence shows that Petitioner's condition of ill-being was caused by a traumatic incident in which his left index finger was crushed by a 70-pound dumbbell. (PX3). The records reflect that Petitioner had an immediate onset of pain and was diagnosed with a comminuted fracture of his left index finger. (PX3). Respondent offered no evidence to rebut this chain of events. While some medical

records mistakenly referenced Petitioner's right index finger, errors in the medical records are not a basis for denial of compensation, as inconsistency and error is inherent in the history taking process. *Blommaert*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011)), *aff'd* by *Farris v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54, *reh'g* denied (Nov. 26, 2014). Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being in his left index finger is casually related to the work accident of July 19, 2016.

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 July 19, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 1 and 7, 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 July 20, 2016 through July 25, 2016. (AX1).

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that he did not work and was unable to work during the timeframe of July 20, 2016 through July 25, 2016, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for this timeframe. In so concluding, the Arbitrator notes that no off work slips covering the timeframe of July 20, 2016 through July 25, 2016 were entered into evidence at the time of arbitration, and as a result thereof the Arbitrator finds that Petitioner has failed to that he was temporarily and totally disabled for that particular period.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed by Respondent. The Arbitrator finds that the nature and demands of his position will likely have some effect on his permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 43 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Golz, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and, as such, there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his left index finger is always numb and that he is unable to feel objects he grasps. Petitioner also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather. At his final office visit with Dr. Golz on July 18, 2017, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, were corroborated by his treating records at the conclusion of his treatment with Dr. Golz. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left index finger as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, MATTHEW
Employee/Petitioner

Case# **16WC026553**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0499

On 12/7/2017, 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 1.45% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

DEC 7 - 2017

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

18IWCC0499

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

Matthew Johnson
Employee/Petitioner

v.

State of Illinois / Shawnee Correctional Center
Employer/Respondent

Case # **16** WC **26553**

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 **November 14, 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 **July 19, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$60,513.76**; the average weekly wage was **$1,163.73**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

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 **$all amounts paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibits 1 and 7** 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. 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 the sum of **$698.24/week** for a further period of **12.9 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **30% loss of use of the left index finger.**

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. Pope-Sullivan

Signature of Arbitrator

12/1/17

Date

DEC 7 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Johnson
Employee/Petitioner

Case # **16** WC **26553**

v.

Consolidated cases: **N/A**

State of Illinois /
Shawnee Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the injury, Petitioner was a 43-year-old Correctional Officer for Respondent working in the pod of its segregation unit. Petitioner's injury occurred during his lunch break on July 19, 2016, when he put a 70-pound dumbbell on the rack and his left index finger was pinned between the dumbbell and the rack.

Petitioner testified that he is not permitted to leave Respondent's premises during his lunch break because he must be able to respond to emergencies. Petitioner testified that Respondent permits him to utilize the gym during his lunch break and that he has done so for over 6 years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. He testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. He testified the while the same facilities are available to inmates, there are separate work out times for staff and inmates.

Respondent's representative at the time of arbitration, Major Terry Grissom, testified that he worked with Petitioner and stated that he was a good employee. Major Grissom testified that there was nothing incorrect about Petitioner's testimony and confirmed that there was no prohibition against weight lifting and that Respondent acquiesces to this activity.

Petitioner testified that despite the improvement from his surgery, his left index finger is always numb and that he is unable to feel objects he grasps. He also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the Emergency Department on July 19, 2016, at which time it was noted that he was injured at work and that he dropped a 70-pound dumbbell on his left index finger. It was noted that Petitioner had a 2 cm laceration with partial nail avulsion. Petitioner underwent x-rays of the left index which were interpreted as revealing comminuted

fracture of the distal phalanx. A splint was applied. Petitioner was instructed to follow up with Orthopedics. (PX3).

The medical records of Graham Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on July 22, 2016, at which time it was noted that he had sustained injury to the left index finger while at work. It was noted that Petitioner was putting away a dumbbell when it began to roll off the stand, that he went to catch the dumbbell and that it smashed his finger between the dumbbell and the stand frame. It was noted that Petitioner reported that his finger was still sore but tolerable. The assessment was noted to be that of fracture of phalanx of finger and left finger laceration. It was noted that Petitioner already had an appointment set up with Dr. Young's office. (PX4).

The medical records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 25, 2016 for left hand pain. It was noted that Petitioner presented with pain, decreased range of motion, fracture and swelling on the left side and that he stated that the symptoms had been acute, traumatic and began on July 19, 2016. It was noted that Petitioner stated that the symptoms began as the result of smashing his finger under a 70-pound weight. It was noted that Petitioner would be kept in his metal finger splint that was given to him in the Emergency Department and that he was to follow-up with Dr. Golz to have the sutures removed and for continuance of care in 4-8 days. It was noted that Petitioner was to remain off work until his follow-up with Dr. Golz. A work slip was issued on July 25, 2016, taking Petitioner off work until he was reevaluated. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on August 2, 2016, at which time it was noted that the pain was improving, that he denied any paresthesias and that he had been in a long AlumaFoam dorsal and volar splint since the time of his injury. It was noted that Petitioner had a few sutures that were present that were placed in the Emergency Department and that they were removed without difficulty. It was noted that Petitioner had tactile sensation present over both the radial and ulnar aspects of the index finger, that he maintained very good range of motion to the MCP as well as PIP joints and that the DIP was restricted. The assessment was noted to be that of left index finger distal phalanx fracture. Petitioner was placed in a Stax splint so that he could work on range of motion to the PIP and MCP joints. A work slip was issued on that date, allowing Petitioner to return to work on August 3, 2016 with restrictions of no lifting, pushing or pulling of the left upper extremity more than 5 pounds. At the time of the August 30, 2016 visit, it was noted that Petitioner was doing well, that he had been wearing his splint, that he had been light duty at work and that he did not have many complaints of pain and that it still felt a little stiff and swollen. It was noted that Petitioner still had some moderate soft tissue swelling of the distal phalanx of his left index finger and that he was developing a second-generation nail plate. It was noted that Petitioner was slightly restricted in end-range composite flexion at the DIP joint but it was certainly less than a fingerbreadth of composite flexion. It was noted that most problematic for Petitioner was the soft tissue wound on the ulnar aspect of his distal phalanx where he may have had a small neuroma which was quite tender to the touch, but the wound itself was well healed. It was noted that the scar was slightly hypertrophic. It was noted that Petitioner was aware that it could possibly go on to a nonunion but that Dr. Golz did not think it would be clinically significant. Petitioner was instructed to discontinue the splint except for with heavy activities and that he was to continue to be protective of the finger. Petitioner was released to full duty work as of August 31, 2016. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on November 2, 2016, at which time it was noted that he was at work full duty, that overall he was improving and that he was still concerned about the nail plate which was irregular. It was noted that Petitioner stated that he always had the numbness and tingling in the tip of his finger and that this caused him to have trouble with grip. It was noted that Petitioner had to alter how he shot on the range and that he

had trouble with fine tasks such as loading a fishing hook or picking up drywall nails. It was noted that Dr. Golz thought that Petitioner was progressing slowly but satisfactorily and that they talked about the generation of the nail plate. It was noted that Dr. Golz thought that the sensibility would continue to improve but that Petitioner was aware of the potential for permanent dysthesias in the digit. Petitioner was to continue with full unrestricted duties, soft tissue massage and range of motion exercises. It was noted that Petitioner did not feel that he was at a point of maximum medical improvement. At the time of the December 9, 2016 visit, it was noted that Petitioner stated that the left index finger had "popped and had pus coming out of it." It was noted that it felt better since it drained but that he continued to have some tenderness. It was noted that Petitioner had a piece of fingernail that was growing out of the side of the finger, which he felt was the culprit in the recent round of infection. Petitioner was started on antibiotics. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on December 21, 2016, at which time it was noted that the antibiotics that he was placed on cleared up the drainage as well as the erythema and that he was there to discuss excision of the nail fragment as well as ablation of the germinal matrix. It was noted that Petitioner had excellent range of motion and excellent strength, and that he had a small piece of fingernail protruding over the radial aspect of the finger. It was noted that a discussion was had regarding surgical excision of the nail and ablation of the germinal matrix and that Petitioner elected to proceed. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by a nurse on February 9, 2017, at which time it was noted that he was doing well and taking Tylenol for pain. At the time of the February 21, 2017 visit, it was noted that Petitioner stated that his pain was negligible and that he had some mild parethesias. Petitioner was to work on range of motion exercises and keeping his finger clean. A work slip was issued, indicating that Petitioner was off work from February 6, 2017 through February 13, 2017. At the time of the March 24, 2017 visit, it was noted that Petitioner stated that his finger was still very hypersensitive to any touch or bumping it but that he was pleased with the motion. It was noted that Petitioner had concerns about what his nail bed would look like down the road. It was noted that Petitioner's wounds were healing well and that he had hypersensitivity to touch. It was noted that Petitioner's motion and strength were excellent and that his nail was slowly growing out. It was noted that it may take upwards of six months for the nail to be grown back out to full length and that the hypersensitivity to the finger if he worked on desensitization should improve over the next several months as well. It was also noted that Petitioner was not at maximum medical improvement due to the sensitivity of the finger. At the time of the July 18, 2017 visit, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Operative Report dated February 6, 2017 noted that Petitioner underwent partial resection of the left nail bed matrix and reconstruction of the lateral nail fold, left index finger, for a pre- and post-operative diagnosis of status post distal phalanx fracture with nail bed injury, left index finger. (PX6).

The list of Petitioner's Out-of-Pocket Expenses were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

The Arbitrator notes that Petitioner relies on the personal comfort doctrine when claiming that he sustained an accidental injury that arose out of and in the course of his employment with Respondent, while Respondent claims this case invokes the voluntary recreation provision of Section 11 of the Illinois Workers' Compensation Act.

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase 'arising out of the employment' refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. [Citations] The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). The personal comfort doctrine provides that an employee, "while engaged in the work of his or her employer, may do things that are necessary to his or her health or comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Company v. Industrial Commission*, 313 Ill. App.3d 347, 350, 732 N.E.2d 49, 52, 247, Ill. Dec. 333 (5th Dist. 2000). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" applies. *Eagle Discount*, N.E.2d at 496-97. Acts of "personal comfort," including engaging in sports activities, are "incidental to employment" and satisfy the "arising out of" requirement. *Id.* So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. *Id.* Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* N.E.2d at 497.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Id.* N.E.2d at 496. The Commission expressly held in the case of *Campbell v. Taylorville*, 13 I.W.C.C. 0574 (2013), *aff'd*, 2014 IL App (5th) 140010WC-U (R23 Order), that the doctrine set forth in *Eagle Discount*, although rendered prior to the Voluntary Recreation Amendment of § 11 of the Act, stands as law. In *Campbell*, the Commission acknowledged the aforementioned distinction while stipulating the purpose of § 11:

> The mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases as noted in Eagle Discount. . . Section 11 of the Act is intended to apply to situations where there are recreational programs such as employer sport teams or employer picnics where the employer may have organized or contributed to the formation of the teams or events. . . (Emphasis added). *Id.*

The Commission also relied on *Eagle Discount* following the Amendment of Section 11 in *Mary Hatfield v. Washington School Dist. # 50*, 00 I.I.C. 0896 (2001).

In *Eagle Discount*, the claimant was on lunch break without pay when he tripped and was injured on the employer's parking lot while playing Frisbee. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). Additionally, although the employees were not per se restricted to the employer's premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. *Id.* The manager would also turn on the parking lot lights so that the employees would have light in which to play. *Id.*

The employer argued that the claimant's injuries were non-compensable for four reasons: (1) The claimant's "parking lot" injury is non-compensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a non-compensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980). The Supreme Court rejected the employer's arguments.

The Court gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. *Id.* N.E.2d at 496. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* N.E.2d at 496-97. Consequently, the Supreme Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises, the claimant did not expose himself to an unnecessary or unreasonable risk and the employer acquiesced to the activity. *Id.*

The undisputed facts in this case show that Petitioner injured himself while engaged in an act of personal comfort which Respondent permitted. Petitioner testified that he utilizes the gym during his lunch break and that he has done so for over six years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. Petitioner testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. Major Grissom confirmed that there is no prohibition against weight lifting and that Respondent acquiesces to this activity. The Arbitrator finds that Respondent benefits when its Correctional Officers are in shape and are able to handle inmate altercations and emergencies. Based upon the aforementioned law, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident, as he was injured during an act of personal comfort that was incidental to his employment. As a result thereof, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the work accident of July 19, 2016.

The uncontroverted evidence shows that Petitioner's condition of ill-being was caused by a traumatic incident in which his left index finger was crushed by a 70-pound dumbbell. (PX3). The records reflect that Petitioner had an immediate onset of pain and was diagnosed with a comminuted fracture of his left index finger. (PX3). Respondent offered no evidence to rebut this chain of events. While some medical

records mistakenly referenced Petitioner's right index finger, errors in the medical records are not a basis for denial of compensation, as inconsistency and error is inherent in the history taking process. *Blommaert*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011)), *aff'd* by *Farris v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54, *reh'g* denied (Nov. 26, 2014). Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being in his left index finger is casually related to the work accident of July 19, 2016.

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 July 19, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 1 and 7, 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 July 20, 2016 through July 25, 2016. (AX1).

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that he did not work and was unable to work during the timeframe of July 20, 2016 through July 25, 2016, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for this timeframe. In so concluding, the Arbitrator notes that no off work slips covering the timeframe of July 20, 2016 through July 25, 2016 were entered into evidence at the time of arbitration, and as a result thereof the Arbitrator finds that Petitioner has failed to that he was temporarily and totally disabled for that particular period.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed by Respondent. The Arbitrator finds that the nature and demands of his position will likely have some effect on his permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 43 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Golz, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and, as such, there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his left index finger is always numb and that he is unable to feel objects he grasps. Petitioner also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather. At his final office visit with Dr. Golz on July 18, 2017, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, were corroborated by his treating records at the conclusion of his treatment with Dr. Golz. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left index finger as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, MATTHEW
Employee/Petitioner

Case# **16WC026553**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0499

On 12/7/2017, 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 1.45% 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:

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

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

DEC 7 = 2017

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

18IWCC0499

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

Matthew Johnson
Employee/Petitioner

v.

State of Illinois / Shawnee Correctional Center
Employer/Respondent

Case # **16** WC **26553**

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 **November 14, 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 **July 19, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$60,513.76**; the average weekly wage was **$1,163.73**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

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 **$all amounts paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibits 1 and 7** 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. 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 the sum of **$698.24/week** for a further period of **12.9 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **30% loss of use of the left index finger.**

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. Grace-Sullivan

Signature of Arbitrator

12/1/17

Date

DEC 7 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Johnson
Employee/Petitioner

Case # **16** WC **26553**

v.

Consolidated cases: **N/A**

State of Illinois /
Shawnee Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the injury, Petitioner was a 43-year-old Correctional Officer for Respondent working in the pod of its segregation unit. Petitioner's injury occurred during his lunch break on July 19, 2016, when he put a 70-pound dumbbell on the rack and his left index finger was pinned between the dumbbell and the rack.

Petitioner testified that he is not permitted to leave Respondent's premises during his lunch break because he must be able to respond to emergencies. Petitioner testified that Respondent permits him to utilize the gym during his lunch break and that he has done so for over 6 years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. He testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. He testified the while the same facilities are available to inmates, there are separate work out times for staff and inmates.

Respondent's representative at the time of arbitration, Major Terry Grissom, testified that he worked with Petitioner and stated that he was a good employee. Major Grissom testified that there was nothing incorrect about Petitioner's testimony and confirmed that there was no prohibition against weight lifting and that Respondent acquiesces to this activity.

Petitioner testified that despite the improvement from his surgery, his left index finger is always numb and that he is unable to feel objects he grasps. He also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the Emergency Department on July 19, 2016, at which time it was noted that he was injured at work and that he dropped a 70-pound dumbbell on his left index finger. It was noted that Petitioner had a 2 cm laceration with partial nail avulsion. Petitioner underwent x-rays of the left index which were interpreted as revealing comminuted

fracture of the distal phalanx. A splint was applied. Petitioner was instructed to follow up with Orthopedics. (PX3).

The medical records of Graham Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on July 22, 2016, at which time it was noted that he had sustained injury to the left index finger while at work. It was noted that Petitioner was putting away a dumbbell when it began to roll off the stand, that he went to catch the dumbbell and that it smashed his finger between the dumbbell and the stand frame. It was noted that Petitioner reported that his finger was still sore but tolerable. The assessment was noted to be that of fracture of phalanx of finger and left finger laceration. It was noted that Petitioner already had an appointment set up with Dr. Young's office. (PX4).

The medical records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 25, 2016 for left hand pain. It was noted that Petitioner presented with pain, decreased range of motion, fracture and swelling on the left side and that he stated that the symptoms had been acute, traumatic and began on July 19, 2016. It was noted that Petitioner stated that the symptoms began as the result of smashing his finger under a 70-pound weight. It was noted that Petitioner would be kept in his metal finger splint that was given to him in the Emergency Department and that he was to follow-up with Dr. Golz to have the sutures removed and for continuance of care in 4-8 days. It was noted that Petitioner was to remain off work until his follow-up with Dr. Golz. A work slip was issued on July 25, 2016, taking Petitioner off work until he was reevaluated. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on August 2, 2016, at which time it was noted that the pain was improving, that he denied any paresthesias and that he had been in a long AlumaFoam dorsal and volar splint since the time of his injury. It was noted that Petitioner had a few sutures that were present that were placed in the Emergency Department and that they were removed without difficulty. It was noted that Petitioner had tactile sensation present over both the radial and ulnar aspects of the index finger, that he maintained very good range of motion to the MCP as well as PIP joints and that the DIP was restricted. The assessment was noted to be that of left index finger distal phalanx fracture. Petitioner was placed in a Stax splint so that he could work on range of motion to the PIP and MCP joints. A work slip was issued on that date, allowing Petitioner to return to work on August 3, 2016 with restrictions of no lifting, pushing or pulling of the left upper extremity more than 5 pounds. At the time of the August 30, 2016 visit, it was noted that Petitioner was doing well, that he had been wearing his splint, that he had been light duty at work and that he did not have many complaints of pain and that it still felt a little stiff and swollen. It was noted that Petitioner still had some moderate soft tissue swelling of the distal phalanx of his left index finger and that he was developing a second-generation nail plate. It was noted that Petitioner was slightly restricted in end-range composite flexion at the DIP joint but it was certainly less than a fingerbreadth of composite flexion. It was noted that most problematic for Petitioner was the soft tissue wound on the ulnar aspect of his distal phalanx where he may have had a small neuroma which was quite tender to the touch, but the wound itself was well healed. It was noted that the scar was slightly hypertrophic. It was noted that Petitioner was aware that it could possibly go on to a nonunion but that Dr. Golz did not think it would be clinically significant. Petitioner was instructed to discontinue the splint except for with heavy activities and that he was to continue to be protective of the finger. Petitioner was released to full duty work as of August 31, 2016. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on November 2, 2016, at which time it was noted that he was at work full duty, that overall he was improving and that he was still concerned about the nail plate which was irregular. It was noted that Petitioner stated that he always had the numbness and tingling in the tip of his finger and that this caused him to have trouble with grip. It was noted that Petitioner had to alter how he shot on the range and that he

had trouble with fine tasks such as loading a fishing hook or picking up drywall nails. It was noted that Dr. Golz thought that Petitioner was progressing slowly but satisfactorily and that they talked about the generation of the nail plate. It was noted that Dr. Golz thought that the sensibility would continue to improve but that Petitioner was aware of the potential for permanent dysthesias in the digit. Petitioner was to continue with full unrestricted duties, soft tissue massage and range of motion exercises. It was noted that Petitioner did not feel that he was at a point of maximum medical improvement. At the time of the December 9, 2016 visit, it was noted that Petitioner stated that the left index finger had "popped and had pus coming out of it." It was noted that it felt better since it drained but that he continued to have some tenderness. It was noted that Petitioner had a piece of fingernail that was growing out of the side of the finger, which he felt was the culprit in the recent round of infection. Petitioner was started on antibiotics. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on December 21, 2016, at which time it was noted that the antibiotics that he was placed on cleared up the drainage as well as the erythema and that he was there to discuss excision of the nail fragment as well as ablation of the germinal matrix. It was noted that Petitioner had excellent range of motion and excellent strength, and that he had a small piece of fingernail protruding over the radial aspect of the finger. It was noted that a discussion was had regarding surgical excision of the nail and ablation of the germinal matrix and that Petitioner elected to proceed. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by a nurse on February 9, 2017, at which time it was noted that he was doing well and taking Tylenol for pain. At the time of the February 21, 2017 visit, it was noted that Petitioner stated that his pain was negligible and that he had some mild parethesias. Petitioner was to work on range of motion exercises and keeping his finger clean. A work slip was issued, indicating that Petitioner was off work from February 6, 2017 through February 13, 2017. At the time of the March 24, 2017 visit, it was noted that Petitioner stated that his finger was still very hypersensitive to any touch or bumping it but that he was pleased with the motion. It was noted that Petitioner had concerns about what his nail bed would look like down the road. It was noted that Petitioner's wounds were healing well and that he had hypersensitivity to touch. It was noted that Petitioner's motion and strength were excellent and that his nail was slowly growing out. It was noted that it may take upwards of six months for the nail to be grown back out to full length and that the hypersensitivity to the finger if he worked on desensitization should improve over the next several months as well. It was also noted that Petitioner was not at maximum medical improvement due to the sensitivity of the finger. At the time of the July 18, 2017 visit, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Operative Report dated February 6, 2017 noted that Petitioner underwent partial resection of the left nail bed matrix and reconstruction of the lateral nail fold, left index finger, for a pre- and post-operative diagnosis of status post distal phalanx fracture with nail bed injury, left index finger. (PX6).

The list of Petitioner's Out-of-Pocket Expenses were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

The Arbitrator notes that Petitioner relies on the personal comfort doctrine when claiming that he sustained an accidental injury that arose out of and in the course of his employment with Respondent, while Respondent claims this case invokes the voluntary recreation provision of Section 11 of the Illinois Workers' Compensation Act.

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase 'arising out of the employment' refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. [Citations] The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). The personal comfort doctrine provides that an employee, "while engaged in the work of his or her employer, may do things that are necessary to his or her health or comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Company v. Industrial Commission*, 313 Ill. App.3d 347, 350, 732 N.E.2d 49, 52, 247, Ill. Dec. 333 (5th Dist. 2000). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" applies. *Eagle Discount*, N.E.2d at 496-97. Acts of "personal comfort," including engaging in sports activities, are "incidental to employment" and satisfy the "arising out of" requirement. *Id.* So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. *Id.* Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* N.E.2d at 497.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Id.* N.E.2d at 496. The Commission expressly held in the case of *Campbell v. Taylorville*, 13 I.W.C.C. 0574 (2013), *aff'd*, 2014 IL App (5th) 140010WC-U (R23 Order), that the doctrine set forth in *Eagle Discount*, although rendered prior to the Voluntary Recreation Amendment of § 11 of the Act, stands as law. In *Campbell*, the Commission acknowledged the aforementioned distinction while stipulating the purpose of § 11:

> The mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases as noted in Eagle Discount. . . Section 11 of the Act is intended to apply to situations where there are recreational programs such as employer sport teams or employer picnics where the employer may have organized or contributed to the formation of the teams or events. . . (Emphasis added). *Id.*

The Commission also relied on *Eagle Discount* following the Amendment of Section 11 in *Mary Hatfield v. Washington School Dist. # 50*, 00 I.I.C. 0896 (2001).

In *Eagle Discount*, the claimant was on lunch break without pay when he tripped and was injured on the employer's parking lot while playing Frisbee. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). Additionally, although the employees were not per se restricted to the employer's premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. *Id.* The manager would also turn on the parking lot lights so that the employees would have light in which to play. *Id.*

The employer argued that the claimant's injuries were non-compensable for four reasons: (1) The claimant's "parking lot" injury is non-compensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a non-compensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980). The Supreme Court rejected the employer's arguments.

The Court gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. *Id.* N.E.2d at 496. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* N.E.2d at 496-97. Consequently, the Supreme Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises, the claimant did not expose himself to an unnecessary or unreasonable risk and the employer acquiesced to the activity. *Id.*

The undisputed facts in this case show that Petitioner injured himself while engaged in an act of personal comfort which Respondent permitted. Petitioner testified that he utilizes the gym during his lunch break and that he has done so for over six years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. Petitioner testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. Major Grissom confirmed that there is no prohibition against weight lifting and that Respondent acquiesces to this activity. The Arbitrator finds that Respondent benefits when its Correctional Officers are in shape and are able to handle inmate altercations and emergencies. Based upon the aforementioned law, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident, as he was injured during an act of personal comfort that was incidental to his employment. As a result thereof, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the work accident of July 19, 2016.

The uncontroverted evidence shows that Petitioner's condition of ill-being was caused by a traumatic incident in which his left index finger was crushed by a 70-pound dumbbell. (PX3). The records reflect that Petitioner had an immediate onset of pain and was diagnosed with a comminuted fracture of his left index finger. (PX3). Respondent offered no evidence to rebut this chain of events. While some medical

records mistakenly referenced Petitioner's right index finger, errors in the medical records are not a basis for denial of compensation, as inconsistency and error is inherent in the history taking process. *Blommaeet*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011)), *aff'd* by *Farris v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54, *reh'g* denied (Nov. 26, 2014). Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being in his left index finger is casually related to the work accident of July 19, 2016.

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 July 19, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 1 and 7, 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 July 20, 2016 through July 25, 2016. (AX1).

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that he did not work and was unable to work during the timeframe of July 20, 2016 through July 25, 2016, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for this timeframe. In so concluding, the Arbitrator notes that no off work slips covering the timeframe of July 20, 2016 through July 25, 2016 were entered into evidence at the time of arbitration, and as a result thereof the Arbitrator finds that Petitioner has failed to that he was temporarily and totally disabled for that particular period.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed by Respondent. The Arbitrator finds that the nature and demands of his position will likely have some effect on his permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 43 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Golz, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and, as such, there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his left index finger is always numb and that he is unable to feel objects he grasps. Petitioner also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather. At his final office visit with Dr. Golz on July 18, 2017, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, were corroborated by his treating records at the conclusion of his treatment with Dr. Golz. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left index finger as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, MATTHEW
Employee/Petitioner

Case# **16WC026553**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0499

On 12/7/2017, 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 1.45% 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:

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
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FAIRVIEW HTS, IL 62208

0502 STATE EMPLOYEES RETIREMENT
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SPRINGFIELD, IL 62794-9208

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

DEC 7 - 2017

RONALD SARGIS, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0499

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

Matthew Johnson
Employee/Petitioner

v.

State of Illinois /
Shawnee Correctional Center
Employer/Respondent

Case # **16** WC **26553**

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 **November 14, 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 **July 19, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$60,513.76**; the average weekly wage was **$1,163.73**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

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 **$all amounts paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibits 1 and 7** 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. 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 the sum of **$698.24/week** for a further period of **12.9 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **30% loss of use of the left index finger.**

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

12/1/17

Date

DEC 7 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Johnson
Employee/Petitioner

Case # 16 WC 26553

v.

Consolidated cases: N/A

State of Illinois /
Shawnee Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the injury, Petitioner was a 43-year-old Correctional Officer for Respondent working in the pod of its segregation unit. Petitioner's injury occurred during his lunch break on July 19, 2016, when he put a 70-pound dumbbell on the rack and his left index finger was pinned between the dumbbell and the rack.

Petitioner testified that he is not permitted to leave Respondent's premises during his lunch break because he must be able to respond to emergencies. Petitioner testified that Respondent permits him to utilize the gym during his lunch break and that he has done so for over 6 years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. He testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. He testified the while the same facilities are available to inmates, there are separate work out times for staff and inmates.

Respondent's representative at the time of arbitration, Major Terry Grissom, testified that he worked with Petitioner and stated that he was a good employee. Major Grissom testified that there was nothing incorrect about Petitioner's testimony and confirmed that there was no prohibition against weight lifting and that Respondent acquiesces to this activity.

Petitioner testified that despite the improvement from his surgery, his left index finger is always numb and that he is unable to feel objects he grasps. He also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the Emergency Department on July 19, 2016, at which time it was noted that he was injured at work and that he dropped a 70-pound dumbbell on his left index finger. It was noted that Petitioner had a 2 cm laceration with partial nail avulsion. Petitioner underwent x-rays of the left index which were interpreted as revealing comminuted

fracture of the distal phalanx. A splint was applied. Petitioner was instructed to follow up with Orthopedics. (PX3).

The medical records of Graham Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on July 22, 2016, at which time it was noted that he had sustained injury to the left index finger while at work. It was noted that Petitioner was putting away a dumbbell when it began to roll off the stand, that he went to catch the dumbbell and that it smashed his finger between the dumbbell and the stand frame. It was noted that Petitioner reported that his finger was still sore but tolerable. The assessment was noted to be that of fracture of phalanx of finger and left finger laceration. It was noted that Petitioner already had an appointment set up with Dr. Young's office. (PX4).

The medical records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 25, 2016 for left hand pain. It was noted that Petitioner presented with pain, decreased range of motion, fracture and swelling on the left side and that he stated that the symptoms had been acute, traumatic and began on July 19, 2016. It was noted that Petitioner stated that the symptoms began as the result of smashing his finger under a 70-pound weight. It was noted that Petitioner would be kept in his metal finger splint that was given to him in the Emergency Department and that he was to follow-up with Dr. Golz to have the sutures removed and for continuance of care in 4-8 days. It was noted that Petitioner was to remain off work until his follow-up with Dr. Golz. A work slip was issued on July 25, 2016, taking Petitioner off work until he was reevaluated. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on August 2, 2016, at which time it was noted that the pain was improving, that he denied any paresthesias and that he had been in a long AlumaFoam dorsal and volar splint since the time of his injury. It was noted that Petitioner had a few sutures that were present that were placed in the Emergency Department and that they were removed without difficulty. It was noted that Petitioner had tactile sensation present over both the radial and ulnar aspects of the index finger, that he maintained very good range of motion to the MCP as well as PIP joints and that the DIP was restricted. The assessment was noted to be that of left index finger distal phalanx fracture. Petitioner was placed in a Stax splint so that he could work on range of motion to the PIP and MCP joints. A work slip was issued on that date, allowing Petitioner to return to work on August 3, 2016 with restrictions of no lifting, pushing or pulling of the left upper extremity more than 5 pounds. At the time of the August 30, 2016 visit, it was noted that Petitioner was doing well, that he had been wearing his splint, that he had been light duty at work and that he did not have many complaints of pain and that it still felt a little stiff and swollen. It was noted that Petitioner still had some moderate soft tissue swelling of the distal phalanx of his left index finger and that he was developing a second-generation nail plate. It was noted that Petitioner was slightly restricted in end-range composite flexion at the DIP joint but it was certainly less than a fingerbreadth of composite flexion. It was noted that most problematic for Petitioner was the soft tissue wound on the ulnar aspect of his distal phalanx where he may have had a small neuroma which was quite tender to the touch, but the wound itself was well healed. It was noted that the scar was slightly hypertrophic. It was noted that Petitioner was aware that it could possibly go on to a nonunion but that Dr. Golz did not think it would be clinically significant. Petitioner was instructed to discontinue the splint except for with heavy activities and that he was to continue to be protective of the finger. Petitioner was released to full duty work as of August 31, 2016. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on November 2, 2016, at which time it was noted that he was at work full duty, that overall he was improving and that he was still concerned about the nail plate which was irregular. It was noted that Petitioner stated that he always had the numbness and tingling in the tip of his finger and that this caused him to have trouble with grip. It was noted that Petitioner had to alter how he shot on the range and that he

had trouble with fine tasks such as loading a fishing hook or picking up drywall nails. It was noted that Dr. Golz thought that Petitioner was progressing slowly but satisfactorily and that they talked about the generation of the nail plate. It was noted that Dr. Golz thought that the sensibility would continue to improve but that Petitioner was aware of the potential for permanent dysthesias in the digit. Petitioner was to continue with full unrestricted duties, soft tissue massage and range of motion exercises. It was noted that Petitioner did not feel that he was at a point of maximum medical improvement. At the time of the December 9, 2016 visit, it was noted that Petitioner stated that the left index finger had "popped and had pus coming out of it." It was noted that it felt better since it drained but that he continued to have some tenderness. It was noted that Petitioner had a piece of fingernail that was growing out of the side of the finger, which he felt was the culprit in the recent round of infection. Petitioner was started on antibiotics. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on December 21, 2016, at which time it was noted that the antibiotics that he was placed on cleared up the drainage as well as the erythema and that he was there to discuss excision of the nail fragment as well as ablation of the germinal matrix. It was noted that Petitioner had excellent range of motion and excellent strength, and that he had a small piece of fingernail protruding over the radial aspect of the finger. It was noted that a discussion was had regarding surgical excision of the nail and ablation of the germinal matrix and that Petitioner elected to proceed. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by a nurse on February 9, 2017, at which time it was noted that he was doing well and taking Tylenol for pain. At the time of the February 21, 2017 visit, it was noted that Petitioner stated that his pain was negligible and that he had some mild parethesias. Petitioner was to work on range of motion exercises and keeping his finger clean. A work slip was issued, indicating that Petitioner was off work from February 6, 2017 through February 13, 2017. At the time of the March 24, 2017 visit, it was noted that Petitioner stated that his finger was still very hypersensitive to any touch or bumping it but that he was pleased with the motion. It was noted that Petitioner had concerns about what his nail bed would look like down the road. It was noted that Petitioner's wounds were healing well and that he had hypersensitivity to touch. It was noted that Petitioner's motion and strength were excellent and that his nail was slowly growing out. It was noted that it may take upwards of six months for the nail to be grown back out to full length and that the hypersensitivity to the finger if he worked on desensitization should improve over the next several months as well. It was also noted that Petitioner was not at maximum medical improvement due to the sensitivity of the finger. At the time of the July 18, 2017 visit, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Operative Report dated February 6, 2017 noted that Petitioner underwent partial resection of the left nail bed matrix and reconstruction of the lateral nail fold, left index finger, for a pre- and post-operative diagnosis of status post distal phalanx fracture with nail bed injury, left index finger. (PX6).

The list of Petitioner's Out-of-Pocket Expenses were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

The Arbitrator notes that Petitioner relies on the personal comfort doctrine when claiming that he sustained an accidental injury that arose out of and in the course of his employment with Respondent, while Respondent claims this case invokes the voluntary recreation provision of Section 11 of the Illinois Workers' Compensation Act.

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase 'arising out of the employment' refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. [Citations] The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). The personal comfort doctrine provides that an employee, "while engaged in the work of his or her employer, may do things that are necessary to his or her health or comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Company v. Industrial Commission*, 313 Ill. App.3d 347, 350, 732 N.E.2d 49, 52, 247, Ill. Dec. 333 (5th Dist. 2000). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" applies. *Eagle Discount*, N.E.2d at 496-97. Acts of "personal comfort," including engaging in sports activities, are "incidental to employment" and satisfy the "arising out of" requirement. *Id.* So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. *Id.* Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* N.E.2d at 497.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Id.* N.E.2d at 496. The Commission expressly held in the case of *Campbell v. Taylorville*, 13 I.W.C.C. 0574 (2013), *aff'd*, 2014 IL App (5th) 140010WC-U (R23 Order), that the doctrine set forth in *Eagle Discount*, although rendered prior to the Voluntary Recreation Amendment of § 11 of the Act, stands as law. In *Campbell*, the Commission acknowledged the aforementioned distinction while stipulating the purpose of § 11:

> The mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases as noted in Eagle Discount. . . Section 11 of the Act is intended to apply to situations where there are recreational programs such as employer sport teams or employer picnics where the employer may have organized or contributed to the formation of the teams or events. . . (Emphasis added). *Id.*

The Commission also relied on *Eagle Discount* following the Amendment of Section 11 in *Mary Hatfield v. Washington School Dist. # 50*, 00 I.I.C. 0896 (2001).

In *Eagle Discount*, the claimant was on lunch break without pay when he tripped and was injured on the employer's parking lot while playing Frisbee. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). Additionally, although the employees were not per se restricted to the employer's premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. *Id.* The manager would also turn on the parking lot lights so that the employees would have light in which to play. *Id.*

The employer argued that the claimant's injuries were non-compensable for four reasons: (1) The claimant's "parking lot" injury is non-compensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a non-compensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980). The Supreme Court rejected the employer's arguments.

The Court gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. *Id.* N.E.2d at 496. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* N.E.2d at 496-97. Consequently, the Supreme Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises, the claimant did not expose himself to an unnecessary or unreasonable risk and the employer acquiesced to the activity. *Id.*

The undisputed facts in this case show that Petitioner injured himself while engaged in an act of personal comfort which Respondent permitted. Petitioner testified that he utilizes the gym during his lunch break and that he has done so for over six years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. Petitioner testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. Major Grissom confirmed that there is no prohibition against weight lifting and that Respondent acquiesces to this activity. The Arbitrator finds that Respondent benefits when its Correctional Officers are in shape and are able to handle inmate altercations and emergencies. Based upon the aforementioned law, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident, as he was injured during an act of personal comfort that was incidental to his employment. As a result thereof, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the work accident of July 19, 2016.

The uncontroverted evidence shows that Petitioner's condition of ill-being was caused by a traumatic incident in which his left index finger was crushed by a 70-pound dumbbell. (PX3). The records reflect that Petitioner had an immediate onset of pain and was diagnosed with a comminuted fracture of his left index finger. (PX3). Respondent offered no evidence to rebut this chain of events. While some medical

records mistakenly referenced Petitioner's right index finger, errors in the medical records are not a basis for denial of compensation, as inconsistency and error is inherent in the history taking process. *Blommaert*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011)), *aff'd* by *Farris v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54, *reh'g* denied (Nov. 26, 2014). Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being in his left index finger is casually related to the work accident of July 19, 2016.

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 July 19, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 1 and 7, 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 July 20, 2016 through July 25, 2016. (AX1).

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that he did not work and was unable to work during the timeframe of July 20, 2016 through July 25, 2016, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for this timeframe. In so concluding, the Arbitrator notes that no off work slips covering the timeframe of July 20, 2016 through July 25, 2016 were entered into evidence at the time of arbitration, and as a result thereof the Arbitrator finds that Petitioner has failed to that he was temporarily and totally disabled for that particular period.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed by Respondent. The Arbitrator finds that the nature and demands of his position will likely have some effect on his permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 43 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Golz, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and, as such, there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his left index finger is always numb and that he is unable to feel objects he grasps. Petitioner also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather. At his final office visit with Dr. Golz on July 18, 2017, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, were corroborated by his treating records at the conclusion of his treatment with Dr. Golz. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left index finger as provided in Section 8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, MATTHEW
Employee/Petitioner

Case# **16WC026553**

SOI/SHAWNEE CORRECTIONAL CENTER
Employer/Respondent

18IWCC0499

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

DEC 7 - 2017

HAROLD GARCIA, Acting Secretary
Illinois Workers' Compensation Commission

18IWCC0499

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)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

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Employee/Petitioner

v.

State of Illinois /
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Case # **16** WC **26553**

Consolidated cases: **n/a**

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DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
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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 **July 19, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$60,513.76**; the average weekly wage was **$1,163.73**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

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 **$all amounts paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **as contained in Petitioner's Exhibits 1 and 7** 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. 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 the sum of **$698.24/week** for a further period of **12.9 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **30% loss of use of the left index finger.**

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. Pope-Sullivan

Signature of Arbitrator

12/1/17

Date

DEC 7 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Matthew Johnson
Employee/Petitioner

Case # **16** WC **26553**

v.

Consolidated cases: **N/A**

State of Illinois /
Shawnee Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the injury, Petitioner was a 43-year-old Correctional Officer for Respondent working in the pod of its segregation unit. Petitioner's injury occurred during his lunch break on July 19, 2016, when he put a 70-pound dumbbell on the rack and his left index finger was pinned between the dumbbell and the rack.

Petitioner testified that he is not permitted to leave Respondent's premises during his lunch break because he must be able to respond to emergencies. Petitioner testified that Respondent permits him to utilize the gym during his lunch break and that he has done so for over 6 years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. He testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. He testified the while the same facilities are available to inmates, there are separate work out times for staff and inmates.

Respondent's representative at the time of arbitration, Major Terry Grissom, testified that he worked with Petitioner and stated that he was a good employee. Major Grissom testified that there was nothing incorrect about Petitioner's testimony and confirmed that there was no prohibition against weight lifting and that Respondent acquiesces to this activity.

Petitioner testified that despite the improvement from his surgery, his left index finger is always numb and that he is unable to feel objects he grasps. He also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The Medical Records List was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the Emergency Department on July 19, 2016, at which time it was noted that he was injured at work and that he dropped a 70-pound dumbbell on his left index finger. It was noted that Petitioner had a 2 cm laceration with partial nail avulsion. Petitioner underwent x-rays of the left index which were interpreted as revealing comminuted

fracture of the distal phalanx. A splint was applied. Petitioner was instructed to follow up with Orthopedics. (PX3).

The medical records of Graham Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on July 22, 2016, at which time it was noted that he had sustained injury to the left index finger while at work. It was noted that Petitioner was putting away a dumbbell when it began to roll off the stand, that he went to catch the dumbbell and that it smashed his finger between the dumbbell and the stand frame. It was noted that Petitioner reported that his finger was still sore but tolerable. The assessment was noted to be that of fracture of phalanx of finger and left finger laceration. It was noted that Petitioner already had an appointment set up with Dr. Young's office. (PX4).

The medical records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on July 25, 2016 for left hand pain. It was noted that Petitioner presented with pain, decreased range of motion, fracture and swelling on the left side and that he stated that the symptoms had been acute, traumatic and began on July 19, 2016. It was noted that Petitioner stated that the symptoms began as the result of smashing his finger under a 70-pound weight. It was noted that Petitioner would be kept in his metal finger splint that was given to him in the Emergency Department and that he was to follow-up with Dr. Golz to have the sutures removed and for continuance of care in 4-8 days. It was noted that Petitioner was to remain off work until his follow-up with Dr. Golz. A work slip was issued on July 25, 2016, taking Petitioner off work until he was reevaluated. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on August 2, 2016, at which time it was noted that the pain was improving, that he denied any paresthesias and that he had been in a long AlumaFoam dorsal and volar splint since the time of his injury. It was noted that Petitioner had a few sutures that were present that were placed in the Emergency Department and that they were removed without difficulty. It was noted that Petitioner had tactile sensation present over both the radial and ulnar aspects of the index finger, that he maintained very good range of motion to the MCP as well as PIP joints and that the DIP was restricted. The assessment was noted to be that of left index finger distal phalanx fracture. Petitioner was placed in a Stax splint so that he could work on range of motion to the PIP and MCP joints. A work slip was issued on that date, allowing Petitioner to return to work on August 3, 2016 with restrictions of no lifting, pushing or pulling of the left upper extremity more than 5 pounds. At the time of the August 30, 2016 visit, it was noted that Petitioner was doing well, that he had been wearing his splint, that he had been light duty at work and that he did not have many complaints of pain and that it still felt a little stiff and swollen. It was noted that Petitioner still had some moderate soft tissue swelling of the distal phalanx of his left index finger and that he was developing a second-generation nail plate. It was noted that Petitioner was slightly restricted in end-range composite flexion at the DIP joint but it was certainly less than a fingerbreadth of composite flexion. It was noted that most problematic for Petitioner was the soft tissue wound on the ulnar aspect of his distal phalanx where he may have had a small neuroma which was quite tender to the touch, but the wound itself was well healed. It was noted that the scar was slightly hypertrophic. It was noted that Petitioner was aware that it could possibly go on to a nonunion but that Dr. Golz did not think it would be clinically significant. Petitioner was instructed to discontinue the splint except for with heavy activities and that he was to continue to be protective of the finger. Petitioner was released to full duty work as of August 31, 2016. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on November 2, 2016, at which time it was noted that he was at work full duty, that overall he was improving and that he was still concerned about the nail plate which was irregular. It was noted that Petitioner stated that he always had the numbness and tingling in the tip of his finger and that this caused him to have trouble with grip. It was noted that Petitioner had to alter how he shot on the range and that he

had trouble with fine tasks such as loading a fishing hook or picking up drywall nails. It was noted that Dr. Golz thought that Petitioner was progressing slowly but satisfactorily and that they talked about the generation of the nail plate. It was noted that Dr. Golz thought that the sensibility would continue to improve but that Petitioner was aware of the potential for permanent dysthesias in the digit. Petitioner was to continue with full unrestricted duties, soft tissue massage and range of motion exercises. It was noted that Petitioner did not feel that he was at a point of maximum medical improvement. At the time of the December 9, 2016 visit, it was noted that Petitioner stated that the left index finger had "popped and had pus coming out of it." It was noted that it felt better since it drained but that he continued to have some tenderness. It was noted that Petitioner had a piece of fingernail that was growing out of the side of the finger, which he felt was the culprit in the recent round of infection. Petitioner was started on antibiotics. (PX5)

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on December 21, 2016, at which time it was noted that the antibiotics that he was placed on cleared up the drainage as well as the erythema and that he was there to discuss excision of the nail fragment as well as ablation of the germinal matrix. It was noted that Petitioner had excellent range of motion and excellent strength, and that he had a small piece of fingernail protruding over the radial aspect of the finger. It was noted that a discussion was had regarding surgical excision of the nail and ablation of the germinal matrix and that Petitioner elected to proceed. (PX5).

The records of Dr. Robert Golz/Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen by a nurse on February 9, 2017, at which time it was noted that he was doing well and taking Tylenol for pain. At the time of the February 21, 2017 visit, it was noted that Petitioner stated that his pain was negligible and that he had some mild parethesias. Petitioner was to work on range of motion exercises and keeping his finger clean. A work slip was issued, indicating that Petitioner was off work from February 6, 2017 through February 13, 2017. At the time of the March 24, 2017 visit, it was noted that Petitioner stated that his finger was still very hypersensitive to any touch or bumping it but that he was pleased with the motion. It was noted that Petitioner had concerns about what his nail bed would look like down the road. It was noted that Petitioner's wounds were healing well and that he had hypersensitivity to touch. It was noted that Petitioner's motion and strength were excellent and that his nail was slowly growing out. It was noted that it may take upwards of six months for the nail to be grown back out to full length and that the hypersensitivity to the finger if he worked on desensitization should improve over the next several months as well. It was also noted that Petitioner was not at maximum medical improvement due to the sensitivity of the finger. At the time of the July 18, 2017 visit, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5).

The medical records of Southern Illinois Orthopedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Operative Report dated February 6, 2017 noted that Petitioner underwent partial resection of the left nail bed matrix and reconstruction of the lateral nail fold, left index finger, for a pre- and post-operative diagnosis of status post distal phalanx fracture with nail bed injury, left index finger. (PX6).

The list of Petitioner's Out-of-Pocket Expenses were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

The Arbitrator notes that Petitioner relies on the personal comfort doctrine when claiming that he sustained an accidental injury that arose out of and in the course of his employment with Respondent, while Respondent claims this case invokes the voluntary recreation provision of Section 11 of the Illinois Workers' Compensation Act.

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase 'arising out of the employment' refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. [Citations] The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). The personal comfort doctrine provides that an employee, "while engaged in the work of his or her employer, may do things that are necessary to his or her health or comfort, even though personal to himself or herself, and such acts will be considered incidental to the employment." *Illinois Consolidated Telephone Company v. Industrial Commission*, 313 Ill. App.3d 347, 350, 732 N.E.2d 49, 52, 247, Ill. Dec. 333 (5th Dist. 2000). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" applies. *Eagle Discount*, N.E.2d at 496-97. Acts of "personal comfort," including engaging in sports activities, are "incidental to employment" and satisfy the "arising out of" requirement. *Id.* So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. *Id.* Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* N.E.2d at 497.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Id.* N.E.2d at 496. The Commission expressly held in the case of *Campbell v. Taylorville*, 13 I.W.C.C. 0574 (2013), *aff'd*, 2014 IL App (5th) 140010WC-U (R23 Order), that the doctrine set forth in *Eagle Discount*, although rendered prior to the Voluntary Recreation Amendment of § 11 of the Act, stands as law. In *Campbell*, the Commission acknowledged the aforementioned distinction while stipulating the purpose of § 11:

> The mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases as noted in Eagle Discount. . . Section 11 of the Act is intended to apply to situations where there are recreational programs such as employer sport teams or employer picnics where the employer may have organized or contributed to the formation of the teams or events. . . (Emphasis added). *Id.*

The Commission also relied on *Eagle Discount* following the Amendment of Section 11 in *Mary Hatfield v. Washington School Dist. # 50*, 00 I.I.C. 0896 (2001).

In *Eagle Discount*, the claimant was on lunch break without pay when he tripped and was injured on the employer's parking lot while playing Frisbee. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). Additionally, although the employees were not per se restricted to the employer's premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. *Id.* The manager would also turn on the parking lot lights so that the employees would have light in which to play. *Id.*

The employer argued that the claimant's injuries were non-compensable for four reasons: (1) The claimant's "parking lot" injury is non-compensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a non-compensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980). The Supreme Court rejected the employer's arguments.

The Court gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. *Id.* N.E.2d at 496. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* N.E.2d at 496-97. Consequently, the Supreme Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises, the claimant did not expose himself to an unnecessary or unreasonable risk and the employer acquiesced to the activity. *Id.*

The undisputed facts in this case show that Petitioner injured himself while engaged in an act of personal comfort which Respondent permitted. Petitioner testified that he utilizes the gym during his lunch break and that he has done so for over six years along with other staff members in a special area of the gym designated for staff that is separate from where the inmates work out. Petitioner testified that he utilized this opportunity to stay fit so that he could "handle himself" during inmate altercations. Major Grissom confirmed that there is no prohibition against weight lifting and that Respondent acquiesces to this activity. The Arbitrator finds that Respondent benefits when its Correctional Officers are in shape and are able to handle inmate altercations and emergencies. Based upon the aforementioned law, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident, as he was injured during an act of personal comfort that was incidental to his employment. As a result thereof, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that the accident of July 19, 2016 arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the work accident of July 19, 2016.

The uncontroverted evidence shows that Petitioner's condition of ill-being was caused by a traumatic incident in which his left index finger was crushed by a 70-pound dumbbell. (PX3). The records reflect that Petitioner had an immediate onset of pain and was diagnosed with a comminuted fracture of his left index finger. (PX3). Respondent offered no evidence to rebut this chain of events. While some medical

records mistakenly referenced Petitioner's right index finger, errors in the medical records are not a basis for denial of compensation, as inconsistency and error is inherent in the history taking process. *Blommaeet*, 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities*, 11 I.W.C.C. 0610 (2011)), *aff'd* by *Farris v. Illinois Workers' Comp. Comm'n*, 2014 IL App (4th) 130767WC, 22 N.E.3d 54, *reh'g* denied (Nov. 26, 2014). Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner's current condition of ill-being in his left index finger is casually related to the work accident of July 19, 2016.

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 July 19, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 1 and 7, 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 July 20, 2016 through July 25, 2016. (AX1).

"[T]o prove temporary total disability, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that he did not work and was unable to work during the timeframe of July 20, 2016 through July 25, 2016, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for this timeframe. In so concluding, the Arbitrator notes that no off work slips covering the timeframe of July 20, 2016 through July 25, 2016 were entered into evidence at the time of arbitration, and as a result thereof the Arbitrator finds that Petitioner has failed to that he was temporarily and totally disabled for that particular period.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed by Respondent. The Arbitrator finds that the nature and demands of his position will likely have some effect on his permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 43 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Golz, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and, as such, there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his left index finger is always numb and that he is unable to feel objects he grasps. Petitioner also testified to sensitivity over his surgical site. Petitioner's finger was described at the time of arbitration to be slightly crooked at the top end with an indentation on the inner aspect of the index finger, and that his nail was also deformed with a bow-shaped tip to it. Petitioner testified that he experiences occasional pain and throbbing in his finger, particularly with cold weather. At his final office visit with Dr. Golz on July 18, 2017, it was noted that Petitioner stated that he continued to have paresthesias over the ulnar aspect of the left index finger and that it made it difficult for him working with small items. It was noted that Petitioner stated that when he was trying to grasp between his thumb and index finger, he could not feel items such as nuts and bolts. It was noted that Petitioner may never regain full sensation over the ulnar aspect of the index finger and that it was difficult to say. It was noted that with his very good motion and very good strength, he was at maximum medical improvement regarding the left finger. Petitioner was instructed to return as needed. (PX5). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, were corroborated by his treating records at the conclusion of his treatment with Dr. Golz. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left index finger as provided in Section 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 KANE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory A. Schneider,

Petitioner,

vs.

NO: 12 WC 19455

City of Elgin,

18IWCC0500

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission following the remand order of Judge Michael T. Caldwell of the Circuit Court of the 22nd Judicial Circuit instructing the Commission to address the issue of temporary partial disability benefits. The Commission, after considering the issue of temporary partial disability benefits, reverses the Decision of the Arbitrator and modifies its February 14, 2017, Decision and Opinion on Review (17 IWCC 91) for the reasons stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

I. Procedural History

The Arbitrator filed an Arbitration Decision on January 11, 2016. Pursuant to Petitioner's Motion to Correct Clerical Error, the Arbitrator filed an Amended Arbitrator Decision on February 2, 2016. The Arbitrator found a compensable accident occurred on March 17, 2012. The Arbitrator further found Petitioner's condition of ill-being through August 1, 2013, causally related to the work accident. The Arbitrator found Petitioner's condition stabilized as of August 1, 2013, and awarded temporary total disability benefits in the amount of $1,110.43/week from September 5, 2012 through August 1, 2013, or 47-1/7 weeks. Finally, the Arbitrator awarded reasonable and necessary medical expenses through August 1, 2013, and declined to award temporary partial disability benefits and penalties and fees.

18IWCC0500

Both parties filed Petitions for Review. In a Decision and Opinion on Review dated February 14, 2017, (17 IWCC 91), the Commission modified the Arbitrator's findings regarding causal connection, temporary total disability, and medical expenses. The Commission found Respondent liable for TTD from September 5, 2012, through May 4, 2014, or 86-4/7 weeks. The Commission also awarded reasonable and necessary medical expenses through May 5, 2014. The Commission otherwise affirmed and adopted the Arbitrator's Amended Decision. In making these modifications, the Commission determined Petitioner's PTSD had not stabilized by August 1, 2013. The Commission Decision did not address Petitioner's claim for TPD.

Both parties appealed the Commission's Decision to the Circuit Court of the 22nd Judicial Circuit. On August 24, 2017, Judge Caldwell issued an order remanding the case to the Commission. Judge Caldwell ordered the following:

1. The Court finds that the Commission's decision with respect to accident, causation, temporary total disability, and medical expenses is not against the manifest weight of the evidence and is affirmed. With respect to the issue of temporary partial disability benefits, the Court remands this case back to the Commission for a determination on this issue.

2. This court maintains jurisdiction on the matter while the Commission decides the issue with respect to temporary partial disability. Once the Commission renders a decision on this issue, the Court will consider and rule on this issue.

II. Facts

The Commission notes that most of the facts of the case were addressed in the February 2, 2016, Amended Arbitrator's Decision and the February 14, 2017, Commission Decision. The Commission primarily adopts the previously established findings of fact regarding Petitioner's treatment following the work accident. The Commission makes the following additional findings to address the issue of temporary partial disability.

On March 17, 2012, Petitioner worked as a police officer in Elgin, IL. On the date of accident, Petitioner was involved in a shooting during an attempted prisoner escape while transporting two prisoners from the Elgin jail to court in Rolling Meadows. Following the work incident, doctors eventually diagnosed Petitioner with PTSD.

The Commission previously awarded temporary total disability from September 5, 2012, through May 4, 2014. Petitioner began working full time as a school security assistant with the Huntley School District on May 5, 2014. On the date of the November 9, 2015, hearing, Petitioner remained in this position. Petitioner testified that pursuant to the applicable bargaining agreement, he would have earned a yearly base salary of $87,189.00 in 2014 and $89,368.00 in 2015. (Tr. at 98-106). Petitioner also testified that pursuant to the agreement, he would have received longevity pay of an additional 2.5% of his base salary. *Id.* Thus, Petitioner would have earned a yearly salary of $89,368.72 in 2014 and $91,602.20 in 2015. There is no evidence contradicting Petitioner's

credible testimony and the submitted bargaining agreements. (PX 9). Petitioner submitted earning statements showing earnings from May 5, 2014, through September 20, 2015. (PX 8). Although the hearing occurred on November 9, 2015, Petitioner did not submit any evidence of earnings after September 20, 2015.

III. Conclusions of Law

Based on the above, and pursuant to the express order of the Circuit Court, the Commission modifies its February 14, 2017, Decision. The Commission finds Petitioner has proven his entitlement to temporary partial disability benefits from May 5, 2014, through September 20, 2015.

Section 8(a) of the Act establishes the necessary requirements for an award of temporary partial disability. The Act states, "When the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits." Furthermore, temporary partial disability "shall be equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his…duties" in the employee's occupation on the date of accident and "the gross amount which he…is earning in the modified job provided to the employee by the employer or in any other job that the employee is working."

Petitioner met his burden of proving his salary would have been $89,368.72 in 2014 and $91,602.20 in 2015. These salaries calculate to an average weekly wage of $1,718.62 in 2014 and $1,761.58 in 2015. Petitioner also met his burden of proving his earnings from May 5, 2014, through September 20, 2015. As Petitioner earned different wages each pay period due to overtime and/or fluctuating work hours, the below chart illustrates the amount of temporary partial disability benefits Petitioner is due for each pay period.

Pay Period	Potential Wage	Gross Pay	Difference	TPD Owed
5/5/14 – 5/11/14	$1,718.62	$564.40	$1,154.22	$769.48
5/12/14 – 5/25/14	$3,437.24	$1,128.80	$2,308.44	$1,538.96
5/26/14 – 6/15/14	$3,437.24	$2,172.22	$1,265.02	$843.35
6/16/14 – 6/29/14	$3,437.24	$1,435.69	$2,001.55	$1,334.37
6/30/14 – 7/13/14	$3,437.24	$1,267.12	$2,170.12	$1,446.75
7/14/14 – 7/27/14	$3,437.24	$1,352.66	$2,084.58	$1,389.72
7/28/14 – 8/10/14	$3,437.24	$1,474.98	$1,962.26	$1,308.17
8/11/14 – 8/24/14	$3,437.24	$1,437.20	$2,000.04	$1,333.36
8/25/14 – 9/7/14	$3,437.24	$1,395.83	$2,041.41	$1,360.94
9/8/14 – 9/21/14	$3,437.24	$1,151.20	$2,286.04	$1,524.03
9/22/14 – 10/5/14	$3,437.24	$1,361.65	$2,075.59	$1,383.73
10/6/14 – 10/19/14	$3,437.24	$1,412.02	$2,025.22	$1,350.15
10/20/14 – 11/9/14	$3,437.24	$1,861.71	$1,575.53	$1,050.35
11/10/14 – 11/23/14	$3,437.24	$1,295.11	$2,142.13	$1,428.09
11/24/14 – 12/7/14	$3,437.24	$1,356.26	$2,080.98	$1,387.32
12/22/14 – 1/11/15	$3,480.42	$1,874.31	$1,606.11	$1,070.74
1/12/15 – 1/25/15	$3,523.16	$1,260.93	$2,262.23	$1,508.15
1/26/15 – 2/8/15	$3,523.16	$1,237.54	$2,285.62	$1,523.75
2/9/15 – 2/22/15	$3,523.16	$1,244.74	$2,278.42	$1,518.95

2/23/15 – 3/8/15	$3,523.16	$1,205.16	$2,318.00	$1,545.33
3/9/15 – 3/29/15	$3,523.16	$1,872.50	$1,650.66	$1,100.44
3/30/15 – 4/12/15	$3,523.16	$1,178.18	$2,344.98	$1,563.32
4/13/15 – 4/26/15	$3,523.16	$1,532.54	$1,990.62	$1,327.08
4/27/15 – 5/10/15	$3,523.16	$1,165.60	$2,357.56	$1,571.71
5/11/15 – 5/24/15	$3,523.16	$1,151.20	$2,371.96	$1,581.31
5/25/15 – 6/14/15	$3,523.16	$1,911.80	$1,611.36	$1,074.24
6/15/15 – 6/28/15	$3,523.16	$1,253.73	$2,269.43	$1,512.95
6/29/15 – 7/12/15	$3,523.16	$1,361.29	$2,161.87	$1,441.25
7/13/15 – 7/26/15	$3,523.16	$1,203.56	$2,319.60	$1,546.40
7/27/15 – 8/9/15	$3,523.16	$1,291.76	$2,231.40	$1,487.60
8/10/15 – 8/23/15	$3,523.16	$1,198.05	$2,325.11	$1,550.07
8/24/15 – 9/6/15	$3,523.16	$1,269.71	$2,253.45	$1,502.30
9/7/15 – 9/20/15	$3,523.16	$1,179.68	$2,343.48	$1,562.32
			Total	**$45,436.68**

The Commission finds that Petitioner is entitled to temporary partial disability benefits from May 5, 2014, through September 20, 2015. in the amount of $45,436.68. The Commission finds that Petitioner did not meet his burden of proving an entitlement to any temporary partial disability benefits from September 21, 2015, through the November 9, 2015, hearing date; therefore, the Commission denies any temporary partial disability benefits during that period.

As a final matter, the Commission notes that Judge Caldwell's Order contains language asserting both that the Circuit Court retained jurisdiction while the Commission considered this matter, and that the court retained jurisdiction to immediately consider this Commission Decision. Regardless of any language in Judge Caldwell's Order, the law is clear that a circuit court loses jurisdiction over a matter upon remand. *See Kudla v. Indus. Comm'n*, 336 Ill. 279 (1929). In *Kudla*, the Illinois Supreme Court stated, "The only authority which the circuit court has on the review by *certiorari* of the decision of the Industrial Commission confirming an award is to affirm the findings and the award of the commission, or to set it aside and enter such a decision as justified by law, or remand the cause to the commission for further proceedings." *Id.* at 281-82. The Court further stated that upon remand, the circuit court exhausted the jurisdiction conferred by the Act; thus, its "attempt to retain further jurisdiction was void." *Id.* at 282. As such, all parties must follow the proper procedure to appeal this Decision pursuant to the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary partial disability in the amount of $45,436.68, as provided in §8(a) of the Act, as Petitioner proved an entitlement to temporary partial disability benefits from May 5, 2014, through September 20, 2015.

IT IS FURTHER ORDERED that Petitioner is not entitled to any temporary partial disability benefits from September 21, 2015, through November 9, 2015.

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

18IWCC0500

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

IT IS FURTHER ORDERED 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.

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 15 2018

o: 3/6/18
TJT/jds
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

Germain Mehinto,

Petitioner,

vs. NO: 15 WC 6051

Tyson Fresh Meats,

18IWCC0501

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary 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 30, 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.

18IWCC0501

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
TJT:yl
o 8/7/18

AUG 15 2018

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

MEHINTO, GERMAIN (ALAIN)
Employee/Petitioner

Case# **15WC006051**

TYSON FRESH MEATS
Employer/Respondent

18IWCC0501

On 6/30/2017, 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 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0714 WARNER & ZIMMERLE
HOWARD ZIMMERLE
423 17TH ST SUITE 201
ROCK ISLAND, IL 61201

2542 BRYCE DOWNEY & LENKOV
MAITAL SAVIN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

18IWCC0501

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

GERMAIN (ALAIN) MEHINTO,
Employee/Petitioner

v.

TYSON FRESH MEATS,
Employer/Respondent

Case # **15** WC **6051**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Rock Island**, on **6/6/17**. 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 **Credit for TTD paid**

FINDINGS

On the date of accident, **12/16/13**, 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 as it relates to his left shoulder and right groin ***is*** causally related to the accident. Petitioner's current condition of ill-being as it relates to his low back is not causally related to the accident.

In the year preceding the injury, Petitioner earned **$54,080.00**; the average weekly wage was **$1,040.00**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$53,429.53** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$53,249.53**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $693.33/week for 83 weeks, commencing 10/23/14 through 5/25/16, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $53,429.53 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical expenses for petitioner's left shoulder through 5/25/16, and for petitioner's right groin complaints through 7/27/14 as provided in Sections 8(a) and 8.2 of the Act. Respondent shall not pay any medical expenses related to petitioner's low back.

Petitioner's claim for prospective medical care is denied.

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.

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

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

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

Signature of Arbitrator

6/28/17
Date

ICArbDec19(b)

JUN 30 2017

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 53 year old chuck line worker, sustained an accidental injury that arose out of and in the course of his employment by respondent on 12/16/13. Petitioner is alleging injuries to his left shoulder, groin, and back. Petitioner legally changed his first name from Alain to Germaine on 11/23/15. Petitioner starting working for respondent on 3/28/06. On 2/28/08 petitioner left this job and went to work in the warehouse. On 9/2/08 he returned to the processing as a roll chuck on the chuck line. Petitioner works 2 shifts a day.

Petitioner's duties on the chuck line included pulling pieces of meat weighing up to 100 pounds, and as long as three feet, off the conveyor belt onto a table, and then cutting the meat with a chuck saw. Petitioner would grab the meat with his left hand off the conveyor belt to his left and slide it onto the table in front of him. He would use his right hand to help slide it over to the table. He would then push the meat through the chain saw with both arms. This would cut the meat in half. He would push one side of the meat to the conveyor on the left using his left arm, and push the other with his right arm to another conveyor. He performed this task briskly.

Every other day he would perform the same job on the alternate side of the conveyor on a similar machine. However, the piece of meat on that conveyor was different. On this machine he would cut the meat into three pieces. He would throw the first piece on the conveyor. He would then cut the second piece into two pieces. He testified that some pieces he would have to lift on its side with his left arm, slice it, and then throw the pieces on the conveyor.

On 12/16/13 petitioner was working this alternate side of the conveyor. He testified that although he put water on the table to push the meat from the table, a lot of force was needed to push the meat. Petitioner performed this alternate job all day long. He testified that he would twist and turn to slide the meat from the conveyor belt on the side, to the table in front of him. Petitioner would grab the meat off the conveyor with his left arm and place it on the table, where he would push it through the saw. He testified that this job was very fast paced, and if he did not keep up, the meat would gather on the conveyor and fall off.

While performing this task on 12/16/13 petitioner developed pain in his left shoulder and right groin area. He described the pain in his groin as "flashing pain". He also complained of right wrist pain that resolved. Petitioner reported the pain to his supervisor. He testified that his supervisor told him to keep working or he would replace him. Petitioner then called another supervisor, Baky, and she took

petitioner to the office to see the general manager. Petitioner was then taken to the nurse's station and reported his symptoms. Petitioner reported that he had no back or leg pain at this time.

On 12/16/13 petitioner completed an accident report. He wrote "At about 8:40 pm, while pulling up pieces up pieces of product, I started developing some throbbing pain in my left shoulder and my right forearm along with a heavy throbbing pain in my groin-right side. I then notified my supervisor who, after using Baky as an interpreter, had him take me to HSD to seek treatment." Petitioner signed and dated it. It also noted "Transl by Yaw A-".

On 12/17/13 petitioner returned to working on the same machine on which he developed his pain. He testified that his supervisor told him to work for a little time and he would find someone to take his place. Petitioner worked the machine for about an hour a day. After that he would stand beside the person who took his place. He would only work the machine when that person went to the bathroom. For an entire month petitioner reported to the nurse's station at 5 pm.

On 1/7/14 petitioner provided respondent with a note for light duty work. Thereafter, petitioner never returned to full duty work for respondent. However, he did return to light duty work.

On 2/21/14 petitioner presented to Springfield Clinic. Petitioner complained of left shoulder pain and pain in his groin on the right side.

On 3/3/14 petitioner presented to MOHA and was evaluated by Dr. Gordon for left shoulder pain and right groin region pain. Petitioner gave a consistent history of the injury. With respect to his right groin, petitioner pointed to the region of the medial thigh adductor region. He told Dr. Gordon that he had to grasp meat products that may weigh up to 100 pounds and pull them towards him and then push them into a saw to cut the meat. He reported that this job required a notable amount of force. He reported that while performing this activity he began noting pain in the left shoulder and right medial thigh region. Following an examination, Dr. Gordon assessed left shoulder strain, right adductor strain. Dr. Gordon restricted petitioner from lifting over 5 pounds with the left upper extremity, and no activities above shoulder height. Petitioner was reevaluated on 3/7/14 and assessed with mild left shoulder impingement and a right groin strain Petitioner's medications were changed. Physical therapy was prescribed and his restrictions remained the same. On 3/14/14 petitioner reported that his shoulder was a little better, but his groin was not any better. Petitioner was assessed with a left shoulder strain and right groin strain. An ultrasound was recommended to rule out an inguinal femoral hernia. Petitioner was continued on restricted duty.

On 3/21/14 petitioner underwent an ultrasound of the scrotum and testes. The impression was negative. On 3/24/14 petitioner returned to MOHA. He continued to complain of discomfort in the groin. He stated that therapy helped a bit, and medicine provided some temporary relief. Petitioner was prescribed Voltaren. His restrictions were continued.

On 4/7/14 petitioner returned to MOHA. He reported increased pain in his left shoulder and continued pain in his right hip adductor region. Petitioner had full range of motion of his left shoulder; impingement features; and, excellent strength. He had no provocation or pain with internal hip rotation, but had tenderness over the hip adductor region. Petitioner's assessment remained the same. An MRI of the right hip was ordered. Petitioner was given a home exercise program.

On 4/15/14 petitioner underwent an MRI of the right hip and thigh. The impressions were unremarkable. On 4/25/14 petitioner underwent an injection into the subacromial space of the left shoulder. Petitioner had a couple of days of relief after the injection. On 5/12/14 petitioner continued to complain of pain with hip flexion, but no pain with rotation of the acrabulum of the femoral head. His gait was normal. His assessment remained left shoulder impingement, and possible right hip flexor strain. An MRI arthrogram of the left shoulder was ordered.

On 5/19/14 petitioner underwent an MR arthrogram of the left shoulder. The impression was severe tendinosis of the supraspinatus infraspinatus tendons with probable partial thickness undersurface tearing of the infraspinatus; SLAP tear of the biceps labral complex; and moderate degenerative changes at the acromioclavicular joint.

On 7/11/14 petitioner followed-up at MOHA and saw Dr. Candler for his left shoulder and right groin pain. He stated that he had been on vacation for about a month. He stated that he was somewhat improved, especially with regard to his left shoulder. Petitioner was examined and his diagnostic tests were reviewed. He was assessed with acromioclavicular joint arthritis of the left shoulder; tendinosis and possible partial tear of the supraspinatus and infraspinatus tendons of the left shoulder; and right inguinal ligament pain. Physical therapy was again ordered for his left shoulder. He was told to continue home exercises for his hip. His work restrictions were no lifting greater than 20 pounds and no lifting above chest level.

On 7/28/14 petitioner returned to MOHA and saw Dr. Candler. He stated that he was somewhat improved, but still had some pain in his anterior shoulder area medial to the AC joint. He also stated that his right medial leg/hip was not improved. He reported increased pain when walking more than 30

minutes, and after he bends and squats. Petitioner demonstrated full range of motion and 5/5 strength in all planes of motion in the left shoulder; pain upon palpation of his anterior left shoulder well medial to the AC joint; pain with external rotation of the right hip; pain the right hip with flexion and when he stood and bent over; and notable lordosis in his back. Dr. Candler assessed improved left shoulder strain, right medial hip pain, and possible lumbar radiculopathy in the L4 distribution. An MRI of the lumbar spine was ordered. Restrictions remained the same.

On 8/6/14 respondent performed a utilization review regarding therapy for petitioner's left shoulder and lumbar spine. It was denied based on the fact that there was limited evidence of sustained improvement from the completed 16 sessions of physical therapy visits. With respect to the request for physical therapy for the lumbar spine, it was denied based on limited evidence of ongoing complaints in the lumbar spine to support additional physical therapy visits.

On 8/8/14 petitioner underwent an MRI of the lumbar spine. The impression was disk bulge/herniation at L5-S1 with some spinal/right lateral recess and foraminal stenosis. Also noted was impingement on the right S1 nerve root at this level.

On 8/18/14 petitioner returned to MOHA and was examined by Dr. Clem. His assessment was history of multiple findings of the left shoulder on MRI, right medial hip pain and groin pain with some possible S1 radiculopathy and questionable herniated disc on the MRI. Petitioner was referred to an orthopedic spine specialist. His restrictions remained the same.

On 8/27/14 petitioner presented to Dr. Dolphin an orthopedic specialist. He reported that he injured himself on 12/16/13. Petitioner gave a history of moving heavy 200 pound carcasses of beef down a conveyor belt and twisting when he began developing low back pain on the right with radiation. Petitioner told Dr. Dolphin that he has not worked since 12/16/13. Petitioner had full range of motion of the shoulders, wrists and elbows; he walked with slight difficulty favoring the right lower extremity; had diminished sensation in the S1 distribution on the right; and had a positive straight leg raise. Dr. Dolphin reviewed the diagnostic tests and assessed lumbar radiculopathy, lumbar disc herniation; and low back pain.

On 9/3/14 petitioner returned to Dr. Dolphin. His condition remained the same. Dr. Dolphin discussed options including observation, injections or surgery.

On 9/24/14 petitioner presented to Dr. Mendel for his left shoulder pain. He reported that he works with large cuts of meat. He described reaching away from his body, pulling the meat to him, and then

pushing the meat through a machine. He reported that he noted sudden pain on 12/18/13. Dr. Mendel noted irritability about the AC joint and biceps on the left, and positive impingement. He reviewed the MRI and assessed left shoulder AC joint arthritis with possible SLAP and partial cuff tear. Options were discussed and surgery was agreed to.

On 2/11/15 petitioner presented to Dr. Labanauskas on the referral of Dr. Mendel. He reviewed records and examined petitioner. Petitioner gave a history of left shoulder pain and strain in his left (sic) thigh, while cutting large pieces of meat on a machine on 12/16/13. Dr. Labanauskas' primary focus was the left shoulder. Petitioner reported that he worked limited duty from the date of accident through October 2014, and has been off work since then. Dr. Labanauskas recommended a new MRI. He was of the opinion petitioner could perform one hand work.

On 2/24/15 petitioner files his Application for Adjustment of Claim. He alleged a left shoulder and back injury due to repetitive use of his hands and shoulders on 12/16/13.

On 3/18/15 petitioner returned to Dr. Labanauskas with results of the repeat MRI performed 2/23/15. This MRI showed an improvement in the partial thickness tear that was noted on the supraspinatus. There were no labral issues. Subacromial impingement was noted. Progression of the degenerative changes of the AC joint were noted. Dr. Labanauskas injected petitioner's shoulder and discussed surgery. His restrictions remained the same.

Petitioner followed-up with Dr. Labanauskas on 6/24/15. Petitioner reported temporary relief following the injection on 3/18/15. Petitioner reported that he wanted to proceed with surgery.

On 7/2/15 petitioner underwent a mini open exploration and left rotator cuff with acromionectomy/acromioplasty, and exploration and debridement of acromioclavicular joint and distal clavicle resection performed by Dr. Labanauskas. The post operative diagnosis was left shoulder posttraumatic arthritis, left acromioclavicular joint and subacomial impingement, and rotator cuff tendinopathy. Petitioner followed-up with Dr. Labanauskas post operatively. This treatment included physical therapy.

On 9/16/15 petitioner returned to Dr. Labanauskas. He was healing well. Petitioner reported that his pain had substantially diminished with less need for pain medication. Petitioner was no longer using a sling. Dr. Labanauskas performed an injection. Petitioner's restrictions were for right arm work, and left arm only below the waist. He was restricted from lifting over 10 pounds.

On 9/21/15 petitioner underwent a Section 12 examination performed by Dr. Julie Wehner at the request of the respondent. Dr. Wehner noted that communication with petitioner was difficult, even with an interpreter. Petitioner gave a history of pushing a 100 piece of meat with his left hand. He reported that he used both hands to pull the meat and then push it with his left hand. While doing this he felt pain in his left shoulder. He reported that he worked 15 hours four days a week, and 8 hours on the fifth day. Petitioner gave a history of his treatment to date. Petitioner had a sling on his left arm and complained of right low back pain and right groin pain. Following an examination and record review Dr. Wehner diagnoses were left shoulder subacromial bursitis, AC joint arthritis, and low back pain with nonanatomic pain radiating down the right leg in a circumferential distribution.

Based on her record review, Dr. Wehner noted that there did not appear to be any major rotator cuff tear; no low back pain initially present at the time of the injury; and, and right groin pain at the time of the injury, that was worked up and no positive findings were noted. She noted that the low back complaints did not surface until August 18th and his circumferential distribution was nonanatomical. She was of the opinion that there were no objective findings to support the low back pain or groin pain. Dr. Wehner opined that petitioner's low back pain is not causally related to a work injury. Dr. Wehner also opined that petitioner's rotator cuff tendinitis of the left shoulder is causally related to the injury on 12/16/13. She opined that there was no specific injury documented on 12/16/13 for a right groin injury, and there was no mechanism of injury that substantiated any right groin injury. She opined no causal connection between any low back or right groin pain to a 12/16/13 work injury. She opined that petitioner was not at MMI for his left shoulder, and would require 3 months more of physical therapy. She believed petitioner had reached MMI for whatever groin complaints occurred after 12/16/13. Dr. Wehner was of the opinion that petitioner currently needs restrictions of no use of the left arm. She recommended continued formal rehabilitation for the left rotator cuff tendinitis and the subsequent surgery of up to 3 months, 3 times a week. She also was of the opinion that he may benefit from a short course of work conditioning.

On 10/28/15 petitioner reported to Dr. Labanauskas significant gains over the past month. He reported that he no longer took pain medication. Petitioner reported that he was still unable to perform any activity above chest level. Petitioner requested additional pain meds. He was continued in physical therapy. By 12/30/15 petitioner was more comfortable and could drive with both hands. He could also rotate arm with the arm extended. Active abduction and elevation were at 90-100 degrees. Dr. Labanauskas continued petitioner in physical therapy. Petitioner was restricted from any physical labor with the left upper extremity.

On 1/14/16 petitioner presented to Dr. Jain for an evaluation of his low back. Petitioner gave a history of packing meat and having to turn to the left grabbing heavy objects and strapping them on to a cutter and then picking up the objects and placing them forward in front of him on a shelf. He reported that he did this motion repetitively and quickly throughout the day. He reported that on 12/16/13 he turned to the left to pick up a heavy block of meat and felt a pop in his back and a sharp pain down his right leg into the right groin. He reported that his current complaint is constant groin pain with radiation down the right leg. He reported that the back pain did not present initially. He reported that it began with groin pain and became progressively worse since the accident. Dr. Jain assessed lumbosacral radiculopathy.

Dr. Jain recommended a right L4-L5 and L5-S1 transforaminal epiduaral steroid injection and selective nerve root block. He provided petitioner with a TENS unit. Dr. Jain did not agree with Dr. Wehner's assessment and opinions. He did not agree with Dr. Wehner's opinion that since petitioner did not complain of low back pain until long after the accident, it is unlikely that he was having symptoms of radiculopathy. He opined that it is possible that the petitioner's right groin pain could be due to his disc herniation at L5-S1, even though the groin dermatomes are typically innervated by the L1 and L2 nerve roots. He noted that petitioner's pain worsened and became shooting pain down the posterior and lateral right leg. He opined that the herniation may have been present before the accident and was aggravated by the injury.

On 1/27/16 the evidence deposition of Dr. Wehner, an orthopedic surgeon, was taken on behalf of respondent. Dr. Wehner was of the opinion that petitioner described no mechanism of injury that would correlate with the onset of pain in his right groin or low back related to the 12/16/13 accident. She testified that petitioner did not have any back pain complaints or pain radiating down his right leg until August 18th. She noted that petitioner specifically reported that on 2/21/14 he did not have any back pain. She testified that she had no mechanism of injury to support a finding that petitioner could have hurt his groin. She was of the opinion that you don't hurt your groin by standing or twisting. She also testified that all tests to the groin were normal. Dr. Wehner was of the opinion that you cannot complain of something six months later and say it is related to an injury from six months before that when he did not have any complaints along that time. Dr. Wehner testified that she could not fully examine petitioner's left shoulder because he had just had surgery. She was of the opinion that petitioner had not yet reached MMI with respect to her left shoulder, but should, approximately 3 months after surgery. Dr. Wehner opined that with respect to petitioner's low back he had a radiologic finding that did not fit with

any of his initial complaints and did not fit with his current complaints. She opined that petitioner did not have any permanent disability as a result of his 12/16/13 accident. Dr. Wehner testified that she did not see in a note in any medical records where petitioner reports how he hurt his groin or back, but did see a mechanism of injury for his left shoulder. Dr. Wehner testified that people do develop spontaneous episodes of disk herniation. She opined that petitioner's back pain has no relationship to the accident on 12/16/13 because there is no mechanism of injury or medical literature to support it, and petitioner developed back pain at a very delayed point in time. She was also of the opinion that when petitioner did report it the doctor never reviewed any of the initial medical records to see that there was no mechanism of injury and that he did not report back pain initially.

On cross-examination Dr. Wehner testified that petitioner did not tell her how many pounds of meat he was required to carry every day, or how long he carried those pounds of meat. Dr. Wehner testified that on 2/21/14 he filled out a form and indicated that he did not have any neck or back pain. Dr. Wehner testified that she did not know how many times petitioner had to grasp meat that might weigh up to 100 pounds and pull it towards him and them push it into a saw to cut the meat, over the years. She opined that this kind of job done repetitively since 2006 could not lead to the wearing down of the tendons, the muscles in the body, or all the supraspinatus muscles. Dr. Wehner noted that on 8/27/14 Dr. Dolphin said there was no problem with petitioner's shoulder and diagnosed him with low back pain, a lumbar disk herniation, and a lumbar radiculopathy. She noted that petitioner's symptoms on 8/27/14 were completely different than they were initially. Dr. Wehner testified that petitioner reported a mechanism of what he does at work with his left shoulder that would correlate with some of his shoulder pain, but did not report any kind of injury. Dr. Wehner was of the opinion that there is no medical literature to support repetitive trauma for back problems.

On 2/5/16 petitioner followed-up with Dr. Jain. Petitioner continued to complain of right-sided back pain radiating down the leg. Dr. Jain assessed lumbosacral radiculopathy. He again recommended a right L4-L5 and L5-S1 transforaminal epiduaral steroid injection and selective nerve root block. Petitioner initially declined. Dr. Jain noted that petitioner initially did not present with any low back pain, but did report symptoms of radiculopathy. Dr. Jain was of the opinion that the symptoms for which petitioner was being seen are directly related to the injury. Dr. Jain continued petitioner off work. On 3/10/16, 5/25/16, 8/23/16, 10/19/16 and 2/27/16 petitioner's condition was unchanged. Each time Dr. Jain noted that he was still awaiting authorization for the injections from the insurance company. He continued petitioner off work.

On 3/2/16 petitioner returned to Dr. Labanauskas. He noted that he was getting better and was more comfortable. His range of motion was better but not entirely normal. Dr. Labanauskas was of the opinion that petitioner was 80-90% of normal with respect to range of motion. He was also of the opinion that petitioner may have some permanent symptoms. He restricted petitioner from physical labor with his arm above chest level or any type of reaching of heavy materials on a permanent basis. He anticipated petitioner would reach MMI in three months. Petitioner was continued in physical therapy.

On 4/13/16 petitioner followed-up with Dr. Labanauskas. Petitioner was in less pain and comfortable. He was moving his arm better and his range of motion was improved and was near 90% of normal. He reported occasional discomfort. Physical therapy was continued. His restrictions were unchanged.

On 5/6/16 petitioner underwent a Section 12 examination performed by Dr. Bryan Neal, at the request of the respondent. Dr. Neal also performed a medical record review from 3/3/14 through 4/19/16. He reviewed the job description for the title of "Operate Chuck Saw". He noted that the job description lists the range of motion including shoulder flexion of up to 90 degrees, shoulder abduction up to 35 degrees, and "no appreciable force" required to perform this job. Dr. Neal also took a history. Petitioner gave a history of cutting meat with a machine for respondent. He described the job of meat processing where a conveyor belt would apparently deliver meat to the area he was working. He would then take the meat off the conveyor belt and move it to the machine on a table in front of him where he would push the meat through the machine. He stated that the meat weighed more than 100 pounds and the machine cut the meat. Petitioner stated that he would push the meat to advance it through the machine and then push it beyond the machine. Once past the machine he would use two hands to push the meat. He would use his left arm to pull the meat from the conveyor belt to the table in front of him. Petitioner reported that he would cut 10 blocks of meat every five minutes. He stated that his symptoms in his left shoulder started on 12/16/13.

Petitioner complained that he was not able to use his left arm correctly and he had pain with shoulder activity. He reported a feeling of internal burning with left arm movement. Petitioner reported that medication helps with his pain.

Dr. Neal performed an examination. Active left shoulder abduction and flexion was 90 degrees. With left shoulder flexion petitioner reported that his arm was "very heavy". His side active external rotation was 50 degrees on the right and 40 degrees on the left. With 90 degrees of abduction petitioner could demonstrate symmetric external rotation of 90 degrees and then symmetric internal rotation of a

normal amount. Left shoulder extension was about 30 degrees and adduction was 20 degrees. Left shoulder internal rotation behind his back was only 3-4 centimeters less than the right side. Petitioner had good internal rotation strength with his arms at his side. He had some giving way with external rotation strength testing. Jamar grip testing on the left was about 1/2 of what it was on the right. Dr. Neal diagnosed subjective left shoulder pain of an unknown etiology, status post left shoulder open distal clavicle resection and subacromial decompression, and suspected underlying, yet to be determined, biopsychosocial undercurrents with an element of symptom magnification.

Dr. Neal opined that there is no causal connection or causal relationship between the petitioner's left shoulder condition and any 12/16/13 alleged accident. Dr. Neal was of the opinion that although it does appear petitioner handled heavy pieces of meat, it appears this activity was at or below a horizontal shoulder position. He noted that petitioner did not describe significant overhead activity or awkward postures with respect to his left shoulder. He opined that petitioner had an instantaneous injury to his left shoulder on 12/16/13, and put forth an instantaneous groin pain and left shoulder pain from the process of working. Dr. Neal was of the opinion that the left AC arthritis was a degenerative arthropathy which was an intrinsic biological process that developed over time, and was preexisting. He noted that petitioner reported symptoms going back to the month of December 2013, and this does not support any acute or instantaneous injury. He noted that the medical records of 3/3/14 revealed an examination consistent with impingement. He opined that petitioner had intrinsic degenerative arthropathy of the acromioclavicular joint producing disease at this joint, as well as degenerative spur formation (osteophytes) on the undersurface of the acromion which led to the impingement process. He did not doubt petitioner experienced left shoulder pain while working, but believed petitioner would have experienced pain from his condition whether working, playing with elevated or similar activity, or overhead activity. He opined that petitioner's impingement process did not come or result from his work but rather from an intrinsic biological degenerative process involving the acromioclavicular joint and subacromial space. Dr. Neal opined that discomfort or pain felt working was an exacerbation of his condition but did not cause his condition, permanently worsen his shoulder condition (that is aggravate it), or change the rate of deterioration of a preexisting and degenerative process (that is accelerate his condition). He noted that the fact that petitioner had less pain on vacation reinforced his opinion that the use of the left shoulder was problematic and not work per se. Dr. Neal noted that it is written that when subacromial impingement syndrome occurs in the setting of a repetitive motion job "it is rarely the result of a single factor". Dr. Neal found petitioner's pain unexplainable. He opined that petitioner had not reached MMI for his left shoulder and recommended a series of corticosteroid injections, or repeat MRI

of the left shoulder. He did not believe petitioner would be able to return to full duty work for respondent without restrictions. He believed petitioner would be able to work with a 10 pound work restrictions up to the shoulder level and may work with an elevated shoulder without any weight in his hand. Dr. Neal did not believe these restrictions would be related to petitioner's work injury on 12/16/13. He found no causal relationship between petitioner's left shoulder and the injury on 12/16/13. Dr. Neal found all treatment reasonable and necessary.

On 5/25/16 petitioner last followed-up with Dr. Labanauskas. Dr. Labanauskas was of the opinion had reached maximum medical improvement.

On 6/30/16 the evidence deposition of Dr. Labanauskas, an orthopedic surgeon, was taken on behalf of petitioner. Dr. Labanauskas testified that the surgery to petitioner's left shoulder went as planned, but petitioner still had some pain. He was of the opinion that over the time petitioner's pain would diminish. He was of the opinion that as of May 2016 he would have restricted petitioner from any significant physical labor with his arm, no overhead lifting, and no reaching with the left arm. He was of the opinion that petitioner could do work at waist level or below. He believed these restrictions were permanent. Dr. Labanauskas opined that if petitioner pushed and pulled meat on a conveyor belt repeatedly, that these activities contributed to his current pathology and his need for treatment. Dr. Labanauskas testified that petitioner always had a translator with him so there was never a problem with communication.

On cross examination Dr. Labanauskas was of the opinion that positive impingement features can be caused by degenerative spurring over time. Dr. Labanauskas testified that he did not perform a rotator cuff debridement. He only performed a decompression of the left shoulder to address petitioner's impingement. He testified that the procedure was a distal clavicle resection to address the AC joint arthritis that developed over time. He also testified that any additional weight puts stress across the joint and could make it more symptomatic. Dr. Labanauskas admitted that he did not review a job description for petitioner, and based all his opinions on petitioner's descriptions of his work activities. He stated that as of 10/28/15 he restricted petitioner to any activity at or above chest level. Dr. Labanauskas testified that the first causal connection opinion he offered with respect to petitioner's left shoulder was given on 6/30/16 even though he had not seen petitioner after 5/25/16.

On 9/2/16 the evidence deposition of Dr. Bryan Neal, an orthopedic surgeon, was taken on behalf of respondent. Dr. Neal opined that petitioner sustained a temporary exacerbation of left shoulder pain on 12/16/13. Dr. Neal opined that petitioner's current condition of ill-being as it relates to his left shoulder is not causally related to any work injury on 12/16/13; that his medical treatment for his left shoulder was

not causally related, aggravated or accelerated by his alleged 12/16/13 accident; and that petitioner's impairment is not causally related to his alleged accident on 12/16/13.

On cross examination Dr. Neal was of the opinion that repetitive work over the years could have played a factor in petitioner's development of impingement syndrome or tendonopathy, but then stated "but not in petitioner's case." Dr. Neal opined that a combination of force and repetition over the years can play a factor in the development of tendonopathy or impingement syndrome. He believed that overhead work above 90 degrees would be a risk factor associated with the development of impingement syndrome or tendonopathy. He did not agree that petitioner's work that required shoulder flexion above 60 degrees would do that. Dr. Neal did not believe work caused petitioner's impingement process, but did believe petitioner was painful at times while working. He believed the natural progression of petitioner's impingement process was not altered by his work activities.

Respondent offered into evidence the records from respondent's health service department. Petitioner was offered light duty work from 1/13/14 through 8/18/14.

On 10/17/16 the evidence deposition of Dr. Jain, a pain management specialist, was taken on behalf of petitioner. Dr. Jain admitted that the groin pain is not the typical pattern for S1 radiculopathy. However, he still opined that petitioner's symptoms as they relate to the groin, neck and low back are casually related to the L5-S1 bulge or herniation, He opined that all his treatment to date was reasonable and necessary. He opined that the recommended epidural steroid injection and selective nerve root block are related to petitioner's work activities.

On cross examination, Dr. Jain admitted that on 1/14/16 his opinion that petitioner's right groin pain could be due to his L5-S1 disc herniation, and that his back pain could be related to his work activities were speculative, but then on redirect examination stated that they were to a reasonable degree of medical certainty. Dr. Jain did not review petitioner's medical records prior to 12/13/16, nor did he review a job description for petitioner. He also did not know what hours petitioner worked, and was unaware if petitioner had any assistance with his work activities. He only knew that his work was "heavy" as described by petitioner. He did not know what weight constituted "heavy". Dr. Jain admitted that petitioner did not present with any back pain. but the nerve pain evolved into low back pain over time. Dr. Jain could not state with any certainty if he reviewed the actual MRI films.

On 4/12/17 petitioner underwent another Section 12 examination performed by Dr. Wehner. Petitioner reported that he last worked on 10/23/14. He also stated that he went to physical therapy until

about one year ago. Petitioner reported that his left arm was heavy. Petitioner reported that he was told to return to work last May, but he did not feel he was capable of returning to work, so he did not, and respondent stopped paying him. He reported the pain in his left shoulder was a 6/10. He complained of pain in the front and back area of the left shoulder, that consisted of burning, stabbing, and numbness and tingling. He also complained of right groin pain which was stabbing and radiates around to the low back area. Petitioner reported that he had an injection the week before at Dr. Jain's office, that did not provide him with any relief.

An examination revealed a normal gait and heel toe pattern. Petitioner self limited himself in bending to the mid knee area. Extension was 10 degrees and causes grimacing. There was no paraspinal spasm or scoliosis, or pain with light palpation. Axial compression and axial rotation caused pain in the right groin area. Hip range of motion was without pain. Straight leg raise was negative. Neck range of motion was normal with grimacing. Petitioner reported pain in the left shoulder with all motor testing on the right. His motor strength on the left was 5/5, but he reported significant pain with all motor testing. Petitioner was able to use his left arm to reach down and pull on his shoes. He was also able to put on his jacket and adjust the back of his jacket behind his back with his left arm without difficulty. Dr. Wehner noted incongruent pain mannerisms during the history not consistent with that observed during the rest of his time in the office.

Following an examination and record review, Dr. Wehner diagnosed continued left shoulder pain for unexplained medical reasons after an acromioplasty and AC joint resection on 7/2/15, and right groin pain that had no medical etiology. She noted that all MRIs of the groin and right thigh, as well as an ultrasound of the right groin were normal. She opined that there is no mechanism of injury to explain the injury to the groin on 12/16/13, but merely the onset of some right groin pain. She opined no causal connection between the right groin pain and an alleged work injury on 12/16/13. She noted that petitioner had no back pain and did not suffer a low back injury on 12/16/13. She opined that the findings on the MRI of a right paracentral protrusion do not correlate with the distribution of his pain in the groin or radiating down the front of his thigh. She noted that his neurological exam was normal. She opined that it defies all reasonable medical explanation to believe that the findings on the lumbar MRI were the cause of his right groin pain, or specifically caused by a work injury. She opined that petitioner reached MMI for any back or right groin injury on 9/21/15 when she last examined petitioner. She did not recommend any further treatment for petitioner. She also discouraged any further use of Norco because there is no medical findings to warrant the continued use. Dr. Wehner opined that petitioner is

capable of returning to full duty work as of 9/21/15. She opined that the MRI of the right groin and right thigh, and ultrasound were all reasonable and necessary. She opined that petitioner had no back complaints from an injury on 12/16/13. She was of the opinion that the protrusion at L5-S1 was small, and would not cause only groin pain and no back pain. She was of the opinion the small protrusion did not cause groin pain, and petitioner had no clinical findings to substantiate this as a cause of his symptoms.

Currently, petitioner feels pain in his left shoulder when he does a reenactment of his job duties. He reported pain when walking and wagging his arm. He has pain when taking a shower and using his arm to clean himself. Petitioner has pain in the left shoulder when driving. He cannot carry things he bought at Walmart in his left arm. Petitioner has no pain in his left arm while resting.

With respect to his groin pain petitioner testified that it has not improved since the date of injury. He reported "fire" in his groin that radiates to the right half of his back and down his right leg. He reported increased pain in his groin and leg when he carries and lifts bags. Petitioner reported pain after walking 20-30 minutes. He also reported pain when his moves his right leg from the accelerator to the brake while driving. Petitioner takes Norco for his pain.

Petitioner speaks many languages, but is not fluent in English. He testified that he understands about 40% of what is said in English.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

Petitioner claims he provided timely notice of the accident on 12/16/13 on 12/16/13. On that date petitioner presented to the nurse's station and reported symptoms in his left shoulder and right groin. He denied any back or leg pain. That same day he completed an accident report alleging injuries to his left shoulder, right forearm, and right groin while pulling up pieces of product. Although petitioner's alleged injury to his back was not mentioned, the arbitrator finds the petitioner did provide respondent with timely notice of the accident on 12/16/13. Whether or not petitioner's claim that his current condition of ill-being as it relates to his low back is causally related to the injury on 12/16/13 will be addressed in the Section that addresses causal connection.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner provided timely notice of the accident on 12/16/13 to respondent.

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

Petitioner alleges his current condition of ill-being as it relates to his left shoulder, right groin and low back are causally related to the injury on 12/16/13. Respondent denies petitioner's current condition of ill-being as it relates to his left shoulder, right groin and low back are causally related to the injury on 12/16/13.

With respect to the left shoulder, petitioner reported that while pulling pieces of meat weighing up to 100 pounds off the conveyor belt onto a table and then cutting the meat with a chuck saw machine that was not working properly, he sustained an injury to his left shoulder. He stated that he would cut the meat into three pieces. He would throw the first piece on the conveyor, and then cut the second piece into two pieces. He stated that some of the pieces he would have to lift on its side with his left arm, slice it, and then throw the pieces on the conveyor. Petitioner stated that a lot of force was needed to perform these tasks, and these tasks were fast paced. Petitioner had been working on this line since 9/2/08.

Petitioner reported the pain in his left shoulder to his supervisor and presented to the nurse's station where he gave a consistent history of his injury to his left shoulder. Petitioner denied any prior problems with his left shoulder.

Petitioner treated for his left shoulder with Dr. Candler and Dr. Gordon at MOHA through August of 2014. Petitioner was assessed with left shoulder impingement and underwent conservative treatment that included physical therapy and injections. Petitioner also underwent diagnostics tests of the left shoulder that showed severe tendinosis of the supraspinatus infraspinatus tendons with probable partial thickness undersurface tearing of the infraspinatus; SLAP tear of the biceps labral complex; and moderate degenerative changes at the AC joint.

Petitioner continued with pain in his left shoulder and eventually presented to Dr. Mendel for treatment of his left shoulder pain. Dr. Mendel noted irritability about the AC joint and biceps on the left, and positive impingement. After examining petitioner and reviewing the diagnostic tests he assessed left shoulder AC joint arthritis with a possible SLAP and partial cuff tear.

Petitioner next presented to Dr. Labanauskas for his left shoulder on 2/11/15. A new MRI showed an improvement in the partial thickness tear on the supraspinatus, no labral issues, and subacromial impingement. Progression of the degenerative changes was also noted. An injection to the left shoulder was performed. When petitioner received no lasting improvement, Dr. Labanauskas performed a mini open exploration and left rotator cuff with acromionectomy/acromioplasty, and exploration and

debridement of AC joint and distal clavicle resection. His post-operative diagnosis was left shoulder posttraumatic arthritis, left AC joint and subacromial impingement and rotator cuff tendinopathy. Petitioner continued to see Dr. Labanauskas for his left shoulder through 5/25/16.

Three doctors offered causation opinions with respect to petitioner's left shoulder. On 9/21/15 Dr. Wehner, who examined petitioner for respondent, diagnosed left shoulder subacomial bursitis, and AC joint arthritis. She opined that the petitioner's rotator cuff tendinitis of the left shoulder is causally related to the injury on 12/16/13. However, during her deposition Dr. Wehner testified that she did not know how often petitioner might grasp meat weighing up to 100 pounds and pull it towards him and then push it into a saw to cut meat, over the years. Despite this fact, she opined that this job done repeatedly since 2006 could not lead to the wearing down of the tendons, the muscles in the body, or all the supraspinatus muscles. She also based her opinion on the fact that there were no documented problems with petitioner's left shoulder when he saw Dr. Dolphin on 8/27/14. The arbitrator gives little weight to the opinions of Dr. Wehner during her deposition, especially given the fact that they contradict the opinions she offered when she first examined petitioner on 9/21/15, and they also ignore all the other treatment records regarding petitioner's left shoulder before and after 8/27/14.

Dr. Neal also examined petitioner on behalf of respondent and offered a causal connection opinion with respect to his left shoulder. Dr. Neal examined petitioner on 5/6/16. Petitioner gave a detailed description of his job duties for respondent. He also reported that he would cut 10 blocks of meat weighing up to 100 pounds every five minutes, and in doing so developed pain in his left shoulder on 12/16/13. Dr. Neal diagnosed subjective left shoulder pain of an unknown etiology. He opined no causal connection between the petitioner's left shoulder condition and any 12/16/13 alleged accident. Although he agreed petitioner handled heavy pieces of meat, he believed this activity was at or below horizontal shoulder position, and was of the opinion that petitioner did not describe any significant overhead activity or awkward postures with his left shoulder. The arbitrator finds this testimony is inconsistent with the credible evidence which shows that petitioner would have to lift some of the pieces of meat on its side with his left arm, and slice it and slide it over to the conveyor. Petitioner described this activity as awkward.

Dr. Neal believed petitioner's AC arthritis developed over time. He was first of the opinion that petitioner had an instantaneous injury to his left shoulder on 12/16/13, but later noted that petitioner reported symptoms going back to the month of December 2013, and that did not support any acute or instantaneous injury. The arbitrator finds these opinions contradictory and confusing, and not persuasive.

He also opined that the discomfort or pain petitioner felt while working was an exacerbation of his condition, but then when on to opined that working did not cause it, permanently worsen it, or change the rate of the current deterioration. The arbitrator finds this opinion also contradictory and inconsistent with the credible evidence. The arbitrator finds it significant that prior to the injury petitioner was asymptomatic, and then after the injury on 12/16/13 he became symptomatic and has remained symptomatic since then. Although petitioner's left shoulder pain may had improved some at times, since 12/16/13 he has never been without left shoulder pain. Based on Dr. Neal's inconsistent and contradictory opinions, and opinions unsupported by the credible medical evidence, the arbitrator gives little weight to Dr. Neal's opinions.

Lastly, Dr. Labanauskas opined that if petitioner pushed and pulled meat on a conveyor belt repeatedly, that these activities contributed to his current pathology and his need for treatment. Dr. Labanauskas based his opinion on the work history provided by petitioner, which the arbitrator finds was credible and unrebutted by respondent. For these reasons, the arbitrator finds the opinions of Dr. Labanauskas more persuasive then the opinions of Dr. Wehner or Dr. Neal.

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 his left shoulder is causally related to the injury he sustained on 12/16/13.

With respect to the right groin injury, the arbitrator finds the petitioner complained of right groin pain on 12/16/13 after repeatedly removing 100 pound pieces of meat from the conveyor onto the table and then forcefully pushing them through the malfunctioning machine that day. Petitioner had no right groin problems prior to 12/16/13 and continued to treat for his right groin after the injury. Petitioner was diagnosed with a right groin strain. Petitioner underwent a multitude of diagnostic tests that were all negative as they related to the right groin. Although Dr. Wehner opined that she had no mechanism of injury of how petitioner could hurt his right groin, the arbitrator notes that Dr. Wehner admitted that she did not know the details regarding petitioner's work activities. For this reason, the arbitrator gives little weight to Dr. Wehner's opinions as they relate to petitioner's right groin injury.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's right groin injury is causally related to the injury he sustained on 12/16/13 through 7/27/14.

Lastly, the arbitrator addresses petitioner's claim that his low back condition is causally related to his injury on 12/16/13. The arbitrator finds it significant that following the injury on 12/16/13 petitioner

presented to the nurse's station and denied any low back problems. Additionally, the arbitrator finds it significant that following the injury on 12/16/13 petitioner made absolutely no complaints with respect to his low back, or complaints of radiculopathy to anyone until Dr. Candler assessed possible lumbar radiculopathy in the L4 distribution on 7/28/14. Despite, this finding, an MRI of the lumbar spine showed no disk at L4, but rather a bulge/herniation at L5-S1 with some spinal/right lateral recess and foraminal stenosis. Also noted was impingement on the right S1 nerve root at this level. For the first time since the injury on 12/16/13 petitioner walked with a slight gait when he saw Dr. Dolphin on 8/27/14. When Dr. Wehner examined petitioner on 9/21/15 she noted that petitioner's low back complaints did not surface until August 18th and his circumferential distribution was nonanatomical. She opined his low back pain was not causally related to the injury on 12/16/13. She opined that the findings on the MRI do not correlate with the distribution of his pain in the right groin or the radiating pain down the front of his thigh. She also noted that his neurological exam was normal.

The other opinions regarding petitioner's low back were offered by Dr. Jain. However, the arbitrator finds the history petitioner provided Dr. Jain is not consistent with the credible evidence. Petitioner told Dr. Jain that on 12/16/13 he felt a pop in his back and a sharp pain down his right leg into his right groin, and that pain has been constant since then. The arbitrator notes that petitioner had no complaints of any radiating pain or low back pain for over 7 months following the injury, and after an extensive period where he was not working his regular duty job. Dr. Jain even admitted that groin pain is not the typical pattern for S1 radiculopathy. He also admitted that the groin dermatomes are typically innervated by the L1 and L2 nerve roots. However, despite this admission he continued to opine that petitioner's low back symptoms are causally related to the L5-S1 bulge/herniation. Given the fact that petitioner did not provide Dr. Jain with an accurate history of the accident and the onset of his low back symptoms, and the fact that Dr. Jain's opinions are not supported by the typical patterns associated with a S1 radiculopathy, the arbitrator finds Dr. Jain's opinions less than persuasive.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his low back condition is causally related to the injury he sustained on 12/16/13. The arbitrator bases this opinion on the fact that petitioner denied any back problems on 12/16/13; that petitioner made absolutely no complaints with respect to his low back or radiculopathy until more than 7 months after the injury; that petitioner did not work his full duty job after 12/16/13; that petitioner had just returned from a month on vacation on or about the time his low back

complaints began; and, the fact that petitioner's symptoms in his groin were not even consistent with the typical patterns associated with a S1 radiculopathy.

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 the petitioner's left shoulder and right groin condition causally related to injury on 12/16/13, the arbitrator will next look at what medical services that were provided for petitioner's left shoulder and right groin were reasonable.

As a result of his left shoulder injury, petitioner treated at MOHA, was seen by Dr. Mendel, and eventually underwent surgery performed by Dr. Labanauskas on 7/25/15. Petitioner followed-up post-operatively with Dr. Labanauskas. Petitioner last followed-up with Dr. Labanauskas on 5/25/16. At that time Dr. Labanauskas was of the opinion petitioner had reached maximum medical improvement.

On 6/30/16 Dr. Labanauskas testified that the surgery to petitioner's left shoulder went as planned. He was of the opinion petitioner had reached maximum medical improvement by 5/25/16.

With respect to the groin strain, petitioner also treated at MOHA. He underwent an ultrasound of the scrotum and testes that was negative, and MRIs of the right hip and thigh that were normal. Nonetheless, petitioner continued to complain of pain in his right groin. On 7/28/14 petitioner's treatment began to focus on a bulge/herniation at L5-S1, and S1 radiculopathy, which are not consistent with the dermatome pattern for right groin pain.

Based on the above, as well as the credible medical evidence, the arbitrator finds all treatment for the petitioner's left shoulder through 5/25/16, and all treatment for petitioner's right groin complaints through 7/27/14 were reasonable and necessary to cure or relieve petitioner from the effects of his injury on 12/16/13. Respondent shall pay all reasonable and necessary medical expenses related to the treatment of petitioner's left shoulder through 5/25/16 and petitioner's right groin through 7/27/14 pursuant to 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.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Petitioner is requesting prospective medical expenses as they relate to his low back. Having found petitioner's low back condition is not causally related to the injury he sustained on 12/16/13, the arbitrator finds the petitioner is not entitled to any prospective medical expenses.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is alleging that he is entitled to temporary total disability benefits from 10/23/14 through 6/7/17. Respondent has paid $53,429.53 in temporary total disability benefits for the period 10/23/14 through 5/15/16.

Having found the petitioner's current condition of ill-being as it relates to his left shoulder is causally related to the injury he sustained on 12/16/13, and that as of 5/25/16, Dr. Labanauskas was of the opinion that petitioner had reached maximum medical improvement for his left shoulder, the arbitrator finds petitioner is entitled to TTD benefits from 10/23/14 through 5/25/16, the date Dr. Labanauskas found petitioner had reached maximum medical improvement with respect to his left shoulder.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner is entitled to TTD benefits from 10/23/14 through 5/25/16. The respondent will receive credit for TTD benefits paid from 10/23/14 through 5/15/16 in the amount of $53,429.53.

O. CREDIT FOR OVERPAYMENT OF TTD PAID.

Having found respondent paid temporary total disability benefits from 10/23/14 through 5/15/16, and having found the petitioner was temporarily totally disabled from 10/23/14 through 5/25/16, the arbitrator finds the petitioner is not entitled to any credit for an overpayment of TTD benefits.

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

Scott Henry,
Petitioner,

vs. NO: 16WC 26685

State of Illinois/Illinois Department of Transportation,
Respondent.

18IWCC0502

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 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 February 7, 2018, 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 15 2018
o080718
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENRY, SCOTT
Employee/Petitioner

Case# **16WC026685**

ST OF IL/DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0502

On 2/7/2018, 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 1.65% 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
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 7 - 2018

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

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
NATURE AND EXTENT ONLY

Scott Henry
Employee/Petitioner

v.

State of IL/IL Dept. of Transportation
Employer/Respondent

Case # 16 WC 26685

Consolidated cases: n/a

18IWCC0502

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on January 9, 2018. By stipulation, the parties agree:

On the date of accident, JUne 23, 2016, 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 $71,293.30; the average weekly wage was $1,371.03.

At the time of injury, Petitioner was 43 years of age, single, with 0 dependent child(ren).

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $755.22 per week for 37.5 weeks because the injury sustained caused the seven and one-half percent (7 1/2 %) loss of use of the body as a whole as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from November 10, 2017, through January 9, 2018, 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.

William R. Gallagher, Arbitrator

February 2, 2018
Date

ICArbDecN&E p. 2

FEB 7 - 2018

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 June 23, 2016. According to the Application, Petitioner was "LIFTING SNOW PLOW BLADES" and sustained an injury to the "BACK/BODY AS A WHOLE" (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that the only disputed issue was the nature and extent of disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a highway supervisor. On June 23, 2016, Petitioner and another employee were conducting an inventory of snow plow blades. As Petitioner was in the process of lifting a snow plow blade with a coworker, the other worker abruptly dropped his end of the blade. When this occurred, Petitioner experienced an onset of back pain.

The day after the accident Petitioner went to the ER of St. Francis Medical Center. Petitioner gave a history of the accident that occurred the day before. X-rays of the lumbar spine were taken which were normal. Petitioner was diagnosed with a low back strain, prescribed medication and directed to follow up with either his family physician or the company physician (Petitioner's Exhibit 3).

Petitioner was subsequently seen and treated by Dr. David Raskas, an orthopedic surgeon, on August 9, 2016. Petitioner informed Dr. Raskas of the accident and that he had low back pain primarily at the lumbosacral junction and left hip, but no radiating pain into the left leg. Dr. Raskas prescribed medication and ordered physical therapy. He noted that if Petitioner's symptoms did not significantly improve, then an MRI would be ordered (Petitioner's Exhibit 5).

Petitioner received physical therapy from August 12 through September 22, 2016, for thoracic and lumbar pain symptoms. When Petitioner was seen by Dr. Raskas on September 19, 2016, he advised that the physical therapy had helped some, but that he had a reoccurrence of his symptoms over the preceding weekend when he was sitting on some bleachers (Petitioner's Exhibit 5).

Dr. Raskas ordered an MRI of both the thoracic and lumbar spine. The MRIs were performed on November 1, 2016. According to the radiologist, the MRI of the thoracic spine revealed a small disc bulge or tiny protrusion at T6-T7 and the MRI of the lumbar spine revealed left sided disc herniations at L2-L3 and a small focal disc herniation at L5-S1 (Petitioner's Exhibits 5 and 6).

Dr. Raskas saw Petitioner on November 22, 2016, and reviewed the MRI scans. He opined that the MRI of the thoracic spine was normal, but that the MRI of the lumbar spine revealed central disc herniations at L2-L3 and L5-S1. Dr. Raskas recommended Petitioner lose weight, do home exercises and be reevaluated in six months (Petitioner's Exhibit 5).

Dr. Raskas subsequently saw Petitioner on May 23, 2017. Petitioner advised that he lost 20 pounds and had begun to work out in a gym. Petitioner advised his back symptoms had improved, but that he still had a lot of pain at night. Dr. Raskas authorized Petitioner to return to work without restrictions, but recommended Petitioner be seen by Dr. Patricia Hurford for trial of epidural steroid injections (Petitioner's Exhibit 5).

Dr. Hurford saw Petitioner on September 5, 2017, and administered an epidural steroid injection at the L5-S1 level. When Petitioner was seen by Dr. Raskas on October 5, 2017, he advised that the injection helped relieve his symptoms. Petitioner also advised that he had continued to both lose weight and work out at the gym (Petitioner's Exhibit 5).

Dr. Raskas again saw Petitioner on November 10, 2017. At that time, Petitioner advised he was asymptomatic for his back and leg symptoms and was working full duty. Dr. Raskas opined Petitioner was at MMI and to follow up with him on an as needed basis (Petitioner's Exhibit 5).

At trial, Petitioner testified that the treatment he received, weight loss and exercise had improved his condition. Petitioner stated he still has some back symptoms, specifically stiffness in his back first thing in the morning. When time permits, Petitioner stated he was able to relieve those symptoms with stretching exercises. Petitioner acknowledged he was released return to work without restrictions; however, Petitioner now seeks assistance from others at work when needed. He has also limited his hobbies of automobile repair and coaching basketball. Petitioner does continue to take over-the-counter medication.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of seven and one-half percent (7 1/2%) loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner was a highway supervisor and sustained the injury when he was lifting a snow plow blade. Petitioner was released to return to work without restrictions; however, Petitioner stated he has modified how he performs his job duties and seeks assistance from others at work when needed. The Arbitrator gives this factor moderate weight.

Petitioner was 43 years old at the time of the accident. He will have to live with his disability for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence that the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

The medical treatment records confirmed that Petitioner sustained lumbar disc herniations at two levels, L2-L3 and L5-S1. While Petitioner made an excellent recovery because of the medical treatment he received, weight loss and exercise, Petitioner still has complaints of early morning back stiffness and takes over-the-counter medication. As aforestated, Petitioner stated he now seeks assistance from others at work when needed. Petitioner's complaints were consistent with the treatment records and the injuries he sustained. The Arbitrator gives this factor significant weight.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BARBARA CURTIS,

Petitioner,

vs. NO: 15 WC 38686

ABBOTT EMS,

18IWCC0503

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability (TTD), and prospective medical, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

For the reasons stated below, the Commission modifies the award of TTD and finds Petitioner is entitled to TTD benefits from November 16, 2016 through September 21, 2017.

The record establishes that Petitioner was taken off work by Dr. James Wade on November 15, 2016. Per the November 15, 2016 medical record, Petitioner was to be off work until she saw Dr. Matthew Gornet. However, the referral to Dr. Gornet was not approved. Instead, Respondent obtained a Section 12 opinion from Dr. Russell Cantrell on December 19, 2016 opining that Petitioner could return to work. However, the Commission is not persuaded by Dr. Cantrell's opinion. Dr. Cantrell readily admitted that he is not a surgeon and has never performed a lumbar surgery or fusion. He also acknowledged that Petitioner was asymptomatic prior to the accident and only had symptoms following the accident. He further acknowledged that it was possible for Petitioner's condition to become symptomatic through trauma. Despite his acknowledgements, he found Petitioner's condition was not caused, accelerated or aggravated by the work accident. The Commission finds no support in the record for his opinion.

Petitioner stopped receiving benefits shortly after Dr. Cantrell's examination and lost her insurance. Petitioner was unable to be examined by Dr. Wade until May 2, 2017 at which time Dr. Wade continued her off work. Petitioner had numerous follow-up examinations thereafter and has not been released back to work as of September 21, 2017, the date of the arbitration hearing. Therefore, the Commission finds Petitioner is entitled to TTD benefits from November 16, 2016 through the date of arbitration, September 21, 2017.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $358.40 per week for a period of 44-2/7 weeks, November 16, 2016 through September 21, 2017, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize the treatment recommended by Dr. Coyle, including but not limited to, the recommended lumbar decompression L5-SI with a Gill laminectomy and posterolateral and anterior interbody fusion.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical services totaling $9,795.49, and as contained in Petitioner's exhibit 1 as provided in Section 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

18IWCC0503

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.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $3,485.02 in medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $3,891.20 for TTD paid.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,400.00. 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 15 2018

MJB/tdm
O: 7/16/18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

CURTIS, BARBARA
Employee/Petitioner

Case# **15WC038686**

ABBOTT EMS
Employer/Respondent

18IWCC0503

On 10/19/2017, 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 1.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1459 LEVENHAGEN LAW FIRM PC
T FRITZ LEVENHAGEN
216 W POINTE DR SUITE B
SWANSEA, IL 62226

4876 ARNETT LAW GROUP
MONICA J KIEHL
223 W JACKSON BLVD SUITE 750
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
19(b)

Barbara Curtis
Employee/Petitioner

v.

Abbott EMS
Employer/Respondent

Case # **15** WC **38686**

Consolidated cases: **N/A**

18IWCC0503

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 21, 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. ☒ 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, **November 12, 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$27,955.20**; the average weekly wage was **$537.60**.

On the date of accident, Petitioner was **45** 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 **$3,891.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,891.20.**

Respondent shall be given a credit of **$3,485.02** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall authorize the treatment recommended by Dr. Coyle, including, but not limited to, the recommended lumbar decompression L5-S1 with a Gill laminectomy and posterolateral and anterior interbody fusion.

Respondent shall pay the reasonable and necessary medical services as contained in **Petitioner's Exhibit 1** 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 **$358.40**/week for **10 1/7**weeks, for the timeframes of **June 2, 2017 through June 29, 2017, July 7, 2017 through August 7, 2017 and September 11, 2017 through September 21, 2017,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$3,891.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,891.20.**

Respondent shall be given a credit of **$3,485.02** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

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

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

Melinda M. Price Sullivan
Signature of Arbitrator

10/17/17
Date

ICArbDec19(b)

OCT 19 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Barbara Curtis
Employee/Petitioner

Case # 15 WC 38686

v.

Consolidated cases: N/A

Abbott EMS
Employer/Respondent

18IWCC0503

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified at the time of arbitration that she was born on December 10, 1969 and was employed by Respondent at the time of the incident of November 12, 2015. She testified that she had been employed with Respondent initially in September 1996 until 2014, and then returned to work for Respondent on February 1, 2015 and has been continuously employed with them since that time.

Petitioner testified that on November 12, 2015, she was employed as a Paramedic/Field Training Officer and was required to hold certain certifications and licenses to practice as a Paramedic. She testified that she was required to lift a minimum amount of 100 pounds and be able to push and pull a minimum of 100 pounds, or whatever a patient may weigh, moving in difficult situations around patient's homes and taking people out of their homes going up and down stairs, carrying them. She testified that she was required to pass a pre-employment physical abilities or lifting test, which involved various physical maneuvers including getting out of the ambulance, pulling all the equipment off the truck, putting it on a stretcher, pulling the stretcher out of the ambulance, taking the equipment, airway bag, drug box and cardiac monitor over to a set of stairs, and going up and down the stairs both forward and backward several times, completing the task. She testified that during part of her pre-employment testing, she was required to lift one end of a backboard holding a mannequin weighting approximately 250 pounds and hold it to her waist for several seconds before reloading the equipment and stretcher back into the ambulance and completing two minutes of CPR. She testified that it was a timed test and that she passed this test before returning to work for Respondent in February 2015. She further testified that she was physically capable of performing all of her Paramedic job duties prior to February 2015.

Petitioner testified that on November 12, 2015, she and her partner, Daniel Williams, the on-duty supervisor, were dispatched to a bariatric patient that they were required to lift on a stretcher out to the truck and then load onto the ambulance. She testified that as she went to lift the stretcher up to put the patient into the truck, she felt a sharp, stabbing, burning feeling going into her low back. She testified that once the patient was loaded into the ambulance she got into the truck and that the patient started to grab ahold of her and used her as a pivot pole or bed post to manipulate herself on the stretcher. She testified that she started feeling pins and needles going down her legs at that time. She testified that she had never experienced low back pain or the pins and needles feeling she described prior to November 12, 2015. She testified that the Supervisor's Report of Injury accurately described what happened on November 12, 2015 and that she notified Respondent that same day.

Petitioner testified that her employer scheduled an appointment for her to be seen at BarnesCare on November 13, 2015. She testified that at BarnesCare an x-ray was performed, and she was given a ThermaCare wrap and Aleve for pain and placed on sedentary duty. She testified that that same day, her husband took her to the emergency room at Memorial Hospital because of her pain to see if they could provide her with additional pain relief. She testified that at the emergency room at Memorial Hospital, she received an injection of Toradol and a muscle relaxer as well as prescription medications. She testified that she was taken off from work for three days and instructed to follow-up with her primary care physician. She testified that her primary care physician is Dr. Wade and that he has been her primary care physician for approximately 10 years. She further testified that she is allergic to narcotics and that she informed the physicians who treated her as well as the medical personnel at BarnesCare that she was allergic to narcotics.

Petitioner testified that she continued to receive treatment at BarnesCare and that in December of 2015, BarnesCare referred her to Brefeld Physical Therapy and Dr. James Doll. She testified that Dr. Doll prescribed different medications and also imposed work restrictions. She testified that she followed up with her primary care physician, Dr. Wade, on January 13, 2016 and that he sent her to Dr. Ravi for a nerve conduction study. She testified that she returned to Dr. Doll for epidural steroid injections that were performed in February 2016 and in March 2016, and that Dr. Doll recommended that she be seen by a surgeon, Dr. Coyle, in St. Louis. She testified that the workers' compensation carrier scheduled an appointment for her to be seen by Dr. Coyle and that at the time of the first visit, Dr. Coyle discussed treatment options, including surgery, for her low back. She testified that Dr. Coyle also recommended that she quit smoking. She testified that in June of 2016, Dr. Wade recommended that she be seen by a different surgeon, Dr. Gornet. She testified that she did not see Dr. Gornet because he did not accept her group insurance and that the workers' compensation carrier would not approve the appointment.

Petitioner testified that on July 27, 2016, she was sent to see Dr. Cantrell. She testified that she saw Dr. Cantrell on one occasion and that he spent approximately 5-10 minutes examining her. She testified that Dr. Wade continued to treat her and that he sent her to be seen by Dr. Du for pain management. She testified that she underwent several injections with Dr. Du and that she continued to treat with Dr. Wade. She testified that in January 2017 an injection was scheduled for her to be performed by Dr. Du, but was not performed because she no longer had health insurance and workers' compensation would not approve it. She testified that Dr. Wade continued to treat her and last saw her on September 11, 2017. She testified that she has seen Dr. Coyle on three separate occasions. She testified that she was aware that Dr. Coyle had recommended low back surgery, but has not had the low back surgery because it has not yet been approved. She testified that she is requesting that an order be issued to authorize and pay for the surgery that was recommended for her by Dr. Coyle.

Petitioner testified that she was kept off from work for three days initially by the physicians at Memorial Hospital from November 13, 2015 through November 15, 2015. She testified that she was then placed on restricted duty and sent to Respondent's Belleville office, where she was not asked to perform any physical work but to simply sit in one of the back offices. She testified that she put two chairs together and laid on the chairs. She testified that in February of 2016, she was sent to perform light duty as a dispatcher in St. Louis for Respondent and that she performed the job as a dispatcher until November 15, 2016 when Dr. Wade took her off from work. She testified that she is still off from work under Dr. Wade's care from November 15, 2016 through the date of arbitration. She testified that she was unable to continue performing the job as a dispatcher because it involved bending and twisting and the use of multiple computer screens in front of her. She testified that the dispatching position required that she continuously twist and that she had issues sitting up straight and would have to sit on her hips because of her back pain. She testified that the pain became so severe that she could not do it any longer.

Petitioner testified that she has throbbing, burning and a pulling feeling in her low back with pins and needles down her legs and that she is unable to stand up completely straight. She testified that she is

unable to sit straight up without being in intense pain. She testified that she had no prior injuries requiring medical treatment for her low back and that she had no medical restrictions before November 12, 2015.

On cross-examination, Petitioner testified that she was asked by Dr. Coyle to quit smoking and that he informed her that she would need to be smoke-free for 30 days before surgery. She testified that she quit smoking on April 15, 2017. She testified that she saw Dr. Cantrell on July 27, 2016 and that she was truthful in the information that she provided to him. She testified that she did have group health insurance through her employer, but did not have group health insurance presently. She testified that some of the medical treatment she had was billed through her group health insurance. She testified that she does not currently have any health insurance. She testified that a week and a half prior to arbitration, she went to Medicaid and applied for Medicaid because she had no health insurance.

On re-direct Petitioner testified that she had not received any weekly workers' compensation benefits since January 2017.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The transcript of the deposition of Dr. James Coyle was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Coyle testified that he is a board-certified orthopedic spine surgeon and performs cervical, thoracic and lumbar spine surgeries for degenerative, traumatic and deformity conditions. (PX2).

Dr. Coyle testified that he first saw Petitioner on April 19, 2016 at the request of Sedgwick CMS. He testified that Petitioner reported that she was working with her partner as a paramedic and that on November 12, 2015, she and her partner were transferring a 650-pound patient onto a stretcher that had no hydraulic lift. He testified that Petitioner reported that she was putting the patient into the ambulance when she felt acute onset of back pain that she described as a hot knife being stabbed into her back. He testified that Petitioner complained of low back pain and tingling in her left leg that she stated had been present since her injury, that she had a burning sensation in the anterior right thigh, that she stated that the only way she could get relief was from lying on her left side and that her symptoms were worse when sitting and standing. He testified that Petitioner stated that she had gained weight since her injury and that she denied any history of prior back injury, symptoms, treatment or surgery. He testified that on examination Petitioner had difficulty sitting and sat with a trunk shift toward the right which was something seen with people who had nerve root compression on the left and that she would stand in a forward flexed posture, which was also indicative that when she leaned backwards she was causing nerve root compression. He testified that he reviewed the MRI and felt that there was a possible spondylolisthesis at L5-S1 which was essentially a bony problem, so he recommended a CT scan. (PX2).

Dr. Coyle testified that Petitioner had an isthmic spondylolisthesis, which meant that there was a slip because there was a pars defect. He testified that he opined that Petitioner's work injury represented an aggravation of spondylolisthesis in all likelihood causing a symptomatic left-sided lower extremity radiculopathy. He testified that no one saw it before because no one looked hard enough. He testified that he believed that the biomechanical stability of L5-S1 was in all likelihood compromised by the work accident of November 12, 2015. He testified that it was his impression that the lumbar radiculopathy that Petitioner now experiences was caused by the lifting accident of November 12, 2015. He testified that he issued restrictions of ten pounds lifting, no repetitive bending, stooping or twisting at the waist and intermittent sitting, standing and walking. He testified that he ordered Petitioner to stop smoking and to follow-up in one month after she had a nicotine test. He testified that he also recommended that Petitioner follow-up with Dr. Doll, but apparently she did not go back. He further testified that he recommended that Petitioner have a lumbar fusion. (PX2).

Dr. Coyle testified that when Petitioner returned on June 21, 2016, her symptoms were worse. He testified that when he walked in, Petitioner was lying on the exam table, could not stand upright and had pain when she would extend her back. He testified that he could not explain Petitioner's anterior thigh dysesthesia. He testified that he referred Petitioner to pain management and that he also wanted her scheduled for a lumbar decompression L5-S1 with a Gill laminectomy and posterolateral and anterior interbody fusion. He testified that he continued Petitioner on light duty restrictions at that time. He testified that at the time of the June 6, 2017 visit Petitioner had complaints of urinary incontinence, which would not be typical for L5-S1 spondylolisthesis. He testified that when Petitioner returned, she was using a cane and stated that she could not stand upright. He testified that Petitioner had tenderness to palpation of the back and stated that her primary care physician took her out of work in early December. He testified that he recommended repeating her MRI. He testified that Petitioner also indicated that she quit smoking 47 days prior and that they verified that with a negative nicotine test. (PX2).

Dr. Coyle testified that he had reviewed the reports of Dr. Cantrell and that he believed that it was significant that he did not note any history of prior symptoms similar to those that Petitioner had had after her lifting injury and that he did not take into consideration the fact that she was working in a reasonably heavy capacity as an emergency medical technician and had no history of prior injuries or symptoms of a similar nature. He testified that it was his position that the mechanism of injury was such that it caused Petitioner to become symptomatic and that it was demonstrated by the fact that she was able to do it beforehand and that she was not even able to sit upright at the present time. He testified that he found Petitioner's examination to be credible, that he found her history to be credible and that the only issue that he had with her was that she was smoking and that was why they delayed things. He testified that there was a delay of a year between when he saw Petitioner and indicated that she needed surgery and when she actually came back, and that in the interim she had seen Dr. Cantrell and was smoking so it probably would not have made any difference. (PX2).

On cross examination, Dr. Coyle agreed that what was contained in his file were the only medical records that he had reviewed. He testified that the isthmic defect and the pars defect were the same thing. He testified that isthmic spondylolisthesis was a spondylolisthesis that occurred with a pars defect. He testified that he recommended a specific kind of lumbar decompression for isthmic spondylolisthesis that was called a Gill laminectomy and that it included removing part of the facets. (PX2).

On cross examination, Dr. Coyle testified that the additional MRI and an intradiscal anesthetic injection at L5-S1 would be helpful from a diagnostic standpoint because the one confounding factor was the fact that Petitioner had anterior thigh pain. He testified that the tingling in Petitioner's left leg was consistent with lumbosacral radiculopathy. He testified that if there was no pain reproduced during the straight leg test, it did not mean that there was no radiculopathy. He testified that that it was not nearly as diagnostic as an MRI that showed pathology or a CT that showed significant foraminal stenosis. (PX2).

On cross examination, Dr. Coyle agreed that when he saw Petitioner on June 6, 2017, she was not working. He testified that he never saw any evidence of a hip infection. He testified that he did not see any evidence of Waddell's signs. (PX2).

The medical records of BarnesCare Midtown were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on November 13, 2015, at which time it was noted that she was on a call and was loading a bariatric patient that weighed approximately 600-650 pounds into the unit when her back felt like "someone had stuck a knife in it." It was noted that the patient was at the head of the cot and that Petitioner felt a sharp pain at the left lower back. The assessment was noted to be that of sprain of ligaments of lumbar spine. Petitioner was ordered to undergo x-rays of the lumbar spine and was also referred for an MRI of the lumbar spine. Petitioner was issued work restrictions of no kneeling, lifting limited to 5 pounds, pushing or pulling limited to 5 pounds, restricted to sedentary

work and no squatting, and it was noted that the anticipated duration until a return to full duty was that of four weeks. (PX3).

The records of BarnesCare Midtown reflect that Petitioner was seen on November 20, 2015, at which time it was noted that she was feeling the same since the last visit, had gone to the emergency room on November 19, 2015 and was currently taking the Flexeril she had been given at the emergency room. It was noted that Petitioner reported that she was currently working with restrictions. It was noted that Petitioner had not had the MRI because it was not approved until the day before. It was noted that Petitioner denied radiation down the legs and denied numbness or tingling in the legs. Petitioner was noted to have several positive Waddell's signs. The assessment was noted to be that of sprain of ligaments of the lumbar spine; concern for disc herniation. Petitioner was ordered to undergo the MRI and to continue her current work restrictions, including no personal driving and no commercial driving. Petitioner was also prescribed medications. At the time of the November 25, 2015 visit, it was noted that Petitioner was feeling the same since the last visit and had had the MRI. It was noted that Petitioner was currently taking Ibuprofen and Flexeril and was currently working with restrictions. It was noted that Petitioner was positive for 2/8 Waddell signs. It was noted that the MRI report was interpreted as abnormal and that there were scattered degenerative changes with L5-S1 disc bulge with mild bilateral foraminal stenosis and mild bilateral lateral recess stenosis and that no canal stenosis or evidence of an acute injury was seen. It was noted that Petitioner's pain level was consistent with the clinical exam, but then later was noted that the pain level of 7 may not be consistent with the clinical exam. Petitioner was instructed to continue work restrictions. Petitioner was prescribed medications and was given a Ketorolac injection and a Thermacare wrap. (PX3).

The records of BarnesCare Midtown reflect that Petitioner was seen on December 4, 2015, at which time it was noted that she was feeling the same since the last visit and that no additional treatment, tests or therapy had been performed since the last visit. It was noted that Petitioner had too much pain to do her exercises that she was given at the last visit and that physical therapy would be started. The assessment was that of subsequent dislocation of sacroiliac and sacrococcygeal joint. Petitioner was prescribed medications, to use heat and ice to the affected area and to return to sedentary work. Petitioner was also prescribed physical therapy. At the time of the December 11, 2015 visit, it was noted that Petitioner had not received permission to start physical therapy. Petitioner was referred to a physiatrist. It was noted that it may be that Petitioner improved with physical therapy, but since she was unable to drive the ambulance the clinician was only comfortable referring her to increased acuity care. It was noted that Petitioner had a less painful stance and gait, but that she was still obviously uncomfortable. It was noted that Petitioner was still tender over the bilateral SI joints with mild PSM tenderness in her lumbar region. The assessment was noted to be that of subsequent dislocation of sacroiliac and sacrococcygeal joint and subsequent strain of muscle, fascia and tendon of lower back. It was noted that Petitioner was to continue her work restrictions and was prescribed medications. Petitioner was also recommended to undergo physical therapy and referred to a physiatrist. (PX3).

Included within the records of BarnesCare Midtown was an interpretive report for x-rays of the lumbar spine performed on November 13, 2015, which were interpreted as revealing (1) four non-rib-bearing lumbar vertebral segments; grade I spondylolisthesis of L4 on L5; could not exclude pars defects; (2) no compression deformity is identified. Also included within the records of BarnesCare Midtown was an interpretive report for an MRI of the lumbar spine performed on November 24, 2015, which was interpreted as revealing (1) the dominant finding is mild degenerative disease without evidence of an acute injury; (2) there is mild bilateral lateral recess and foraminal stenosis at L5-S1; (3) no cord signal abnormality. (PX3).

The medical records of Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on November 13, 2015, at which time it was noted that she presented for severe low back pain from lifting greater than 600 pounds at work the day before that radiated to her buttocks and caused tingling. Lumbar spine x-rays were performed on that date,

which were interpreted as revealing (1) no acute osseous abnormality of lumbar spine: (2) grade 1 anterolisthesis of L5 on S1 with suspected bilateral pars defects; (3) multilevel lumbar spondylosis. It was noted that Petitioner was allergic to narcotics. Petitioner was prescribed various medications, discharged home and instructed to see her primary care physician, Dr. Wade, in three days. The records further reflect that Petitioner underwent EMG nerve conduction studies of the left lower extremity on January 22, 2016, which was interpreted as revealing no abnormal EMG findings. (PX4).

The medical records of Brefeld Physical Therapy Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent physical therapy for the timeframe of December 14, 2015 through February 4, 2016. At the time of the Physical Therapy Evaluation on December 14, 2015, it was noted that Petitioner was on an ambulance call to a patient weighing 600-650 pounds with a total of 6 persons and that Petitioner was lifting the patient on a gurney into the ambulance when her back felt like someone stuck a knife into it. At the time of the December 21, 2015 visit, it was noted that Petitioner was sensitive to the touch at the lumbosacral area and that her pain was unchanged with treatment. At the time of the December 23, 2015 visit, it was noted that Petitioner was very sensitive to pressure and even light touch in the lumbar paraspinal region and that she completed transitions at a slower pace with increased effort and needed initial minimal assist for balance when standing up from the plinth. At the time of the December 31, 2015 visit, it was noted that Petitioner reported pain at 7.5/10 after twisting yesterday and was having nausea and vomiting from the pain. At the time of the January 6, 2016 visit, it was noted that Petitioner reported pain at 10/10 after having to attempt to climb up/down out of the rig on that date. (PX5).

The medical records of Dr. James Wade were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on January 13, 2016 for a follow-up on anxiety and complaints of back pain. It was noted that Petitioner sustained an injury while working lifting an obese patient and that she felt immediate "hot burning" in the lumbar spine. The clinical impression was noted to be that of lumbar strain, sacroiliac joint degenerative joint disease and lumbosacral radiculitis, among others. Petitioner was recommended to undergo nerve conduction studies of the left lower extremity. At the time of the January 27, 2016 visit, Petitioner was seen in follow-up for the back pain and nerve conduction studies. The remainder of the handwriting on the note was illegible. (PX6).

Included within the records of Dr. Wade was an interpretive report for an MRI of the lumbar spine performed on January 29, 2016, which was interpreted as revealing mild disc bulging at the L5-S1 level which is minimally compressive on the neural foramen; findings are unchanged from prior study. Also included within the records of Dr. Wade was an interpretive report for an MRI of the lumbar spine performed on March 7, 2016, which was interpreted as revealing degenerative changes with facet arthropathy, disc bulging and questionable non-displaced pars defects at L5/S1 resulting in bilateral foraminal narrowing without central stenosis. The records further reflect that Petitioner underwent a CT of the lumbar spine on May 4, 2016, which was interpreted as revealing (1) bilateral pars defect at L5 with mild listhesis and associated degenerative changes; (2) listhesis and disc bulging at L5-S1 contribute to bilateral foraminal stenosis without significant central stenosis. (PX6).

The records of Dr. Wade reflect that Petitioner was seen on June 29, 2016, at which time it was noted that she stated that the pain in the lumbar spine and pain in the legs was getting worse, that she stated that the pain was becoming unbearable, that it was becoming more difficult to walk and that she was becoming more immobile. The assessment was noted to be that of (1) right-sided sciatica; (2) lumbar pain. Petitioner was given medications and referred to Dr. Garnett at Barnes. (PX6).

Included within the records of Dr. Wade was a work slip dated July 7, 2017, indicating that Petitioner could not return to work until August 7, 2017. The records reflect that Petitioner was seen on September 14, 2016, at which time it was noted that she had continual pain in the lumbar back with sciatica, that she was eating the Neurontin like candy, that nothing was helping the pain and that she had continual

pain in the right thigh. The assessment was noted to be that of (1) right-sided sciatica; (2) hip pain; (3) lumbar pain. Petitioner was prescribed various medications and referred to Dr. Du. (PX6).

The records of Dr. Wade reflect that Petitioner was seen on October 5, 2016, at which time it was noted that she returned to the office after being sent there by pain management with high blood pressure. It was noted that Petitioner stated that the pain in the back and the leg was excruciating. The assessment was noted to be that of (1) right-sided sciatica; (2) hip pain; (3) lumbar pain. Petitioner was started on medication for her high blood pressure. (PX6).

The records of Dr. Wade reflect that Petitioner was seen on November 15, 2016, at which time it was noted that the pain was getting worse, that nothing was working and that the pain was becoming unbearable. The assessment was noted to be that of (1) right-sided sciatica; (2) hip pain; (3) lumbar pain. Petitioner was given a refill of her medications and was also given a work slip indicating that she could not return to work until evaluated by Dr. Gornet. At the time of the May 2, 2017 visit with Dr. Wade, it was noted that Petitioner continued to have the lumbar back pain and pelvic pain, that she stated that she was getting no better and that she was now using a cane. The assessment was noted to be that of (1) right-sided sciatica; (2) hip pain; (3) lumbar pain. Petitioner was given medication refills. (PX6).

The records of Dr. Wade reflect that Petitioner was seen on June 2, 2017, at which time it was noted that she had persistent lumbar pain secondary to foraminal stenosis at L5-S1, that she was unable to sit or stand for greater than 20-30 minutes without needing to change position, that she was getting hip bursitis secondary to this being the most comfortable position for her with side lying and that she was still having right sciatica and left leg paresthesias. The assessment was noted to be that of (1) lumbosacral pain; (2) lumbar foraminal stenosis; (3) radicular pain of both lower extremities. A work slip was issued on that date, indicating that Petitioner needed to be off work until she was reevaluated by a doctor in four weeks. At the time of the July 7, 2017 visit, it was noted that Petitioner had complaints of persistent and worsening of pain in the lumbar and sacral area, that she was unable to sit for greater than 30 minutes and stand for up to 30 minutes and that she got increased pressure and pain in the lumbar area with either of these. It was noted that Petitioner was getting weaker and was having less stamina of the lumbar paraspinal muscles as well as lower extremities, that she was getting frustrated and had no idea what to do, that she was scared that things were worsening and that there was no resolution other than surgery which was being held up. The assessment was noted to be that of (1) lumbar pain; (2) right-sided sciatica; (3) lumbar foraminal stenosis; (4) radicular pain of both lower extremities; (5) lumbar spondylosis. Petitioner was instructed to continue her current medications and continue off work. (PX6).

The records of Dr. Wade reflect that Petitioner was seen on August 4, 2017, at which time it was noted that she stated that she still had severe pain in the hips and the lumbar spine, that she stated that the pain was becoming unbearable and that she was getting worse. The assessment was noted to be that of (1) lumbar pain; (2) right-sided sciatica; (3) hip pain. Petitioner was instructed to continue her medications. At the time of the September 11, 2017 visit, it was noted that Petitioner stated that she continued to have the lumbar back pain with muscle spasms and that she continued to take her medications. It was noted that Petitioner's pain was persistent and worsening in the lumbar and sacral area, that she was unable to sit greater than 30 minutes and stand for up to 30 minutes, that she got increased pressure and pain in the lumbar area with either of these and that she was getting weaker and having less stamina of the lumbar paraspinal muscles as well as the lower extremities. It was noted that the only resolution for Petitioner at that point was surgery. The assessment was noted to be that of (1) right-sided sciatica; (2) hip pain; (3) lumbar spondylosis; (4) lumbar pain. Petitioner was given refills of her medications. A work slip was issued on that date, indicating that Petitioner could not return to work until re-evaluated in one month. (PX6).

Paycheck Stubs (2/1/15-11/21/15) were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The transcript of the deposition of Dr. Russell Cantrell was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Cantrell testified that he is board-certified and estimated that 75% of the patients that he sees have some type of spinal pain or injury either in reference to their cervical, thoracic or lumbar spine. He testified that he saw Petitioner for an independent medical examination on July 27, 2016 for problems referable to her lower back. (RX1).

Dr. Cantrell testified that at the time of the IME, Petitioner's current complaints were those of low back pain that was aggravated with any prolonged sitting or prolonged standing and could only be partially relieved if she would lay in a left-side lying position. He testified that Petitioner's complaints were increased if she laid in a supine position even if her legs were bent and that they were also increased if she laid on her right side. He testified that Petitioner complained of tingling that was diffusely present in her left lower extremity and was present on a constant basis, that it was not changed with position and that she also described symptoms in her right anterior thigh that were constant and unchanged with position. (RX1).

Dr. Cantrell testified that at the time of the November 13, 2015 visit at BarnesCare, it was noted that there were several positive Waddell's signs and that these were considered findings on an examination or symptoms reported by a patient that would not typically be manifest by usual anatomic pathologies. He testified that if someone had a traumatic radiculopathy meaning a radiculopathy as a result of some kind of blunt trauma or lifting event where there was a disc herniation or some type of acute spinal pathology, the nerve symptoms that followed that trauma would typically present themselves usually within 2-3 days of an injury. (RX1).

Dr. Cantrell testified that on examination, one of Petitioner's complaints was that of tingling in the left leg that was present constantly but that this was not consistent with a lumbosacral radiculopathy. He testified that there were a few things that caused tingling in the entirety of the leg because there were multiple nerves that supplied sensation to any one extremity. He testified that he did not have a specific explanation for that symptom and that it would be considered one of the positive Waddell's signs. When asked whether Petitioner's subjective complaints were consistent with the objective findings, Dr. Cantrell responded that technically there were not any objective findings in that her strength and reflexes were normal, that the range of motion limitations were really limited volitionally and that he did not document any spasms. He testified that his review of the MRIs of January 29, 2016 and November 24, 2015 did not have any changes present between the two and that they both showed a grade 0-1 spondylolisthesis at the L5-S1 level with mild disc space narrowing and mild disc space dessication and that there was a broad-based bulging disc at the same level but that there were no disc herniations. He testified that his review of the CAT scan of May 4, 2016 showed a bilateral pars defect at the L5 level, degenerative disc disease at L5-S1 with the CT showing some bony spurring off of the inferior end plate of the L5 level, some mild disc space narrowing and grade 0-1 spondylolisthesis. (RX1).

Dr. Cantrell testified that after he performed the examination, he did not feel that Petitioner was at maximum medical improvement and that he believed at that point that he had recommended SI joint injections for both diagnostic and therapeutic purposes. He testified that he suggested that if there was no substantial relief from her pain complaints, then consideration could be given to a lumbar myelogram and CAT scan because of the evolving nature of her symptoms. (RX1).

Dr. Cantrell testified that he was then forwarded additional medical records and the March 7, 2016 MRI, and that he authored the December 19, 2016 addendum report thereafter. He testified that his review of the March 7, 2016 MRI was that it showed degenerative facet arthropathy, bulging disc, broad-based in nature at the L5-S1 level and a questionable non-displaced pars defect at L5-S1 that was resulting in bilateral foraminal narrowing without stenosis. He testified that his diagnosis after review of the additional records was that of chronic lumbar back pain with subjective complaints of numbness and tingling in her lower extremities that was not consistent with a lumbosacral radiculopathy. He testified that there were not any electrodiagnostic abnormalities that would support Petitioner's radiculopathy and that she did not have

any responses to an interlaminar injection to the spine. He testified that the significance in particular of the transforaminal injections at the L5-S1 level was that if her symptoms were as a result of the minor pathology present at L5-S1, the lack of response to the L5 nerve blocks would indicate that it was not the source of her symptoms. He further testified that it was his opinion that the work injury did not cause any pathology in Petitioner's lumbar spine and that it did not accelerate or aggravate her preexisting conditions. (RX1).

On cross examination, Dr. Cantrell agreed that he saw Petitioner on one occasion. He testified that he did not know whether he had noted how long Petitioner had worked for Respondent. He testified that Petitioner told him that she was lifting an obese patient on the date of injury. He agreed that it was his understanding that Petitioner was working full duty without restrictions prior to the injury that took place on November 12, 2015. He testified that he did not think whether Petitioner did or did not finish out her workday would have any significance to the symptoms that she was reporting to him when he saw her or, for that matter, the symptoms she was reporting to the physicians that saw her the next day. (RX1).

On cross examination, Dr. Cantrell when shown the anatomical diagram dated November 13, 2015 agreed that there was an indication of pins and needles in the lower extremities bilaterally at the bottom portion of the buttocks. He testified that the symptoms of radiculopathy were usually unilateral because if someone had a disc herniation it usually herniated to the right or left and therefore caused either right or left symptomatology. He agreed that in this case, they were not talking about a disc herniation and that they were talking about spondylolisthesis with a pars defect. He testified that mild spondylyolisthesis typically did not cause radicular symptoms but that if it was advanced, it certainly could. (RX1).

On cross examination, Dr. Cantrell testified that he was not a surgeon and that he has never performed a lumbar spine surgery or fusion. He agreed that Dr. Coyle was a spine surgeon and that his area of expertise was in physical medicine. He agreed that a lumbar decompression at L5-S1 with laminectomy and posterolateral and anterior interbody fusion was a recognized type of surgical intervention for individuals suffering from symptoms resulting from L5-S1 spondylolisthesis. (RX1).

On cross examination when asked if positive findings in the Waddell's testing necessarily meant that there was malingering, Dr. Cantrell responded that malingering would imply that the person had no symptom and that Waddell's findings were construed to be someone who might be exaggerating their symptoms but it did not imply that they did not have a symptom. He agreed that he reviewed the records from Dr. Wade going back to 2009 and that from his review of the records, Petitioner did not have any prior treatment for her low back from Dr. Wade that he could see. He testified that he disagreed with Dr. Coyle who believed that Petitioner's condition of isthmic spondylolisthesis with pars defect was symptomatic and responsible for her symptoms that she experienced. He testified that he thought it was difficult to establish a diagnosis when a person had a number of non-organic clinical findings and did not have any objective basis to correlate with the distribution of symptoms that they had. (RX1).

On cross examination, Dr. Cantrell agreed that all of the radiographic studies showed the presence of a pars defect at L5-S1 and that it was a bony condition. He testified that a negative nerve conduction study did not rule out L5-S1 spondylolisthesis with pars defect as being the cause of Petitioner's symptoms and testified that it was purely analyzing whether there was dysfunction of a nerve root. (RX1).

The medical records of Dr. Kevin Du were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner was seen on September 15, 2016, at which time it was noted that she presented for evaluation of her lower back pain and leg pain. It was noted that Petitioner stated that on January [*sic*] 12, 2015, she injured her back by lifting a heavy patient and that the pain from the lower back radiated to her bilateral legs. It was noted that Petitioner had her first lumbar epidural injection in February 2016, which helped her pain somewhat. It was noted that Petitioner complained that her pain was a 10/10, that it was constant, that it interfered with her sleep and that she had tried physical therapy and aquatic therapy which did not help her pain. The impression was noted to be

that of (1) L5-S1 spondylolisthesis; (2) bilateral L5-S1 radiculopathy; (3) lumbar spondylosis; (4) bilateral sacroiliac joint degenerative joint disease. Petitioner was recommended to take Mobic and Zanaflex for her back pain as well as her back muscle spasm. Petitioner was recommended to undergo bilateral L5-S1 transforaminal epidural injections to relieve her back and leg pain, which were performed on September 21, 2016 for the diagnoses of (1) bilateral L5-S1 spondylolisthesis; (2) bilateral L5-S1 radiculopathy; (3) lumbar spondylosis. (RX2).

The records of Dr. Du reflect that Petitioner underwent bilateral L5-S1 transforaminal epidural steroid injection with fluoroscopic guidance on October 12, 2016 for diagnoses of (1) L5-S1 spondylolisthesis; (2) multilevel lumbar spondylosis; (3) bilateral L5-S1 radiculopathy. The records reflect that Petitioner underwent bilateral L5-S1 and right L4-L5 transforaminal epidural steroid injection with fluoroscopic guidance on November 9, 2016 for diagnoses of (1) L5-S1 spondylolisthesis; (2) L4-L5 spondylosis; (3) low back pain with bilateral leg pain; (4) bilateral lumbar radiculopathy. The History and Physical dated December 15, 2016 noted that Petitioner had a history of chronic lower back pain and bilateral leg pain secondary to lumbar spondylolisthesis and lumbar spondylosis. It was noted that Petitioner was treated with bilateral lumbar transforaminal epidural steroid injection and that her leg pain had pretty much gone, but that her lower back pain still bothered her somewhat. It was noted that the pain was in the lower back on both sides across her waistline and that her lumbar spine x-rays demonstrated multilevel lumbar degenerative joint disease and multilevel degenerative disc disease, as well as SI joint degenerative joint disease. The impression was noted to be that of (1) lumbar facet joint degenerative joint disease at multiple levels; (2) lumbar degenerative disc disease at multiple levels; (3) multilevel lumbar spondylosis; (4) lumbar spondylolisthesis; (5) chronic lower back pain. Petitioner was recommended to try bilateral lumbar facet joint steroid injections to manage her low back pain, which were performed on December 19, 2016. (RX2).

The medical records of Dr. James Doll were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was issued a Work Status Report on November 12, 2015, allowing her to return to work with restrictions including no repetitive bending, twisting or squatting activities and no climbing stairs. The records reflect that Petitioner was seen on March 7, 2016, at which time it was noted that she was seen for follow-up after a repeat MRI study of the lumbar spine. It was noted that Petitioner continued to report severe back pain with pain radiating throughout the bilateral lower extremities, that she continued to report 10/10 level of pain and that she denied any new symptoms or injuries. It was noted that the MRI study performed on March 7, 2016 revealed multilevel degenerative changes including a broad-based disc bulge at the L5-S1 level, questionable non-displaced pars defects noted at L5-S1 and bilateral foraminal narrowing without central canal stenosis. It was also noted that Petitioner appeared in moderate distress, moving in a slow and guarded fashion with significant grimacing and groaning during attempted motion and that she preferred to lean on the counter in a mildly forward flexed position. The impression was noted to be that of (1) lumbosacral strain – acute on November 12, 2015; (2) lumbar spondylosis; (3) bilateral lower extremity pain. Petitioner was instructed to continue her current medications, home exercise program and current restrictions. It was noted that they also discussed obtaining a spine surgical consultation. (RX3).

The records of Dr. Doll reflect that Petitioner was seen on February 23, 2016, at which time it was noted that she reported that her condition had worsened in her lower back. It was noted that Petitioner reported that she had a new onset of 10/10 right thigh burning pain, that this had occurred since her lumbar epidural steroid injection and that she had a coughing fit as well which led to a stiff neck sensation. It was noted that Petitioner had continued to use Gabapentin, which helped mildly with her symptoms. It was also noted that Petitioner appeared in moderate distress, moving in a slow and guarded fashion with significant grimacing and groaning during attempted motion and that she preferred to lean on the counter in a mildly forward flexed position. The impression was noted to be that of (1) lumbosacral strain – acute on November 12, 2015; (2) mild lumbar spondylosis; (3) new onset of right lower extremity pain – severe. Petitioner was

recommended to continue restricting her activity as she had been doing. Petitioner was also recommended to undergo a new MRI of the lumbar spine and to continue her current restrictions and medications on an as-needed and as-tolerated basis. The records reflect that on February 9, 2016, Petitioner underwent lumbar epidural steroid injection under fluoroscopic guidance. (RX3).

The records of Dr. Doll reflect that Petitioner was seen on February 3, 2016, at which time it was noted that the new MRI study was compared to the prior study, that no significant changes were identified and that the new study also revealed degenerative changes including facet arthropathy, disc dessication, disc bulging and minimal neuroforaminal narrowing. It was noted that Petitioner reported ongoing disabling low back pain with limited movement with ongoing oral medications and her home exercise program. It was noted that Petitioner continued to move in a slow and guarded fashion with limited voluntary lumbar range of motion associated with complaints of low back pain and that increased tissue tension was palpable in the left lumbar paraspinal musculature compared with the right. The impression was noted to be that of (1) lumbosacral strain – acute on November 12, 2015; (2) mild lumbar spondylosis. Petitioner was recommended to undergo a lumbar epidural steroid injection for localized anti-inflammatory treatment. At the time of the January 20, 2016 visit, it was noted that Petitioner reported no improvement in her condition, that the therapist had tried working with her but she had not been able to increase her ambulation and that she was still walking slowly and with a limp favoring the left lower extremity. It was noted that Petitioner reported ongoing severe pain with radiation down her left leg, that she described a pins and needles-type sensation throughout her left leg and that she sought attention from her primary care physician who suggested a trial of Gabapentin, which had been taking the edge off her pain mildly. The impression was noted to be that of (1) lumbosacral strain, acute, on November 12, 2015; (2) mild lumbar spondylosis. It was noted that Petitioner had tried a sacroiliac joint belt and additional physical therapy, but there was no improvement in her condition thus far. Petitioner was recommended to undergo a repeat MRI study of the lumbar spine for comparison with her original study and was instructed to continue with restricted activities and her home exercise program. It was noted that Petitioner stated that she had had significant difficulty climbing up into the ambulance in order to drive the ambulance due to her persistent severe pain, and that she would subsequently avoid climbing activities and follow-up after her new diagnostic test. (RX3).

The records of Dr. Doll reflect that Petitioner was seen on January 5, 2016, at which time it was noted that on November 12, 2015 she was working as a part of her regular job duties as a paramedic for Abbott EMS and was attempting to assist in the lift of a 650-pound patient up into place while in the ambulance on a stretcher. It was noted that Petitioner reported that she developed severe low back pain at a level of 10/10 in intensity and had had ongoing symptoms despite conservative care through BarnesCare. It was noted that Petitioner found that therapy was helpful as was the use of a TENS unit, that she used Flexeril to help her sleep and that she continued to have difficulty with sitting and lying on her back as well as twisting. It was noted that Petitioner reported that when she was sitting for a prolonged period of time she would experience numbness throughout her entire left leg without any specific pattern and that she had not had such symptoms in the right lower extremity. The impression was noted to be that of (1) lumbosacral strain – acute on November 12, 2015; (2) mild lumbar spondylosis; (3) history of an occupational injury on November 12, 2015. Petitioner was recommended aquatic physical therapy and a change in medication. Petitioner was instructed to avoid lifting over 15 pounds and to avoid repetitive bending, twisting and squatting activities and a sacroiliac joint belt for support during her rehabilitation was recommended. (RX3).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being is causally related to the accident of November 12, 2015.

The Arbitrator finds Dr. Coyle's opinions to be more authoritative and persuasive by virtue of the fact that he is a board-certified orthopedic spine surgeon, whereas Dr. Cantrell admitted on cross examination that that he was not a surgeon and that he has never performed a lumbar spine surgery or fusion. (RX1). The Arbitrator finds to be significant in this case that even despite his admission that he does not perform surgery, Dr. Cantrell himself agreed that a lumbar decompression at L5-S1 with laminectomy and posterolateral and anterior interbody fusion was a recognized type of surgical intervention for individuals suffering from symptoms resulting from L5-S1 spondylolisthesis. (RX1).

The Arbitrator places significant weight upon Dr. Coyle's testimony that he believed Petitioner's work injury represented an aggravation of spondylolisthesis in all likelihood causing a symptomatic left-sided lower extremity radiculopathy and that no one saw it before because no one looked hard enough. (PX2). The Arbitrator notes that Dr. Coyle testified that he found Petitioner's examination to be credible, that he found her history to be credible and that the only issue that he had with her was that she was smoking and that was why they delayed things. (*Id.*). The Arbitrator further notes that Petitioner appeared to be quite uncomfortable throughout the entirety of the proceedings, that she stood up leaning against the chair in the arbitration hearing room and that she leaned to her left when seated.

Having reviewed and considered the entirety of the medical evidence in the case and placing greater weight upon the opinions of Dr. Coyle in this matter, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being is causally related to the accident of November 12, 2015.

With respect to disputed issue (J) pertaining to reasonable and 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 her work accident of November 12, 2015. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 1, 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. Coyle, including, but not limited to, the recommended lumbar decompression L5-S1 with a Gill laminectomy and posterolateral and anterior interbody fusion.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner claimed entitlement to temporary total disability benefits for the timeframe of November 15, 2016 through September 21, 2017. (AX1).

The Arbitrator notes that only four work slips were included within the medical records of Dr. Wade: (1) a slip dated November 15, 2016 taking Petitioner off work until evaluated by Dr. Gornet; (2) a work slip dated June 2, 2017, taking Petitioner off work until she was reevaluated in four weeks; (3) a work slip dated July 7, 2017, taking Petitioner off work until August 7, 2017; (4) a work slip dated September 11, 2017, taking Petitioner off work until reevaluated in one month. (PX6).

"[T]o prove **temporary total disability**, the employee must demonstrate not only that he did not work, but also that he was unable to work." *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256, 899 N.E.2d 365, 378, 326 Ill. Dec. 148 (2008). As the Arbitrator finds that Petitioner has failed to demonstrate that she did not work and was unable to work during the timeframes of November 15, 2016 through June 1, 2017, June 30, 2017 through July 6, 2017 and August 8, 2017 through September 10, 2017, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits for these specific timeframes.

As to the timeframes of June 2, 2017 through June 29, 2017[1], July 7, 2017 through August 7, 2017 and September 11, 2017 through September 21, 2017 (*i.e.*, the date of arbitration), the Arbitrator finds that Petitioner has demonstrated that she did not work and was unable to work during these timeframes based upon the work slips that were entered into evidence at the time of arbitration. As such, the Arbitration finds that Petitioner is entitled to temporary total disability benefits only for these specific timeframes.

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.

[1] The Arbitrator calculates the date of June 29, 2017 based upon the June 2, 2017 work slip from Dr. Wade's office having taken Petitioner off work until reevaluated in four weeks.

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BONNIE BARKMAN,

Petitioner,

vs. NO: 13 WC 42199

ILLINOIS DEPARTMENT OF TRANSPORTATION,

18IWCC0504

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision of the Arbitrator only to vacate the compensation awarded under Section 8(d)2 of the Act for the fracture of Petitioner's fourth rib. The Commission does not dispute Petitioner sustained what was described in the Decision of the Arbitrator as "a very small nondisplaced slightly impacted fracture of the fourth rib" but concludes the fractured rib did not result in a permanent disability.

Petitioner's rib was fractured when she fell against the doorframe of office door on May 2, 2013. She fell against the doorframe when her feet got entangled in the wheels of her office chain and lost her balance.

Petitioner was taken to OSF St. Elizabeth Medical Center immediately after the accident where she complained of and was treated for injuries involving her left upper extremity. X-rays were taken at that time and revealed no acute injury to her left shoulder but did reveal a radial head fracture of her left elbow. Petitioner was discharged from OSF St. Elizabeth Medical Center

with a prescription for pain medications and with an instruction to follow-up with an orthopedic surgeon. Petition came to be seen by Dr. Eric Ortinau, an orthopedic surgeon at Rezin Orthopedics, on May 6, 2013.

Dr. Oritnau performed a physical examination of Petitioner and elicited a finding of tenderness to the lateral side of her upper rib cage. The subsequently ordered x-rays revealed a non-displaced fracture of the left fourth rib. Dr. Oritnau's examination of Petitioner was cut short due to Petitioner experiencing dizziness and shortness of breath attributable to pain that necessitated her to be transported by ambulance to OSF St. Elizabeth Hospital.

Petitioner did not return to Dr. Ortinau for further treatment of injuries but opted to treat with Dr. Michael Morrow at Family Health Center on May 13, 2013. She presented to Dr. Morrow principally to address her fractured elbow. Her fractured rib was also addressed by Dr. Morrow. He concluded no further treatment was necessary as the pain about the rib had largely resolved. Dr. Morrow's May 13, 2013, assessment that no further treatment of Petitioner's rib was necessary appears to be accurate as Petitioner's subsequent medical records never again recorded her complaining about her rib.

More than four years after Petitioner's May 2, 2013, she testified that her rib was "fine." She offered no testimony of any tenderness about the rib or of any pain when either inhaling or exhaling.

Absent any testimony or medical record to the contrary, the Commission finds the evidence indicates the rib Petitioner fractured in her fall on May 2, 2013, resolved within weeks of her fall and resulted in no permanent disability to the rib.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $686.77 per week for a period of 3-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $618.09 per week for a period of 25.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $618.09 per week for an additional 10.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 5% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that the Order that Respondent pay to Petitioner the sum of $618.09 per week for 5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 1% loss of use of the person as a whole for the fractured fourth rib is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner for medical expenses incurred under §8(a) and §8.2 of the Act related to the treatment of Petitioner's left arm and left hand. Respondent shall be given a credit for all amounts paid

towards Petitioner's medical care and shall Petitioner harmless from any claims from any obligations of her personal insurance for bills it paid relative to this matter as well as any obligations by any providers of services for which Respondent is receiving credit as provided for in §8(j) 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 in the amount of $1,290.51 for temporary total disability benefits that have been paid and shall reimburse Petitioner's vacation time.

DATED:
KWL/mav
O: 07/10/18
42

AUG 15 2018

Kevin W. Lamborn

David L. Gore

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARKMAN, BONNIE
Employee/Petitioner

Case# **13WC042199**

IL DEPT OF TRANSPORTATION
Employer/Respondent

18IWCC0504

On 11/20/2017, 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 1.36% 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:

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
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PERU, IL 61354

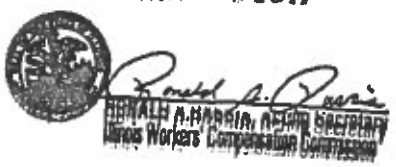
5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
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 20 2017



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

Bonnie Barkman
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 13 WC 42199

Consolidated cases: ____

18IWCC0504

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 **Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **October 27, 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 **May 2, 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 **$53,567.80**; the average weekly wage was **$1,030.15**.

On the date of accident, Petitioner was **58** 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 **$1,290.51** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,290.51**.

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 $686.77/week for 3 5/7 weeks, commencing May 2, 2013 through May 27, 2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $1,290.51 for temporary total disability benefits that have been paid and shall reimburse Petitioner's vacation time. SEE DECISION

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related injury pursuant to Sections 8 and 8.2 of the Act and shall pay to Petitioner the out of pocket expenses incurred. Respondent shall be given a credit for all amounts paid and shall hold Petitioner harmless from any claims from any obligations of her personal insurance for bills it paid relative to this matter as well as any obligations 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 $618.09 per week for 25.3 weeks in that Petitioner sustained 10% loss of use of the left arm pursuant to Section 8(e) of the Act. Respondent shall pay Petitioner $618.09 per week for an additional 10.25 weeks in that Petitioner sustained 5% loss of use of the left hand pursuant to Section 8(e) of the Act. Respondent shall pay Petitioner $618.09 per week for an additional 5 weeks in that Petitioner sustained 1% loss of use of the person as a whole for the fractured 4th rib pursuant to Section 8(d)(2) of the Act.

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

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

Carolyn M. Doherty

Signature of Arbitrator

11/17/17

Date

FINDINGS OF FACT

Petitioner testified that on 5/2/13 she worked for the Respondent Illinois Department of Transportation as an executive secretary in the bureau of administration. Petitioner testified that she had worked 17 years for IDOT on 5/2/13. Petitioner's duties included general secretarial duties such as filing reports and sign out sheets for 150 employees. Petitioner had her own office which she described as very small and measuring approximately 8 to 9 feet wide. The office contained an L shaped desk, a chair, and 3 filing cabinets. The office was also full of boxes and "crammed" full of furniture.

PX 9 contains photos of Petitioner's office. The photos specifically depict a tall 4 drawer filing cabinet in the office. On top of the cabinet are two tall vertical boxes with multiple slots for filing papers. Petitioner testified that she is 5'6" tall and that when filing in the vertical boxes above the filing cabinet she reached above her head at a 90 degree angle and slightly to the back of the shelves. She further estimated that she reached over 6 feet into the filing boxes. She testified that while filing her feet are generally on the ground in front of the cabinet but that she might be on her toes when reaching for the top filing slot.

The photos at PX 9 also depict a chair placed on an angle and used to keep the door propped open. Petitioner testified that the chair always remains in the same position and is not moved to different areas in the office. The chair is at an angle facing the desk with the seat of the chair approximately 2 feet from the desk. The chair has a metal frame. PX 9 D and E depict the chair from a different angle as holding the door open and its close proximity to the 4 drawer filing cabinet. Petitioner testified that the area between the filing cabinet and the chair is about a 2 foot area.

Petitioner testified that on 5/2/13, she was filing papers in the vertical filing shelves on top of the filing cabinet. She testified that she finished filing the stack she had in her hand while standing in the 2 foot area between the chair and the filing cabinet and facing the cabinet. She testified that she intended on getting another pile of papers from the chair. Petitioner testified that she backed up and turned to get another stack of documents off the chair behind her. Petitioner testified at that point that she "caught" the chair and "went backwards". She further described stumbling on the chair or somehow "getting tripped" by the chair behind her. Petitioner struck the steel office door with her left shoulder, side and back. Petitioner's left arm hit the metal arm of the chair. Petitioner noticed immediate swelling of her left arm and hand. The swelling is depicted in a PX 9 photo A.

Petitioner testified that she was in severe pain but refused an ambulance. She was assisted by two co-workers and taken to the Ottawa Medical Center clinic. The history indicates, "pt said she was filing at work this am and not sure what happened but she "went back" and ell on her left elbow/arm. C/o let shoulder, arm and elbow pain." Further history states, "...The onset of arm pain has been sudden and has been occurring in a persistent pattern for 1 hour. The course has been increasing. The pain is described as moderate. Note for "pain." Pt sustained a fall while at work. Occurred while standing. Pt unsure of how she lost balance. Denies tripping. Denies LOC. Denies head trauma. No witnesses. Pt reports stepping backwards due to imbalance, hit left shoulder in doorway, continued to step backwards and fell onto a desk, hitting left elbow and forearm. Colleagues heard the fall and immediately attended to pt. Report was she was conscious and alert but in pain. Following x-rays Petitioner was diagnosed with a radial head fracture of the left arm and a long arm volar splint

was applied. Petitioner was recommended ice and rest with elevation and Hydrocodone as needed. She was to follow up with an ortho in 5-7 days. PX 2.

Petitioner completed an accident report on 5/4/13. PX 8. The report indicates the place of accident as Petitioner's office at the east wall of filing cabinets. Petitioner was standing facing the filing cabinet. Petitioner wrote, "lost balance. Fell backwards. Hit arm on chair. Kept going backwards. Hit door frame with shoulder." PX 8

Petitioner testificd that she followed up with orthopedic Dr. Ortinau on 5/6/13. PX 4. Petitioner complained of left elbow and left shoulder pain. He noted she fell "in the office." Prior shoulder x-rays from 5/2/13 were normal. Additional X-rays revealed a very small nondisplaced slightly impacted fracture of the fourth rib. He noted the prior left elbow and forearm x-ray report from 5/2/13 revealed irregularity involving the cortex of the radial head suggesting fracture with no significant displacement and small elbow joint effusion. Dr. Ortinau read the elbow x-ray to read as showing "a nondisplaced slight impacted fracture of the radial neck." He diagnosed a non-displaced left 4th rib fracture and a radial neck fracture of the left elbow and took Petitioner off work. PX 4. He noted the rib did not to be immobilized and would be treated with "expected management." He recommended a brief period of sling immobilization for the radial head fracture and follow up in one week. Pctitioncr was also light headed at the visit due to pain so she was taken by ambulance to OSF for further evaluation. PX 3.

Petitioner testified that on 5/13/13 she next saw her own family doctor, Dr Morrow and reported that she "fell at work while she was standing filing. Fell over backwards onto her left shoulder and resulted in injury elbow fx. Denies light headedness, vertigo, palpations prior no syncope denies any of those symptoms since as well except one episode presyncope associated with severe pain of wrist. Occurred several days after initial episode." Petitioner also offered a history of fainting through her life usually associated with noxious stimuli i.e. getting shots, standing in church etc." Lastly, she reported episodes of palpation lasting one minute and not associated with light headedness or vertigo. PX 5. Dr. Morrow diagnosed a closed elbow fracture and a closed fracture of the rib. He told Petitioner to follow up with Dr. Shin, an ortho, for the elbow and noted "no further treatment for the rib fracture. Pain already largely resolved." PX 5.

Petitioner saw Dr. Shin on 5/14/13 and reported filing at work and falling hitting her left elbow on a chair and then on a doorway. PX 6. Petitioner reported taking Norco with her pain level at 1/10 with no arm movement but 8 out of 10 with any movement of her arm. She reported no numbness or tingling since the swelling subsided in her left arm and no radiation of pain. Petitioner described the elbow pain as very sharp and the 4th rib pain as dull and throbbing worse with coughing or breathing. Petitioner was kept in the sling for her arm to protect from further damage but was told to begin gentle exercise out of the sling 2 to 3 times per day. Petitioner was kept off work through May 28, 2013 when she would return to work with restriction of no use of the left arm other than typing with the sling on. Petitioner was to return in 5 weeks for re-evaluation and that PT would be prescribed if she had difficulty with stiffness or range of motion. PX 6.

Petitioner returned on 6/18/13. Petitioner reported full range of motion in the elbow but continued stiffness and swelling of the left wrist and hand as well as discomfort into the shoulder with popping sensation and tightness and pulling in the left shoulder as she reaches up and behind. Dr. Shin noted that Petitioner was doing well in regard to the left elbow and had returned to essentially normal function and range of motion. She was told to use her left arm at work and to take her arm out of the sling to eliminate shoulder stiffness. Dr. Shin indicated Petitioner's wrist issues are likely a secondary issue following from the radial head fracture. Dr. Shin

recommended Ms. Barkman continue to treat with ice, anti-inflammatories and stretching. No physical therapy was ordered at this visit and Petitioner was to return in one month.

On 7/16/13, Dr. Shin reviewed x-rays of the left elbow which revealed a healed radial head fracture with obliteration of the fracture line and some callus formation. Petitioner was ordered to attend PT in July 2013 after seeing Dr. Shin and complaining of elbow pain and continued left shoulder stiffness and difficulty with overhead movement as well as left wrist problems. Dr. Shin released Petitioner to full duty work on 7/17/13. She was to follow up in 5 weeks.

Petitioner initially participated in physical therapy two to three times a week for four weeks. Px. 7. Petitioner's physical therapy records from July 25, 2017 note that her goals were to reduce swelling in her left wrist and to be able to use both arms to put on undergarments. Id. She also expressed difficulty washing her hair at that time. Id. The Petitioner's therapy was continued from time to time by Dr. Shin through November 2013. Px. 6 and 7.

Dr. Shin examined Petitioner again on August 19, 2013. Px. 6. The Petitioner continued to experience continued, but less, pain at this visit. Id. She complained her left wrist was still swollen, had a loss of range of motion and was painful. Id. Ms. Barkman testified Dr. Shin had her continue with physical therapy and perform stretching and exercises at home. Despite this, her left wrist continued to bother her. On September 23, 2013, Dr. Shin wrote that Petitioner experienced pain in her left hand even when doing something as simple as lifting her telephone. After his examination, he diagnosed her with left de Quervains tenosynovitis that occurred due to overuse. Dr. Shin also discussed potential treatment options with Ms. Barkman, which comprised continued therapy and possibly injections.

Dr. Shin's medical records from Petitioner's visit of October 21, 2013, indicate Ms. Barkman still complained of swelling and pain in her left wrist aggravated by movement. Dr. Shin explained the de Quervains developed as a result of the fracture and secondary to the Petitioner's left elbow and her left wrist sprain. Dr. Shin indicated the left radial head fracture and left wrist sprain from Petitioner's work accident "caused the change in use of the upper extremity subsequently leading to the de Quervains tenosynovitis". PX 6.

Petitioner attended physical therapy at St. Margaret's from July through November 2013 for her left arm, shoulder stiffness and some wrist pain. She was discharged from PT in November 2013. Surgery was not prescribed for Petitioner's left arm or wrist and the rib fracture eventually healed without treatment. Her last appointment with Dr. Shin for her radial head fracture was on November 26, 2013. At that visit, Petitioner was released at MMI for the left elbow radial head fracture and told to return as needed. Petitioner has not received any treatment since that time for her left arm or wrist. PX 6.

Petitioner testified that she returned to work full duty as an executive secretary for Respondent. She testified that after two months her rib fracture healed but that immediately after the accident every movement caused her rib pain and specifically that it was hard to breathe, sneeze, cough or shower. She testified that her left arm is not the same. She is unable to wear a watch due to swelling in her left wrist and has had to adjust how she holds the steering wheel while driving. Any lifting strains her left wrist and her left arm strength is diminished. Overhead movement with the left arm is limited. Petitioner is right handed. She testified that she uses both hands to perform her job duties.

Petitioner testified that her case was initially accepted by Respondent and she was paid 3-5/7 weeks of TTD. Respondent also paid medical bills from St. Margaret's. However, 9 months later, Respondent denied the claim, took back 5 days of time via reduction of sick days and "took back" the bills it paid to St. Margaret's. Petitioner's penalty petition was withdrawn on the record at trial.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's trial testimony is unrebutted. Petitioner testified that she worked in a small office with large cabinets, furniture and boxes crowding the office. Petitioner further testified that a metal frame chair propped open her office door and as such was behind her as she stood facing the filing cabinets and filing papers on the shelves above the cabinets. Petitioner testified that there was approximately 2 feet of space between where she stood to file papers and the chair. PX 9 supports Petitioner's testimony regarding the physical layout of the office. Petitioner further testified that on 5/2/13, she finished filing a stack of papers, stepped backward to turn and get another stack off the chair, when she came in contact with the chair, lost her balance and fell striking her left arm on the metal chair and on the door. Again, Petitioner's testimony is unrebutted regarding how she fell.

The Arbitrator finds that despite negligible differences in the medical histories, it remains clear from the medical records that Petitioner continuously reported stepping backward hitting the chair and losing balance. The Arbitrator therefore finds that Petitioner's testimony regarding the circumstances of her fall is buttressed by the immediate medical records. Based on Petitioner's testimony as buttressed by the medical records, the Arbitrator finds that Petitioner sustained accidental injury to her left elbow, right 4th rib and left wrist arising out of and in the course of her employment as an executive secretary for Respondent on 5/2/13. It is clear from the record that Petitioner was in the course of her employment, filing papers, at the time of her fall. The Arbitrator further finds that Petitioner faced an increased risk of injury via the crowded office which restricted the flow of movement in the small space and as such Petitioner's accident arose out of her employment with Respondent.

Based on the record in its entirety, the Arbitrator further finds that Petitioner's 4th rib fracture, her left radial head non displaced fracture and the subsequently diagnosed left wrist dc Quervains are causally related to the accident of 5/2/13. As discussed above, Petitioner's complaints were immediate, acute, documented and consistently treated through November 2013, the date of MMI per Dr. Shin. The record contains no evidence to the contrary.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in connection with her causally related injuries through the date of MMI, 11/26/13 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, including credit under Section 8(j) of the Act for which Respondent shall hold Petitioner harmless. Respondent shall also reimburse out of pocket expenses paid by Petitioner.

K. What temporary benefits are in dispute? TTD

Based on the Arbitrator's findings on the issue of accident and causal connection, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 3-5/7 weeks commencing 5/2/13 through 5/27/13 pursuant to Section 8(b) of the Act. Respondent shall receive credit for TTD amounts paid while refunding Petitioner 5 days of vacation time or the monetary equivalent thereof.

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

The Arbitrator notes that Petitioner's injuries occurred after September 1, 2011. Therefore, in determining permanent partial disability value, the Commission shall base its determination on the following factors:

1. The reported level of impairment pursuant to the Section 8.1(b),
2. The occupation of the employee,
3. The age of the employee at the time of injury,
4. The employee's future earning capacity,
5. Evidence of disability corroborated by the treating medical records.

First, the Arbitrator notes that an impairment rating was not provided by either party and this factor will not be considered. With regard to the remaining factors, the Arbitrator notes the 58 year old Petitioner returned to her full duty executive secretary job with Respondent in July 2013. Petitioner testified that she has been able to perform her full duty job using both of her arms and hands since 2013. Petitioner has not suffered any future earnings impairment per her own testimony at trial. No weight is given these factors. With regard to Petitioner's level of disability, Petitioner testified that her rib fracture caused significant pain immediately after the accident but that it resolved after two months. She testified that her left arm and left wrist are not the same. She is unable to wear a watch due to swelling and has had to adjust how she holds the steering wheel while driving. Any lifting strains her left wrist and her left arm strength is diminished. Overhead movement with the left arm is limited. Petitioner is right handed. She testified that she uses both hands to perform her job duties. Again, Petitioner's last date of treatment for the left radial head fracture, the related shoulder complaints of stiffness and limited movement and the left wrist de Quervains was in November 2013. Petitioner received conservative care for her complaints including some physical therapy and splinting prior to her release. Petitioner's fracture was non-displaced and no surgery was warranted. Petitioner received conservative care for her wrist. Based on a consideration of these factors with greatest weight given to the 5th factor, the Arbitrator finds that Petitioner sustained 10% loss of use of the left arm pursuant to Section 8(e) of the Act; 5% loss of use of the left hand pursuant to Section 8(e) of the Act and 1% loss of use of the person as a whole pursuant to Section 8(d)(2) for the rib fracture.

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

Craig Markiewicz,

Petitioner,

vs. NO: 12 WC 13692

James McHugh Construction,

Respondent.

18IWCC0505

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability benefits (TTD), maintenance, nature and extent, 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.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

While the Commission finds that Petitioner is partially incapacitated from pursuing the duties of his usual and customary line of employment as an iron worker, the Commission notes that Respondent did offer to accommodate Petitioner and provide work within the medium physical demand level. The Commission finds that Petitioner made no attempt to work in this

accommodated position. Rather, Petitioner went to his treating physician, Dr. Stephen Gryzlo, and summarily obtained an opinion from him that simply stated that Petitioner could not perform the accommodated duties offered by Respondent. Despite Respondent having work for Petitioner, he refused to attempt the accommodated work. Instead, he proceeded with a vocational assessment with Tom Grzesik, at his attorney's request, and began a self-directed job search.

For these reasons and the reasons stated below, the Commission modifies the Arbitrator's Decision and finds that Petitioner is only entitled to TTD from December 19, 2011 through January 17, 2013. The Commission further vacates any award for maintenance benefits, and vacates the award for the vocational expert's bill of $2,000.00 to Thomas Grzesik. As to permanency, the Arbitrator awarded 40% loss of use of the left leg and 25% loss of the person as a whole for Petitioner's loss of trade. The Commission modifies the permanency award to 40% loss of the person as a whole which, as a matter of law, is the proper award for a loss of trade finding pursuant to Section 8(d)2 of the Act. The Arbitrator's award of 40% loss of use of the left leg and 25% loss of the person as a whole is thus vacated.

The Arbitrator awarded TTD through January 31, 2013; Petitioner claimed this cutoff date on the Request for Hearing form submitted at arbitration. Respondent's position is that Petitioner is entitled to TTD only through October 5, 2012, the date Respondent presented its offer of accommodated work to Petitioner. Respondent did not provide the written job description at that time. Respondent claims that Petitioner never attempted the modified work offered to him. Respondent further asserted that its October 5, 2012 offer clearly stated, "you will only be assigned tasks consistent with Dr. Gryzlo's work restriction recommendations." The letter also stated that if Petitioner felt that the work was in excess of the restrictions of Dr. Gryzlo, that he was to contact Respondent.

In response, Petitioner stated that both Dr. Gryzlo and Dr. Ram Aribindi, Respondent's Section 12 examiner, opined that Petitioner could not return to work as an ironworker – period. Respondent offered Petitioner a modified version of his work as an ironworker rodbuster – Petitioner's full duty position at the time of his injury. The Arbitrator noted that Respondent had initially failed to provide Petitioner with a formal job description with Respondent's job offer, and the Arbitrator stated that, "Petitioner has a right to know what he is agreeing to." (Arbitrator's Decision, pg. 21). The Respondent eventually provided the written job description to Petitioner, which he reviewed with Dr. Gryzlo on January 17, 2013. The Arbitrator acknowledged Dr. Gryzlo's January 17, 2013 opinion that Petitioner could not perform the modified work, and indicated that there was no other physician opinion to rebut Dr. Gryzlo. The Arbitrator further noted that Respondent did not rebut Petitioner's evidence that by union rules, light duty work does not exist for iron workers.

Based on the record, the Commission disagrees with the Arbitrator's assessment of Dr. Gryzlo's January 17, 2013 opinion. His opinion is based upon his reading of the written job description. Nowhere in the office visit note of January 17, 2013 does Dr. Gryzlo comment on Respondent's willingness to accommodate Petitioner's work restriction recommendations. Dr. Gryzlo ignores the content of Respondent's job offer letter and Respondent's unequivocal assertion that Petitioner would not be required to perform any task that did not comport with Dr. Gryzlo's restrictions.

The Commission finds that Petitioner never attempted the modified work offered to him, despite Respondent's willingness to work with Petitioner. Respondent's October 5, 2012 offer clearly stated, "you will only be assigned tasks consistent with Dr. Gryzlo's work restriction recommendations." The letter also asserted that if Petitioner felt that the work was in excess of the recommendations, that he was to contact Respondent, ostensibly for any additional job modifications.

Petitioner made no effort to cooperate with Respondent in this regard. Instead, he ran to Dr. Gryzlo and obtained a letter that indicated that Petitioner was unable to perform the tasks as outlined. Concomitantly, Dr. Gryzlo never commented on Respondent's assertions that it would modify the job based upon any of Dr. Gryzlo's restrictions.

Based upon Petitioner's obvious effort to avoid a return to accommodated employment, the Commission finds that Petitioner is not entitled to any maintenance benefits, and vacates the award of same and the award for the vocational expert's bill of $2,000.00 to Thomas Grzesik. Benefits may be suspended or terminated if the claimant refuses work offered to him that comports with the physical restrictions imposed by his treating physician. *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill. 2d 132, 146 (2010). Here, the Commission finds that Respondent was willing to accommodate Petitioner's restrictions and return Petitioner to work; Petitioner refused Respondent's offer.

The Commission is vexed by Petitioner's assertion that by the terms of his union contract, the Respondent was precluded from offering Petitioner a light-duty position. It is his contention that Respondent cannot offer accommodated work to journeyman ironworkers, thus precluding him from accepting such a position.

We have scoured the Act and appropriate interpretive case law, and nowhere do we find language that precludes an employer from offering light duty work to a Petitioner, based upon a union contract. Rather, the Act is silent as to such a proposition. The Act and its interpretive case law seemingly command that the Respondent is obligated to make an offer of accommodation when the Petitioner is precluded from returning to his usual employment, because of a work injury. The Commission believes that absent a statutory directive to the contrary, the Petitioner's assertion is misplaced.

Respondent is not precluded from offering Petitioner work within the restrictions recommended by his physician. Respondent did not limit its offer of accommodated work to the job description or job title. Respondent, in fact, left ample room to modify the existing offer in the event that given tasks were in excess of Dr. Gryzlo's recommendations. Petitioner was instructed in the offer letter of October 5, 2012, "not to attempt or perform such tasks" that were not within his restrictions, and instead notify Respondent immediately, again, ostensibly to adjust Petitioner's duties.

The Commission not only gives weight to Respondent's offer of employment, the Commission further finds that Petitioner was, at a minimum, obligated to prove that Respondent's offer of employment was not genuine. By refusing a legitimate offer of employment, Petitioner

acted at his own peril and to his own detriment.

Petitioner is also only entitled to TTD from December 19, 2011 through January 17, 2013; by this date Petitioner had Respondent's written job offer and job description. Again, Respondent made clear in its offer that Petitioner would only be assigned tasks consistent with Dr. Gryzlo's work restriction recommendations, and if the work was in excess of the recommendations, that he was to inform Respondent. Petitioner had the opportunity to, at the very least, attempt the modified work provided by Respondent, but he instead chose to reject Respondent's job offer outright.

As to the nature and extent of Petitioner's injury, the Arbitrator noted that Petitioner waived his rights under Section 8(d)1 of the Act, and instead requested a finding of permanent and total disability under an odd-lot theory pursuant to Section 8(f) of the Act. The Arbitrator found that Petitioner was not permanently and totally disabled under an odd-lot theory, but instead found that Petitioner suffered a loss of profession. With that, the Arbitrator considered the five factors under Section 8.1(b) of the Act, assigned appropriate weight to each factor, and awarded 40% loss of use of the left leg and further awarded 25% loss of the person as a whole for Petitioner's loss of trade. The Commission modifies the permanency award to 40% loss of the person as a whole which, as a matter of law, is the proper manner by which to award compensation for a loss of trade finding pursuant to Section 8(d)2 of the Act. The Arbitrator's award of 40% loss of use of the left leg and 25% loss of the person as a whole is thus vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed September 12, 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 $1,140.00 per week for a period of 56 4/7 weeks, from December 19, 2011 through January 17, 2013, 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 receive a credit of $93,000.00 for TTD previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that any award for maintenance benefits be vacated in its entirety.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 200 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 40% loss of the person as a whole. The Arbitrator's award of 40% loss of use of the left leg and 25% loss of the person as a whole is thus vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of $2,000.00 for payment of the vocational expert's bill to Thomas Grzesik be vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties under Sections 19(k), 19(l), and 16 of the Act is hereby denied.

18IWCC0505

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 other 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 the Circuit Court.

DATED: AUG 15 2018
MJB/pm
O: 07-10-18
052

Michael J. Brennan

David L. Gore

Kevin W. Lamboth

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARKIEWICZ, CRAIG
Employee/Petitioner

Case# **12WC013692**

McHUGH CONSTRUCTION
Employer/Respondent

18IWCC0505

On 9/12/2017, 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 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

2965 KEEFE CAMPBELL & ASSOC LLC
EUGENE F KEEFE
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Craig Markiewiez
Employee/Petitioner

v.

McHugh Construction
Employer/Respondent

Case # 12 WC 13692

Consolidated cases:

18IWCC0505

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

DISPUTED ISSUES

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

FINDINGS

On **12/16/11**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$88,920.00**; the average weekly wage was **$1710.00**.

On the date of accident, Petitioner was **44** 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 **$93,000.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$93,000.00**.

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

ORDER

Respondent shall be given a credit of **$93,000.00** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$93,000.00**.

Respondent shall pay Petitioner temporary total disability benefits of $1,140.00/week for 58 3/7 weeks, commencing 12/19/11 through 1/31/13, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,140.00/week for 125 4/7 weeks, commencing 2/1/13 through 6/30/15, as provided in Section 8(a) of the Act.

Based upon the five factors considered, Petitioner is awarded 40% of the left leg for 86 weeks at the statutory maximum PPD rate of $695.78. Petitioner is further awarded 25% of the person or an additional 125 weeks for loss of trade due to the permanent restrictions. The total PPD award equals 211 weeks totaling $94,626.08 at the statutory maximum PPD rate of $695.78.

Vocation expert bill of $2000 to Mr. Thomas Grzesik is awarded.

Penalties under Sections 19(k), 19(l) and Section 16 fees are denied.

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

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

Signature of Arbitrator Ketki Shroff Steffen: KSSteffen Date: Sept. 11, 20 17

SEP 12 2017

Procedural History

This 19b) petition was tried before Arbitrator Gary Gale on 1/19/16. The Parties have agreed to have the decision rendered by a different Arbitrator. Arbitrator Ketki Steffen has examined the transcript and submitted records and evidence in rendering her opinion.

Factual History

On December 16, 2011, Petitioner was employed by McHugh Construction as a journeymen ironworker foreman. He had worked for Respondent off and on for approximately 10 years. He worked full time (40hrs/week) for the Respondent and was 44 years old at the time of his accident.

On December 16, 2011, Petitioner was working for Respondent as a rodbuster on the Lower Wacker Drive Reconstruction Project. His job duties included installing rebar, wire mesh, and post tension cables. To prepare for the concrete pours, they framed out the structure with reinforcing rebar, ranging from one half inch to one inch thick, and ranging from 2 feet to 50 feet in length. They also framed out structures with rebar for the vertical crush barriers. The job required him to walk to the stock pile and carry rebar to the work position, install the rebar by bending or climbing and working while standing on vertically placed rebar for a period of time ranging from a couple minutes to an hour. He worked 6 to 8 hours per day, carrying anywhere from 5 pounds to 60 to 70 pounds alone, walking over flat or uneven ground including rocks and mud.

On December 16, 2011, he was walking to his work position on a freshly installed slab that was covered with a concrete blanket, when he stepped into an unmarked area for a manhole that was 14 to 18 inches below the slab surface, and

twisted his left knee. He experienced immediate pain but finished the day. He continued to experience pain with walking and movement. The injury occurred on a Friday. On the following Monday, December 19, 2011, he came in and told his supervisor that his knee was not better and he needed to seek medical care. He was then sent by his employer to Northwestern Corporate Health. Prior to this accident, Petitioner had never injured his left knee, received medical care for his left knee, missed time from work due to his left knee or had any difficulty doing his job as a Local 1 journeymen ironworker due to left knee issues.

On December 19, 2011, Petitioner was seen by Dr. Mitton at Northwestern Corporate Health. Petitioner received crutches and knee immobilizer, was released to light duty work and ordered to undergo an MRI. The MRI took place at Advantage MRI on December 23, 2011. Petitioner then followed up with Dr. Eugene Lopez on December 27, 2011. Dr. Lopez diagnosed a meniscal tear, recommended physical therapy and authorized Petitioner off work. Petitioner underwent physical therapy at ATI from December 29, 2011 through April 27, 2012. When Petitioner returned to Dr. Lopez on January 13, 2012, Dr. Lopez reviewed the MRI, administered a steroid injection and authorized Petitioner off work. Petitioner experienced no change following the injection. On February 9, 2012, Dr. Lopez administered the first of a series of 5 Supartz injections to Petitioner's left knee. Petitioner testified that he received no improvement from those injections, the last of which occurred on April 11, 2012. On February 20, 2012, Respondent had Petitioner evaluated by Dr. Mark Levin. Dr. Levin recommended exploratory arthroscopy of the left knee. He further stated that Petitioner's condition of ill-being was causally related to the accident, as was the need

for surgery. Petitioner testified that Dr. Lopez did not agree with the recommendation for surgery.

While at Northwestern Corporate Health, Petitioner testified that he was referred by Dr. Mitton to Dr. Stephen Gryzlo. He saw Dr. Lopez instead since he was located closer to his home. Now wanting a second opinion, he saw Dr. Stephen Gryzlo on May 3, 2012. Dr. Gryzlo examined Petitioner, took x-rays, and recommended a repeat MRI followed by surgery. Dr. Gryzlo also authorized Petitioner off work. On June 22, 2012, Petitioner underwent surgery by Dr. Gryzlo at Northwestern Memorial Hospital. The procedure consisted of a partial medial meniscectomy, debridement of patella femoral grade four chondromalacia and debridement of ACL ganglion cyst. Following surgery Petitioner remained off work under Dr. Gryzlo's care and began physical therapy at ATI. He underwent therapy from July 3, 2012 through August 28, 2012, followed by work conditioning/work hardening from September 4, 2012 through October 22, 2012.

On September 27, 2012, Dr. Gryzlo released Petitioner to return to work at the medium physical demand level, with no lifting over 50 pounds, and recommended possible vocational retraining. On October 5, 2012, Petitioner testified he received an offer of light duty work from Respondent via email through is attorney. (PX#10) Petitioner testified that he was employed out of Ironworkers Local 1 since 1996, and it was his understanding that light duty work did not exist under their collective bargaining agreement while working in Local 1 jurisdiction. Petitioner identified a letter from his union stating that ironworkers work under rules that require the member to be 100% capable of performing all job duties. (RX#8, Ex.5) Petitioner's counsel demanded a job description of the alleged light duty work as an ironworker on October 8, 2012. (PX#10) Petitioner testified that the job description was eventually provided in January, 2013.

On October 22, 2012, Petitioner underwent a Functional Capacity Evaluation at ATI. The FCE was a valid study, and placed Petitioner at the medium physical demand level with no standing more than 4 hours per day for durations of one hour only, no walking more than 4 to 5 hours, and only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. (PX#7) On January 7, 2013, Petitioner received a job description of the modified job offer through his attorney. (PX#11) The job title was rodbuster, the job that Petitioner said he was doing at the time of the accident. The job description indicated that Petitioner would need to bend to tie rebar for 4 to 6 hours in an 8-hour day, and would be expected to install rebar, including standing on rebar for 3 to 4 hours out of an 8-hour day. (Id.) Petitioner testified that he took the job description to Dr. Gryzlo for review.

On January 17, 2013, Petitioner was seen by Dr. Gryzlo and reviewed the modified job offer. Dr. Gryzlo stated that Petitioner was unable to perform the modified job duties. On January 24, 2013, Dr. Gryzlo's opinion was faxed to Respondent, and Petitioner rejected the job offer. (PX#11) Petitioner testified the following this fax, he was not brought up on to date TTD benefits, which had been terminated on October 4, 2012.

On February 1, 2013, Petitioner began a self-directed job search.

On April 17, 2013, Petitioner was seen by Dr. Ram Aribindi at the request of Respondent. Dr. Aribindi examined Petitioner and stated he was restricted from climbing ladders, kneeling or squatting and fell within the medium physical demand level outlined by the functional capacity evaluation. Petitioner testified that following this exam, he was not brought up to date on TTD or maintenance benefits. On June 20, 2013, Petitioner saw Dr. Gryzlo for his one year post-op follow up visit. Dr. Gryzlo

opined the Petitioner could not return to work at ironwork, was at maximum medical improvement and could work at the medium physical demand level or less.

On September 5, 2013, Petitioner enrolled in the CDL Mega Driving School to obtain a Class A truck driving license. He testified that he was offered this training by Respondent, with the understanding that Respondent would begin payment of maintenance benefits. Petitioner testified that maintenance benefits were paid beginning September 5, 2013, the day he began the program. He testified he did not receive payment for benefits owed from October 5, 2012 through September 4, 2013. He further testified that he did not receive a written explanation why these benefits were not paid. Petitioner also testified that he did not undergo a vocational assessment before the starting the CDL Mega Driving School Program and did not receive anything in writing from a vocational counselor saying that truck driving was suitable employment for him.

The driving school program consisted of obtaining a permit, 40 hours of classroom training and behind the wheel training. To complete the course, Petitioner needed to obtain a CDL drivers permit, an IDOT medical card and pass drug testing. (PX#8) Petitioner requested payment of the fees for the CDL drivers permit from Respondent, and those fees were paid. (PX#12) Petitioner was then referred by the school to Concentra for a DOT physical. (Id.) He was given different locations to obtain the physical, and choose to have it done at the Grand Avenue location in Franklin Park. On September 17, 2013, he was seen by Dr. Simon at that clinic and underwent a physical. Dr. Simon did not clear Petitioner to drive a truck, but instead ordered that he undergo an SPE before being medically cleared to drive. Dr. Simon gave Petitioner an order to undergo the SPE. (PX#9, Ex.8, p.2) Petitioner testified that the SPE was a

physical test to see if he could physically do the job of truck driving safely. It required him to climb into the cab, climb up into the engine, climb on the truck to connect air lines, crawl under the truck to check brakes and tire pressure, and climb onto the trailer to secure the loads with straps. The SPE requirement was necessary to complete his medical qualification for his DOT physical. To complete the SPE, he needed a semitrailer vehicle, a Class A truck. The Petitioner testified that the truck could not be supplied by the school to perform the test. Petitioner testified that on several occasions, through his attorney, he requested authorization for the SPE and for a truck from Respondent to complete the test. (RX#8, Ex. 4; PX#7, Ex.7) Petitioner made requests to complete the SPE on November 14, 2013, March 26, 2014, June 6, 2014, September 5, 2014 and August 5, 2014 and August 17, 2015. (Id.) Respondent refused to authorize the SPE or provide the vehicle for Petitioner to undergo the testing. Because of not completing the SPE, Petitioner testified that he was unable to finish the CDL course. He testified that his maintenance benefits were terminated on June 3, 2014 because he failed to complete the class.

Petitioner testified that the school would supply the truck for the driver's test portion after he completed the SPE, but would not supply the truck for the SPE itself. Lawrence Kahan, the vocational consultant hired by Respondent, testified that he contacted Mega, spoke to Jan Neely and was told they do provide students with a tractor trailer for road tests, (RX#8, p. 28) but he had no reason to doubt that they would not provide a truck for the SPE. (Id. at 76)

On October 30, 2014, Petitioner met with Tom Grzesik, a certified rehabilitation counselor, at the request of his attorney. The Respondent hired, Lawrence Kahan to

provide a vocational opinion. The Petitioner did not meet with Mr. Kahan. Neither parties attempted to meet and speak with each other in person.

Petitioner testified he began his self-directed job search on February 1, 2013, and continues to perform his self-directed job search through the date of arbitration. He identified as Petitioner's Exhibit #14 his job logs, which represent his self-directed job search efforts from February 1, 2013 through the date of arbitration. He testified he has not received any offers of employment as a result of his job search, and desired to have the Arbitrator award him odd-lot permanent total disability benefits in his case. He identified his bill from Tom Grzesik for $2,000.00, representing his charge for the vocational assessment and requested payment for the same.

He testified that he continues to have constant pain in his left knee with activities, especially walking stairs and sitting in a chair. He day to day activities are limited because his knee gets sore and stiff, and testified that the injury has changed his life. He further testified that the left knee gets sore from being bent.

Petitioner testified that he was aware video was taken of him both in the gym and getting in and out of his truck. He testified that his workouts at the gym are continuation of the work- outs he performed at ATI during his work conditioning program, and that he was directed by his physician to exercise and lose weight. Concerning getting in and out of his full-size pick- up truck, he testified that he had to have running boards added to the outside of the truck to aide him in getting in and out the vehicle.

On cross examination, Petitioner testified that he never actually went in and attempted to perform the rodbuster job that was offered to him in October 2012. He testified that he gave a full effort in his functional capacity evaluation which took place on October 22, 2012. He has no medical appointments scheduled, and still works out

at the gym three to four times per week. He worked off and on for Respondent for approximately 10 years at 6 or more different job sites, all with similar duties which he was doing at the time of the accident. He testified that he is aware that the union prohibits light duty, but did not know whether the Respondent was authorized to extend him work in a non-union capacity.

On re-direct examination, Petitioner testified that he does plan to see his physician in the future that he continues to exercise on elliptical machines and perform the weight lifting he learned in work conditioning and physical therapy. He testified that he believes that Local1 jurisdiction extends from the Wisconsin border to the Indiana border to Elgin.

Petitioner's treating physician and surgeon, Dr. Stephen Gryzlo, testified in this matter. He received a history from Petitioner in stepping into a manhole area that was covered by a tarp, twisting his left knee and falling. (PX#5, p.8) He reviewed outside records, noted Petitioner failed conservative care and performed surgery on June 22, 2012. (Id. at 12-16) He discharged Petitioner to medium work on September 27, 2012. (Id. at 19) He reviewed the modified job description that was provided by Respondent. (Id. at 22) He testified that Petitioner was not capable of doing the modified job for his safety or the safety of others. (Id.) He noted that some degeneration was present in the left knee on the first MRI, but Petitioner could perform all aspects of his job prior to the accident. (Id. at 23-24) He testified that the accident aggravated and accelerated the underlying degenerative condition, and the surgery and post-op care was related to the accident. (Id. at 25) He further testified that the meniscal tear was caused by the accident. (Id. at 25-26) He testified that Petitioner's medium restriction is permanent, and Petitioner is unable to return to work as an ironworker due to the accident. (Id. at

26) His last appointment with Petitioner was on June 20, 2013, his one year post-op visit, and testified that Petitioner had lost weight doing home exercise. (Id. at 27)

On cross examination, Dr. Gryzlo testified that he deferred to the FCE regarding the medium duty restriction. (Id. at 28) He testified that he has been treating ironworkers for 23 years, and is aware that there is no modified medium duty in ironwork. (Id. at 37) In January 2013 he tightened Petitioner's restrictions from the original restriction he imposed in September 2012. (Id. at 43) He explained that Petitioner's meniscus was removed because it could not be repaired, and Petitioner had grade 4 chondromalacia in his patella femoral joint and grade 3 chondromalacia in his medial compartment, which was nearly grade 4. (Id. at 43-49) He testified Petitioner could never return to work as an ironworker and doubts he could do so even if he lost 150 pounds. (Id. at 53-54)

On re-direct examination, Dr. Gryzlo explained that his January 17, 2013 note made specific responses to actual activities that Petitioner would be expected to perform from the modified job duty description. (Id. at 55) He testified that the specific activities listed in the job offer accounts for more specific restriction that he imposed in his January 17, 2013 report. (Id.) He testified that he would not release Petitioner to return to work based on what he could do only occasionally, versus frequently. (Id. 56)

Respondent offered into evidence the evidence deposition of its Section 12 examiner, Dr. Aribindi. Dr. Aribindi noted a twisting injury after Petitioner stepped into a manhole. (RX#7, p. 8) He testified Petitioner had no significant pain in his left knee prior to the accident, but complained of pain to the inside part of his knee and the top of his knee with weight bearing and ambulation. (Id. at 9) He testified that 2 out 3 of Petitioner's compartments of his knee had arthritic changes and that obesity could

make the arthritis worse. (Id. at 12-14) He diagnosed Petitioner with a left knee anterior pain attributable to underlying degenerative arthritic changes. (Id. at 15) He testified that the arthritic condition was long standing, and was not due to the acute injury. (Id. 15-16) He testified that Petitioner was at maximum medical improvement, could not perform his regular job, and would not be able to squat or go up and down stairs. (Id. at 17)

On cross examination, he testified that the accident was the causative factor in the onset of the left knee pain. (Id. at 19) He further testified that the traumatic injury Petitioner sustained could have aggravated the underlying arthritic changes which caused his arthritis to become symptomatic. (Id. at 23) He is unable to say what grade of arthritis Petitioner had prior to the accident, and testified that even though underlying arthritic change was likely present in the left knee, it wasn't until after the accident that Petitioner became unable to return to work as an ironworker. (Id. at 23-26) Dr. Aribindi testified that Petitioner can perform medium work, but cannot climb ladders, cannot kneel or squat, and cannot return to work due to his underlying arthritis. (Id. 26-28) He testified that Petitioner's medical care was reasonable and necessary and that the accident could be a contributing factor to the onset of pain the Petitioner experienced. (Id. at 29, 33)

On re-cross examination, Dr. Aribindi testified that Petitioner was working full duty as an ironworker before the accident, and after treating for the injury is no longer able to return to work as an ironworker. (Id. at 38) He further testified that even if the arthritis in the Petitioner's left knee was present for a matter of time, it was the onset of pain that lead to the recommendation for active treatment. (Id. at 40)

Tom Grzesik testified on behalf of Petitioner with his vocational opinions. He prepared a report dated January 19, 2015. (PX#9, p.7) He testified that Petitioner tried to complete the truck driving school, but the training was terminated prior to completion in June of 2014 due to lack access to a truck and failure to complete the DOT physical. (Id. at 10) He noted that Petitioner's restrictions from the valid FCE were at the medium level with a limit of 4 hours standing in an 8-hour day. (Id. 13-14) He testified that Petitioner needed a truck to undergo the SPE, it was not provided and the course was therefore terminated. (Id. at 26-27) He confirmed with Jan Neely on November 7, 2014 that the course was terminated because Petitioner failed to perform the SPE. (Id. at 27)

Dr. Grzesik testified that Petitioner is not able to return to work as an ironworker. (Id. at 34-35) He further testified that Petitioner is not able to work as a commercial truck driver, and the job does not represent suitable employment. (Id.) He testified that Petitioner met the need for vocational rehabilitation under the National Tea guidelines. (Id. at 35-36) Dr. Grzesik reviewed Petitioner's job logs from February 2013 through June or July 2014. (Id. at 28) He testified that Petitioner performed a diligent but unsuccessful job search. (Id. at 36) He also identified his outstanding bill totaling $2,000.00. (Id. at 39)

On cross examination, Dr. Grzesik testified that Petitioner was not at the full level of medium work. (Id. at 44) He further stated that Petitioner required to pass the DOT physical to continue the truck driving program. (Id.at 53) On re-direct examination, he testified that the Mega Driving School required both the DOT physical and the SPE testing, but the SPE testing was never authorized. (Id. at 69-70)

Lawrence Kahan testified for Respondent. He testified that he is a certified rehabilitation counselor and prepared a report dated July 13, 2015. (RX#8, p. 5-6) He testified that Petitioner was a steelworker. (Id. at 13) He testified that his familiar with the truck driving position Petitioner was training for, and performed a labor market survey based on Class A truck driving job. (Id. at 15-16) He did not evaluate Petitioner face to face. (Id. at 19) He testified that he called Jan Neely at the Mega Driving School, and was told that they do provide tractor trailers for the driving portion of the program, also called the road test. (Id. at 28)

On cross examination, Mr. Kahan testified that his labor market survey was based entirely on truck driving jobs. (Id. at 34-35) The truck driving job would require Petitioner to load or unload trucks, inspect truck equipment and supplies, including tires, lights, brakes, gas, oil and water. (Id. at 35) Petitioner would have to squat to inspect tires, squat to check tire pressure, may need to put tire chains on the tires and change out the spark plugs. (Id. at 35) Mr. Kahan did not review Petitioner's job logs, and does not know which of Dr. Gryzlo's records he reviewed. (Id. at 41) He did not review Dr. Aribindi's deposition testimony. (Id.)

Mr. Kahan testified he had no opinion to a reasonable degree of vocational certainty whether Petitioner's job search efforts were diligent but unsuccessful. (Id. at 41-42) He further testified that he did not request Petitioner's job logs to review. (Id.)

Concerning the offer of modified employment, he testified that the job offer was that of an ironworker. (Id. at 43) He never reviewed the job description regarding the offer of employment. (Id. at 43-44) He testified that was not provided any information that Petitioner ever responded to the offer. (Id. at 44) He was then shown deposition exhibit 2, which included nine faxes from October 18, 2012 through November 7, 2012

responding to the offer, but would not retract his statement that Petitioner failed to respond to the job offer. (Id. at 47) He was then shown Dr. Gryzlo's January 17, 2013 report indicating that Petitioner could not perform the modified job, and testified that he was not provided a copy of that report. (Id.) He acknowledged that Dr. Gryzlo opined Petitioner could not do the modified job, and was not aware whether Dr. Aribindi addressed it, but did not agree with Dr. Gryzlo's opinion that Petitioner could not do the job. (Id at 47-50) He testified that his opinion Petitioner could do the modified job and was not based on Dr. Gryzlo's opinion. (Id. at 54)

He was shown deposition exhibit 6, a Commission case in which he was found not credible. (Id. 58-59) He testified he was not aware of the Commission finding. (Id.) He also testified that his labor market survey was based only on CDL Class A license jobs. (Id. at 60) He was not supplied any records from the Mega Driving School, and was not sure Petitioner completed the classroom work. (Id. at 68) He also never saw Dr. Simon's report ordering the SPE, but was aware that Dr. Simon required it. (Id.at 69) He agreed that the SPE was needed to pass the physical, and that if Petitioner did not pass the SPE he would not qualify for the jobs listed in this labor market survey. (Id. at 70) He was not aware that Petitioner requested authorization for the SPE testing and was denied, and was never asked to contact Dr. Simon about the need for the SPE. (Id. at 71-73) He agreed that the classroom work alone was not enough for completion of a CDL Class A license. (Id. at 73)

Concerning is conversation with Jan Neely at the Mega Driving School, he testified that she told him they supply a truck for the road test, but to take the road test Petitioner must first undergo and pass the DOT physical. (Id. at 74-75) The school only provides a truck once the participant passes the DOT physical. (Id. at 75) He agreed that

Petitioner needed at truck to pass the SPE, and that Dr. Simon would not pass the Petitioner for the DOT physical unless he underwent the SPE. (Id.) He did not ask Jan Neely if they supply a truck for the SPE, but had no reason to doubt that they do not. (Id. at 76)

He was shown a document in deposition exhibit 5, setting forth the ironworker work rules. He acknowledged that ironworker contract rules require members to be 100% capable of performing their job duties and that no light duty work was available in ironwork. (Id. at 78) He testified that assuming this to be true, he would change his opinion whether the modified job was available to Petitioner under his contract rules, and would agree that the modified job would not be appropriate or available to Petitioner. (Id. at 79-80) He acknowledged that he missed the job history that Dr. Grzesik had in his vocational report when Mr. Kahan indicated in his report that it was unconscionable that Dr. Grzesik had omitted it. (Id. at 80-81) He testified he did not perform a transferrable skills analysis, and testified that he was only hired to analyze Dr. Grzesik' s report and that no vocational assessment was done. (Id. at 81-82) He was not sure if Petitioner was a structural ironworker, and never asked to speak to Petitioner. (Id.) Mr. Kahan testified that Petitioner self-directed job search would be appropriate under the National Tea guidelines. (Id.at 91) He further testified that the help of vocational specialist could be detrimental to Petitioner's job search. (Id. at 92)

On re-direct examination, Mr. Kahan testified that Petitioner could perform the modified job that was provided to him. (Id. at 113) On re-cross examination, he testified he was not sure what the job title was of the modified job position. (Id. at 120)

Analysis/Findings

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

The accident is uncontested. Petitioner, a long-term, full-time union iron worker with no restrictions suffered a work accident on December 16, 2011. At only 43 years of age, the Petitioner stepped into an unmarked area of a manhole that was 14 to 18 inches below the slab surface and severely injured his left knee. Dr. Gryzlo testified that Petitioner's meniscal tear was an acute injury caused by the accident and related to his work accident. He explained that Petitioner's meniscus was removed because it could not be repaired, and Petitioner had grade 4 chondromalacia in his patella femoral joint and grade 3 chondromalacia in his medial compartment, which was nearly grade 4. Dr. Levin, Respondent's first Section 12 examiner, agreed with the causation and with the surgery recommendation and treatment. Although Petitioner suffered from an underlying degenerative condition in his left knee, both medical doctors concurred that the same was aggravated and/or accelerated by the accident.

It is noted that Petitioner had no prior left knee issues and could perform all aspects of his job as a journeyman ironworker before this accident. Following physical therapy, injections and failure of conservative treatment, Petitioner underwent surgery which consisted a partial medial meniscectomy, debridement of patella femoral grade four chondromalacia and debridement of ACL ganglion cyst. Following surgery, physical therapy, followed by work conditioning/work hardening, Petitioner was released to medium physical demand level work, with no lifting over 50 pounds, and recommended possible vocational retraining.

On October 22, 2012, Petitioner underwent a Functional Capacity Evaluation at ATI. The FCE was a valid study, and placed Petitioner at the medium physical demand

level with no standing more than 4 hours per day for durations of one hour only, no walking more than 4 to 5 hours, and only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. (PX#7)

This medical history, Petitioner's current restrictions and causal connection are largely uncontroverted. Although there is surveillance video and testimony that Petitioner vigorously works out 3-4 times a week, can get in and out of his own truck and can bend and pick up; the Arbitrator notes the unique nature of the ironworker in American workplace. The heavy physical demands and dexterity requirements are unlike other physical professions. In fact, union rules, in recognition of these requirements, do not allow for individuals with physical work restrictions to return to full time work. This is done to ensure the safety and security of the worker and his fellow co-workers who depend on him being at 100% capacity.

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally connected to his work accident. His ability at the gym of in his daily life does not negate this finding.

K. What temporary benefits are in dispute?

1. **TTD Benefits**

Petitioner testified that he was temporary and totally disabled from December 19, 2011 through January 31, 2013, representing a period of 58 3/7 weeks. Respondent disputes this claim, and claims that benefits are owed only until October 5, 2012 when Petitioner was offered modified duties. The Arbitrator agrees with Petitioner's claim of benefits, and awards temporary total disability benefits from December 19, 2011 through January 31, 2013, representing 58 3/7 weeks.

In so finding, the Arbitrator closely analysis the period between October to January of 2013 and finds that the offer of employment was fluid during that time period and did not solidify until January when Dr. Gryzlo found that the modified job duties did not fit within the Petitioner' s medical restrictions.

Specifically, on October 5, 2012 Petitioner was offered modified employment. However, the parties disagreed as to what the exact nature of the work would be and whether union/contractual regulations would allow Petitioner to be placed at light duty. October 22, 2012, a valid FCE study placed Petitioner at medium physical demand level with no standing more than 4 hours per day for durations of one hour only, no walking more than 4 to 5 hours, and only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. (PX#7) On January 7, 2013, Petitioner received a job description of the modified job offer through his attorney. (PX#11) The job title was rodbuster, the job that Petitioner said he was doing at the time of the accident. The job description indicated that Petitioner would need to bend to tie rebar for 4 to 6 hours in an 8-hour day, and would be expected to install rebar, including standing on rebar for 3 to 4 hours out of an 8-hour day. (Id.)

This job description was reviewed by Dr. Gryzlo who opined that Petitioner was unable to perform the modified job duties. The same was forwarded to Respondent and the Petitioner officially rejected the job offer. (PX#11)

Respondent reasonably argues that the job offer dated October 5, 2012 (RX1) and the later modified work descriptions were fluid and that the Petitioner would be allowed to work within his restrictions. The Respondent finds fault that the Petitioner never attempted to return and try the modified duty work.

The Arbitrator finds that both sides present reasonable and valid arguments in support of their position. The Arbitrator recognizes the although Petitioner was released to medium duty that this makes him capable of many job duties. The Arbitrator also recognizes that Petitioner made no attempts to try to return to the modified employment although the Respondent offered to fit his employment within work restrictions. Ultimately, the Arbitrator, while acknowledging the lack of crystal clarity on this issue, sides with the Petitioner's positions for the following reasons:

The Respondent's initial offer lacked proper job description and the Petitioner has a right to know what he is agreeing to. This is evident by the Respondent's attempts to clarify the work requirements and job descriptions. Although the Respondent had offered to mold the job to the medical restrictions, Dr. Gryzlo's was the only medical opinion presented at arbitration whether Petitioner could perform the modified job. Respondent did not have either Dr. Levin or Dr. Aribindi address whether Petitioner was capable of doing the modified job. Lastly, the Respondent does not counter or disagree the contention that union/contraction rules do not allow Petitioner to work at a restricted capacity.

Therefore, the Arbitrator finds that the Petitioner has met his burden that he was entitled to TTD benefits from December 19, 2011 through January 31, 2013, representing a period of 58 3/7 weeks.

2. **Maintenance Benefits**

Petitioner claims he was entitled to maintenance benefits from February 1, 2013 through June 30, 2015, representing 125 4/7 weeks. Respondent disputes this claim, alleging that work was offered within Petitioner's restrictions. Based, in part, on the Arbitrator's finding above that the modified job offer was not suitable or appropriate, the

arbitrator further awards maintenance benefits from February 1, 2013 through June 30, 2015, representing 125 4/7 weeks.

Petitioner testified that he began a self-directed job search on February 1, 2013. Petitioner identified his job logs, and testified that because of his job search activities, he was unable to find work within his restrictions. He testified that no job offers were made to him as a result of his self-directed job search. Tom Grzesik testified that he interviewed Petitioner, reviewed his job logs and testified that Petitioner performed a diligent but unsuccessful job search as of July 1, 2015, Mr. Kahan testified that he did not review Petitioner's job logs, and therefore could not give an opinion whether Petitioner's job search was diligent but unsuccessful.

Based upon this evidence and in light of the National Tea guidelines the Arbitrator finds that the Petitioner has proven that he was entitled to Maintenance Benefits.

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

Petitioner has provided evidence of a left knee and leg injury related to the December 6, 2011 injury which required permanent restrictions. After physical therapy, injections and failure of conservative treatment, Petitioner underwent knee surgery. His meniscus was removed because it could not be repaired, and Petitioner had grade 4 chondromalacia in his patella femoral joint and grade 3 chondromalacia in his medial compartment (Id. at 43-49) Dr. Gryzlo testified that Petitioner could never return to work as an ironworker.

When considering the appropriate award for permanent partial disability the five factors considered are: (1) the report level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment"; (2) the occupation of the injured employee; (3) the age of the employee at the time of the

injury; (4) the employee's future earning capacity; and (5) evidence of disability corroborated by the treating medical records.

In the case at bar, no report has been offered into evidence with a level of impairment assessment by either the treating doctor or through an independent medical examination. There is no impact on the permanency based upon this factor.

The Petitioner was previously employed as a journeyman iron worker but is unable to continue such employment due to his medium duty work restrictions and restrictions on bending which effectively prevent him from continuing his profession. The Arbitrator assigns significant weight to this finding.

The Petitioner was 44-years-old on the date of the accident. Although he has worked for over two decades, he had a substantial work life left and will continue to have to work within his restrictions for a long time. The Arbitrator assigns moderate to medium weight to this fact. Although he has many years of work ahead of him, he is only limited to not being able to do heavy work. His medium duty restrictions still allow him to function is many other job situations. His physical ability is evidenced in his fitness workout 3-4 time a week.

As to earning capacity, the Arbitrator finds that the restrictions do impact his ability to earn the higher income of an ironworker. However, Petitioner has not presented any additional evidence regarding his future earning capacity other than stating that there are no jobs available within his restrictions. The Arbitrator does not find this evidence/testimony to be convincing. Petitioner's job efforts were self-directed and although he has a right to do the same, the Arbitrator is not persuaded by his testimony. The Petitioner never met with Lawrence Kahan (Respondent's vocational expert). The Petitioner also only met with Tom Grzesik (Vocational counselor) in late 2014 at the

request of his attorney. His job logs alone are not sufficient considering his failed CDL license search.

As to the criteria that evidence of disability is corroborated by the treating medical records the Arbitrator finds that all the medical records support that Petitioner became disabled due to his work accident. Although there is evidence that Petitioner has some pre-existing arthritis in his knee, he was able to work full time. Therefore, the Arbitrator finds that the medical evidence corroborates Petitioner's claim.

In assessing his permanency, Petitioner has requested a finding that he permanently and totally disabled based on the 'odd-lot' theory. In support, he presents evidence and testimony of his inability to find gainful work after a proper effort. The Arbitrator declines to find the same.

Initially, the Arbitrator notes that Petitioner has not presented a wage differential claims. Although Mr. Grzesik gave testimony regarding some available minimum wage work in the market, a proper market analysis is lacking. The Respondent and urged for a finding of permanency as to the left leg and a finding of 'loss of profession'. The Arbitrator disagrees that the Petitioner is permanently and totally disabled but finds that the Petitioner has suffered a loss of profession.

The Arbitrator notes that the record is devoid of any medical evidence to support a total disability claim. In the absence of such medical evidence where a claimant's "disability is limited in nature so that he is not obviously unemployable... he may qualify for 'odd-lot' status." *City of Chicago v. Illinois Workers' Compensation Commission*, 373 Ill. App. 3d 1080, 1089, 871 N.E.2d 765 (Ill. App. Ct. 1st Dist. 2007). It is the claimant's burden to establish that he is not altogether incapacitated from work, but nonetheless not regularly employable in any well-known branch of the labor market. *Ceco Corp. v.*

Industrial Commission, 95 Ill. 2d 278, 286, 447 N.E.2d 842 (1983); *City of Chicago*, 373 Ill. App. 3d at 1089-90. A claimant can establish that he falls in the odd-lot category by showing either: (1) that he engaged in a diligent, but, unsuccessful job search; or (2) that his age, training, education, experience, and physical condition prevent him from engaging in stable and continuous employment. *Westin Hotel v. Industrial Commission*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (Ill. App. Ct. 1st Dist. 2007). If the claimant meets his burden by a preponderance of the evidence, the burden then shifts to the employer to show that work is available for the claimant. *City of Chicago*, 373 Ill. App. 3d at 1091.

The evidence in this case does not show that there is no steady job market for the Petitioner. His attempts to become a commercial driver were either not appropriate (due to physical restrictions) or not fruitful due to the loan-truck issue. His logs alone are insufficient to convince the Arbitrator that there are no 'medium duty' jobs available in the market. The testimony of the Petitioner and his vocational expert, Mr. Grzesik, highlights Petitioners misdirected or less then diligent 'self-directed' work search. For example, Mr. Grzesik testified that the Petitioner's logs showed that was contacting employers that advertising jobs that were outside of his area, engineering jobs. (PX9, p. 29) Mr. Grzesik also stated the fact that Petitioner chose of do a self-directed job search and that he applied for 'maximum earning capacity' jobs also hurt his chances. (PX9, p. 30-31) Mr. Grzeski also stated that Petitioner's job seeking efforts were on-line and that the failure to do some additional training or apply in person or meet employers face to face at the job fair lessened his chances. (PX9 at 32)

In addition to the weakness in Petitioner's job efforts, the testimony of Mr. Grzesik is not persuasive or reasonable. He did not meet or help the Petitioner at the inception

of the job hunt. He also did not do a proper job market survey or analysis. He lists generic low wage available jobs but does little to use his expertise and training to fine-tune the job efforts for the Petitioner. Without these details or a proper market analysis, the Arbitrator is reluctant to place great weight on his testimony.

Therefore, based on the Petitioner's and Mr. Grzesik's testimony and well as examination of the unsuccessful outcome of the CDL classes, the Arbitrator finds that the Petitioner has not proven that the job search was diligent but unsuccessful. The Arbitrator also notes that unlike many low wage, lesser skilled claimants, the Petitioner is experienced. He has transferrable skills, a high school diploma, and a B.S. degree from Illinois State University. He is articulate and organized and takes care of himself by exercising diligently. Luckily, he does not suffer from lack of work permits or language barriers. Although he was injured, he can work at 'medium duty' capacity and is still young of age. Based on these factors, the Arbitrator declines to find the Petitioner an 'odd-lot' permanent total disability case.

The Arbitrator does find that the Petitioner suffered a loss of Trade under **8(d)2** of the Act. 820 ILCS 305/8(d)2 states in pertinent part as follows:

If, as a result of the accident, the employee sustains serious and permanent injuries not covered by paragraphs (c) and (e) of this Section or having sustained injuries covered by the aforesaid paragraphs (c) and (e), he shall have sustained in addition thereto other injuries which injuries do not incapacitate him from pursuing the duties of his employment but which would disable him from pursuing other suitable occupations, or which have otherwise resulted in physical impairment; or if such injuries partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earning capacity, or having resulted in an impairment of earning capacity, the employee elects to waive his right to recover under the foregoing subparagraph 1 of paragraph (d) of this Section then in any of the foregoing events, he shall receive in addition to compensation for temporary total disability under paragraph (b) of this Section, compensation at the rate provided in subparagraph 2.1 of paragraph (b) of this Section for that percentage of 500 weeks that the partial disability resulting from the injuries covered by this paragraph bears to total disability...

Petitioner suffered a serious work accident. Following physical therapy, injections and failure of conservative treatment, Petitioner underwent surgery which consisted a partial medial meniscectomy, debridement of patella femoral grade four chondromalacia and debridement of ACL ganglion cyst. Following surgery, physical therapy, followed by work conditioning/work hardening, Petitioner was released to medium physical demand level work, with no lifting over 50 pounds, and recommended possible vocational retraining. A valid FCE placed Petitioner at the medium physical demand level with no standing more than 4 hours per day for durations of one hour only, no walking more than 4 to 5 hours, and only occasional balancing, bending, stooping, climbing stairs, crouching, or squatting. (PX#7) Although these limitations may allow for other jobs, Petitioner is unable to work in his usual and customary trade as a journeyman ironworker. Dr. Gryzlo's testimony in this opinion is clear, persuasive and uncontroverted.

Bases upon the above consideration, Petition is awarded 40% of the left leg for 86 weeks at the statutory maximum PPD rate of $695.78. Petitioner is further awarded 25% of the person or an additional 125 weeks for loss of trade due to the permanent restrictions. Total PPD award equals 211 weeks at the statutory maximum PPD rate of $695.78. Respondent shall have credit for all amounts paid. Respondent shall have credit for $93,000 paid for TTD and/or maintenance.

M. Should penalties or fees be imposed upon Respondent?

The employer has the burden to show that any delay in paying benefits is reasonable. *Electro-Motive Division v. Industrial Comm.*, 250 Ill. App. 3d 432, 436, 621 N.E.2d 145 (1993); *Cook County v. Industrial Comm.*, 160 Ill. App. 3d 825, 830, 513

N.E.2d 870 (1987). It is insufficient for an employer to merely assert its belief that "the employee's claim is invalid or that his award is not supported by the evidence; the employer's belief is 'honest' only if the facts which a reasonable person in the employer's position would have would justify it." *Cook County*, 160 Ill. App. 3d at 830 (*citation omitted*).

A failure to pay because of a good faith belief that no payment is due will not warrant a penalty. See generally, *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 302, 412 N.E.2d 470 (1980). Generally, when the employer acts in reliance upon reasonable medical opinion or when there are conflicting medical opinions, penalties ordinarily are not imposed. *USF Holland, Inc. v. Industrial Comm'n*, 357 Ill.App.3d 798, 805, 293 Ill. Dec. 885, 829 N.E.2d 810, 817 (2005).

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable basis to deny benefits. There was a legitimate dispute as to whether Petitioner's rejected a modified job offer. The Respondent make sufficient efforts to offer modified employment and then responded in a timely and appropriate fashion to alleviate Petitioner' s concerns regarding the duties of such employment vis-a-vis his medical restrictions. Petitioner also did not make any attempts to try-out the modified employment offer based on his doctor's opinion. The Arbitrator notes that Respondent had agreed to modify the work duties to fit any further-future restrictions. Therefore, the Arbitrator finds that the Respondent has reasonable, articulable basis for denying TTD and or maintenance benefits to Petitioner. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

Additionally, the Arbitrator also finds that Petitioner did not adequately or

appropriately pursue the truck driver employment. The Arbitrator is not convinced by the presented testimony that the Petitioner was unable to get access to a truck for his SPE exam. At most, this testimony is inconclusive as to whether the driving school would provide a truck. Petitioner was doing a self-directed job search. He embarked on trying to obtain a CDL from Mega Driving school without checking with a vocational counselor if this was suitable employment. Although he continuously requested that Respondent provide him with a truck for testing purposes, he failed to show what efforts, if any, he made to secure a truck for the pre-test. Instead, he quit the program. He was aware that Lawrence Kahan was hired to provide a vocational opinion for the Respondent but he never called or met with him. It should be noted that Mr. Kahan also did not seek to meet with the Petitioner. The Petitioner also opted not to hire or seek the services of his own vocational expert until a period of time.

There is little surprise that the CDL job search was a failure. The efforts to pursue proper, gainful employment are half-hearted at best. Both sides deserve some blame in this area. The fact that at all witnesses agree that Mega driving school provides a tractor trailer for road test, but neither vocational expert can clearly tell the court that Mega will not provide a truck for SPE, is lamentable. Lawrence Kahan (Respondent's vocational expert) stated he did not doubt that they would provide the truck for the SPE test. (RX8, p. 76) In the Arbitrator's opinion, this sounds reasonable. Therefore, the Arbitrator is disinclined to find the Respondent's conduct was unreasonable and vexatious and deserving of penalties.

Vocational Assessment Bill

Petitioner seeks payment for the $2000 fee for his vocational expert, Mr. Grzesik. Mr. Grzesik interviewed the Petitioner and reviewed other relevant documents, including

medical and FCE report, to perform a vocational assessment and provide a report. The Arbitrator therefore awards the bill for his services.

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

Keith Miller,
Petitioner,
vs.

NO: 15WC 28932

City of Chicago,
Respondent.

18IWCC0506

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2018, 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 15 2018
o080718
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MILLER, KEITH
Employee/Petitioner

Case# **15WC028932**

CITY OF CHICAGO
Employer/Respondent

18IWCC0506

On 3/8/2018, 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 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
PATRICK C ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0113 CITY OF CHICAGO LAW DEPT
STEPHAIE 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
NATURE AND EXTENT ONLY

Keith Miller
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **28932**

Consolidated cases: **D/N/A**

18IWCC0506

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 20, 2018**. By stipulation, the parties agree:

On the date of accident, **April 30, 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 $**71,494.96**, and the average weekly wage was $**1,374.90**.

At the time of injury, Petitioner was **49** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of $**4,190.40** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,190.40**.

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 $735.37/week for a further period of 45 weeks, as provided in Section **8d(2)** of the Act, because the injuries sustained caused **a loss of 9% of a person as of a whole** (with the Arbitrator assigning 4% loss to the hernia and 5% loss to the right shoulder).

Respondent shall pay Petitioner compensation that has accrued from through , 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.

Molly C Mason

Signature of Arbitrator

3/8/18
Date

Keith Miller v. City of Chicago
15 WC 28932

18IWCC0506

Summary of Disputed Issues

The parties agree Petitioner injured his right shoulder and developed a hernia on April 30, 2015 while working as a motor truck driver for Respondent. They also agree the accident brought about the need for a mesh hernia repair. Petitioner resumed full duty for Respondent in mid-August 2015, following the repair. The only issue in dispute is nature and extent. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified he was born on June 16, 1965. He has lived on the south side of Chicago for four years.

Petitioner testified he has worked as a motor truck driver for Respondent for 24 years. He transports materials and laborers to various sites, as directed. He has to load and unload his assigned vehicle on occasion. The items he lifts include 30-pound boxes and toolboxes.

Petitioner testified he felt good when he woke up on the morning of April 30, 2015. He denied having any right shoulder or hernia-related problems before that date. On that date, he was hooking up a gang box to his truck when he felt his right shoulder pop and experienced pain in the right side of his groin. He was able to drive to the next assigned location. He then contacted his boss and informed him of the accident. He told his boss he would wait to see how he felt the following day. When he awoke that day, he felt right shoulder pain and noticed a "bump" on the right side of his groin area. He went to MercyWorks, where he saw Dr. Diadula. PX 1, p. 2.

Dr. Diadula's initial note of May 1, 2015 sets forth a consistent history of the work accident. The doctor noted complaints of 7/10 right shoulder pain, worse with movement, and 6.5-7/10 right-sided groin pain. On right shoulder examination, he noted slight tenderness in the acromioclavicular joint. On right groin examination, he noted a reducible tender mass with no sign of incarceration or strangulation. He obtained right shoulder X-rays, which showed minimal degenerative changes. He diagnosed a right shoulder sprain/strain and a right inguinal hernia. He prescribed Ibuprofen and an ice pack. He released Petitioner to full duty, noting he was doing so at Petitioner's request. He recommended a general surgery consultation for the hernia. He directed Petitioner to return to MercyWorks on May 7, 2015. PX 1, pp. 2-3.

Petitioner returned to MercyWorks on May 7, 2015 and again saw Dr. Diadula. The doctor's examination findings were essentially unchanged. He recommended a right shoulder MRI and directed Petitioner to return to MercyWorks three days after the MRI. PX 1, p. 4.

The right shoulder MRI, performed without contrast on May 19, 2015, showed a "likely postero-inferior glenoid labral tear" and a likely Grade 1 sprain of the acromioclavicular joint. The radiologist was not able to exclude the possibility of an antero-superior glenoid labral tear. PX 2, pp. 2-4.

Petitioner saw Dr. Diadula again on May 21, 2015. The doctor noted the MRI results and recommended an orthopedic consultation. He released Petitioner to full duty at Petitioner's request. PX 1, p. 4.

Petitioner first saw Dr. Deziel, a general surgeon, on June 3, 2015, with the doctor noting a referral from "Adullah" of MercyWorks. The doctor recorded a history of the work accident. He noted that Petitioner planned to see a shoulder surgeon shortly. He also noted a complaint of persistent right groin pain. On examination, he noted a reducible right inguinal hernia. He proposed a mesh repair and indicated Petitioner wanted to pursue this. PX 3, pp. 7-8.

Petitioner testified that MercyWorks referred him to Dr. Nicholson, an orthopedic surgeon. Petitioner first saw Dr. Nicholson on June 10, 2015. The doctor recorded a history of the work accident and noted Petitioner was scheduled to undergo a hernia repair. He also noted the results of the right shoulder MRI. He indicated that Petitioner had continued performing full duty since the accident but was complaining of right shoulder pain when trying to sleep or move his arm. He described Petitioner as right-handed.

On initial right shoulder examination, Dr. Nicholson noted moderate tenderness over the acromioclavicular joint, some mild tenderness in the long head of the biceps, pain with crossover testing and active elevation above 120 degrees and 5/5 rotator cuff strength. Dr. Nicholson interpreted the MRI images as showing no evidence of rotator cuff tearing, no acute labral injury and a "very high signal in the AC joint." He diagnosed an acromioclavicular joint sprain and arthrosis. He indicated that "the injury may have caused almost an impaction of the AC joint and now [Petitioner] is having significant pain in this area." He prescribed a Medrol Dosepak and physical therapy, along with regular icing over the joint. He allowed Petitioner to continue performing full duty until the hernia surgery. PX 4, pp. 15-16.

Petitioner underwent an initial physical therapy evaluation at Total Rehab on June 22, 2015. PX 5, pp. 44-45. He continued attending therapy thereafter. The treatment consisted of shoulder taping, E-stimulation, ultrasound and exercises.

On July 16, 2015, Petitioner underwent a right inguinal hernia repair at Rush University Medical Center. Dr. Deziel performed this procedure, inserting a mesh plug and patch. PX 3, pp. 77-80. Petitioner was discharged from the hospital later the same day.

Petitioner returned to Dr. Nicholson on August 12, 2015 and reported having been off work since the hernia surgery. Petitioner indicated he was attending therapy but was still experiencing right shoulder pain, especially with overhead activity and rotation. He reported taking Ibuprofen for his symptoms. According to the doctor, he indicated he felt capable of resuming full duty.

On right shoulder re-examination, Dr. Nicholson noted active forward flexion to about 160 degrees, active external rotation to about 50 degrees, 4/5 rotator cuff strength, increased pain with supraspinatus and infraspinatus testing and tenderness to palpation about the acromioclavicular joint. The doctor advised Petitioner to discontinue formal therapy, indicating he feared Petitioner "may aggravate the AC joint if he pushes it too hard." He recommended that Petitioner continue home exercises, ice applications and Ibuprofen as needed. He released Petitioner to full duty and directed him to return in six weeks. PX 4, pp. 9-10.

Petitioner testified he performed home exercises for his shoulder for about a month after formal therapy was discontinued.

Petitioner saw Dr. Nicholson again on September 23, 2015. The doctor described him as "continuing to work full duty" and having "no pain with overhead activity" but experiencing "some increased pain with shrugging motion and with any heavy lifting." On re-examination, he noted active forward flexion to about 170 degrees, active external rotation to about 50 degrees, 5/5 rotator cuff strength, some mild tenderness to palpation about the acromioclavicular joint and negative Hawkins and Neer impingement testing. He allowed Petitioner to continue full duty and described him as "probably at maximum medical improvement." PX 4, p. 6.

Petitioner last saw Dr. Nicholson on November 4, 2015. On that date, the doctor noted that Petitioner had "done remarkably well" but was still experiencing a little pain down the lateral aspect of the deltoid and on the right acromioclavicular joint. He found Petitioner to be at maximum medical improvement and allowed him to continue full duty. PX 4, p. 3.

Petitioner testified his right shoulder still hurts at night, when he is trying to sleep, and when he has to push anything heavy, such as a mower. He is right-handed. He no longer takes medication for his shoulder.

Petitioner testified it is his understanding that the mesh used for his hernia repair will remain inside his body indefinitely. Because he does not want to disturb the repair, he exercises caution and moves slowly when lifting anything. The surgical site itches a lot at times.

Under cross-examination, Petitioner testified he has to lift at work every day. He no longer performs home exercises for his shoulder. He had no right shoulder problems before the accident and has not injured his right shoulder since the accident. He works for Respondent's water department. He is continuing to perform full duty. He has no upcoming appointments for his shoulder or hernia.

Respondent did not call any witnesses or offer any documentary evidence.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in his favor, credibility-wise. He came across as a hard-working, stoical individual.

Arbitrator's Conclusions of Law

<u>What is the nature and extent of the injury?</u>

The only disputed issue is nature and extent. Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. That section sets forth five factors to be considered in making a permanency award, with no single factor to be given greater weight than any other.

The Arbitrator assigns no weight to the first factor, i.e., any AMA Guides impairment rating, since neither party offered such a rating into evidence. The Arbitrator gives some weight to the second factor, i.e., the injured employee's occupation. Petitioner's job title is motor truck driver but he credibly testified to having to lift items of varying weight every day. He also testified he lifts more slowly and cautiously now, to avoid disrupting the hernia repair. The Arbitrator also assigns some weight to the third factor, i.e., the injured employee's age at the time of the accident. Petitioner was 49 years old at

the time of the 2015 accident. He could reasonably be expected to remain in the workforce for another 10 or 12 years. He is not subject to any formal restrictions but credibly testified to adjusting his lifting, both in terms of speed and mechanics. The Arbitrator also assigns some weight to the fourth factor, future earning capacity. Petitioner resumed full duty following his hernia repair and continues to perform his motor truck driver job. He does not claim any impairment of earnings. The Arbitrator also assigns some weight to the fifth and final factor, "evidence of disability corroborated by the treating medical records." With respect to the hernia, the Arbitrator notes the use of mesh to accomplish the repair. There is no evidence of recurrence. With respect to the right shoulder, the Arbitrator notes that, while the radiologist suspected labral tearing and a Grade 1 sprain and suggested an arthrogram (PX 2) no such study was performed. Petitioner's orthopedic surgeon, Dr. Nicholson, did not appreciate such tearing when he looked at the films but he did see a "very high signal in the AC joint and even on the acromial side." PX 4, p. 16. He opted to treat the shoulder conservatively. When he last saw Petitioner, on November 4, 2015, he noted some persistent pain but did not recommend any restrictions or further care. PX 4, p. 3.

The Arbitrator, having considered all of the foregoing, along with Petitioner's credible testimony as to his ongoing symptoms and limitations, and the involvement of Petitioner's dominant right arm, finds that Petitioner is permanently partially disabled to the extent of 4% loss of use of the person (equivalent to 20 weeks) with respect to the hernia and an additional 5% loss of use of the person (equivalent to 25 weeks) with respect to the right shoulder.

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

Dorothy Luckett,
Petitioner,
vs.

NO: 11WC 14121

City of Chicago,
Respondent.

18IWCC0507

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2017, 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 15 2018

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

o080718
KWL/jrc
042

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LUCKETT, DOROTHY
Employee/Petitioner

Case# **11WC014121**

CITY OF CHICAGO
Employer/Respondent

18IWCC0507

On 6/5/2017, 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 1.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0070 BOGUSZ & BOGUSZ LTD
RICHARD P BOGUSZ
166 W WASHINGTON ST SUITE 500
CHICAGO, IL 60602

0113 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

Dorothy Luckett
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **11** WC **14121**

Consolidated cases: **N/A**

18IWCC0507

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **4/25/17**. 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 _____

18IWCC0507

FINDINGS

On **3/28/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$69,859.22**; the average weekly wage was **$1,343.45**.

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

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

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

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

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

ORDER

The Respondent shall pay Petitioner $669.64 for 10.25 weeks because the injuries sustained caused a of 5% loss of use of the left hand, pursuant to Section 8(e) of the Act.

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

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

FINDINGS OF FACT
The disputed issues in this matter are 1) causal connection; and the nature and extent of Petitioner's injury. *See*, AX1.

Petitioner's testimony
Dorothy Luckett, (the "Petitioner"), was employed with the City of Chicago ("Respondent") for approximately 38 years. On March 28, 2011, she was 64 years old and working at a truck driver foreman. This job entailed primarily office work, wherein she entered schedules into the computer for approximately 6 to 7 hours per day. In addition, she ensured that her crews were timely and she also drove and picked up trucks for repair. On the day of accident, March 28, 2011, Petitioner complained to her foreman of pain in her left wrist and opted to not go to MercyWorks until the following day. From MercyWorks the petitioner saw her primary care physician who then referred her to Dr. Fernandez.

The petitioner testified that she is now retired after working for the respondent for 38 years. She was employed as a truck driver foreman, for 4 years in the Department of Water. Prior to that, she worked as a motor truck driver for 22 years. She verified that she drove different trucks each day. The petitioner has been diagnosed with diabetes mellitus type 2; is right-hand dominate and admitted that she uses her right hand more than her left.

As a foreman, she was responsible for getting her crew out and lining them up for the next day. When she was not supervising, she was on the computer. She further testified that she had no pads at her computer station on which to rest her hands.

She initially testified that she was on her computer 6-7 hours a day then testified that she took a 30-minute lunch and at least two 15 minute breaks and had other job duties. She agreed that there were further duties that she performed but could not recall at the time of trial.

In March of 2011, the petitioner testified that her left wrist started bothering her and that the pain became worse when she was tying. She started using one finger to type. She testified that she reported to MercyWorks two days later and provided a history of what happened to her to the medical provider.

On March 30, 2011, Petitioner reported to MercyWorks and indicated that she was typing on March 28, 2011 and felt a pain in her left wrist. She was diagnosed with a wrist sprain. She returned to this provider on April 4, 2011 and an x-ray revealed a mild widening of the scapholunate joint space. The diagnosis on that date was an improved left wrist sprain and left carpal tunnel which was "not work related".

The petitioner then reported to her primary care physician, Dr. Katherine Park. The doctor's records state that "she woke up with pain". While the records did indicate that she worked as a truck driver

for many years and is now doing desk work there was no mention of the left wrist pain beginning at work. She was referred to Midwest Orthopedic at Rush. PX4.

When she initially presented to Dr. Fernandez on May 5, 2011, she told him that the pain began on March 28, 2011, but she did not tell him it began at work. By way of history, Dr. Fernandez states that: "Ms. Luckett is here today for her patient evaluation regarding left hand numbness and tingling. Ms. Luckett stated that this started 3/28/2011. States that she all of a sudden had severe sharp shooting pain along the volar aspect of the left wrist that brought her to tears. She also noted numbness and tingling of the index, middle, and ring fingers that has been waking her up at night every single night since 3/28/2011. Ms. Luckett states that she was so concerned regarding the pain in her wrist that she went to the emergency room that day". The Arbitrator notes that this history conflicts with the petitioner's evidence that she wanted to see if the pain would go away, thus she waited two (2) days to go to MercyWorks. She underwent an EMG at Dr. Fernandez's direction which revealed mild carpal tunnel syndrome ("CTS") on the left. PX5.

On June 9, 2011, the doctor reviewed the results with her. She rejected surgery and chose to continue with conservative treatment, which was helping. She did not see him again until January 2, 2014, when she again rejected CT surgery. A "New Patient Information Form" completed that date indicated that she was retired and her symptoms began on September 1, 2013 at home. A "New Patient Information Form" completed May 5, 2011, indicates that her symptoms began on 3/28/11 at work. Dr. Fernandez did not comment on causation with respect to Petitioner's CTS.

CONCLUSIONS OF LAW

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

To be compensable under the Illinois Workers' Compensation Act, the injury complained of must be one "arising out of and in the course of the employment." *Ill.Rev.Stat.1991, ch. 48, par. 138.2.* The employee has the burden of establishing both requirements. *Castaneda v. Industrial Comm'n* (1983), 97 Ill.2d 338, 341, 73 Ill.Dec. 535, 454 N.E.2d 632. The burden is also upon the employee to prove that her injuries are causally related to the employment. *New Guard v. Industrial Commission, 58 Ill.2d 164, 317 N.E.2d 524* (1974).

Pursuant to Illinois law an accident alleged for the purpose of claiming benefits under the Illinois Workers' Compensation Act (Act"), must be traceable to a definite time, place and cause. *Mithiessen & Hageler Zinc Co. v. Industrial Commission, 284 Ill. 378, 120 N.E. 249* (1918). This is a longstanding and necessary requirement that must be met by the petitioner, to trigger the protection of the Act. The date on which the injury "manifests itself" is the date that the causal connection between the injury alleged and the petitioner's employment is apparent to a "reasonable person". *Peoria County Belwood Nursing Home v. Industrial Comm'n* (1987); *115 Ill.2d 524, 505 NE2d 1026.*

The burden is also upon the employee to prove that his or her injuries are causally related to the employment. *New Guard v. Industrial Commission, 58 Ill.2d 164, 317 N.E.2d 524* (1974).

As the petitioner is alleging an accident date of March 28, 2011 for a repetitive trauma, she must establish a manifest date to prove her claim. She also alleged that she worked 6-7 hours a day on her computer, then admitted that she performed other tasks such as answering the phone and driving trucks. She did not provide evidence regarding what or how consistently she was typing.

There is no comment on causation with respect to the CTS, by any doctor. The physician at MercyWorks, however, does indicate that this condition is not work related. She is right hand dominate and admitted that she uses her right hand more than her left. She is a diabetic. If the CTS were work related, it would follow that her right hand would be compromised as well.

Further complicating her claim for benefits are the new patient forms; one indicates that her left wrist was injured at work while another indicates that the injury occurred at home. The petitioner has not proven by a preponderance of the evidence that her condition of ill-being regarding CTS is causally related to her employment by Respondent.

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

The Arbitrator concludes that the petitioner has failed to prove by a preponderance of the evidence, that her job duties of typing on a computer were sufficiently repetitive to cause the trauma that she alleges. At most, she established that she suffered a sprain to her left wrist on March 28, 2011. Thus, she is entitled to receive 10.25 weeks of benefits at a rate of $669.64, because the injuries sustained caused a loss of 5% use of the left hand.

18IWCC0507

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11 WC 14121
SIGNATURE PAGE

Signature of Arbitrator

June 5, 2017
Date of Decision

JUN 6 - 2017

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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES DOWNES,

Petitioner,

vs.

NO: 16 WC 8645

18IWCC0508

STATE OF ILLINOIS,
CENTRALIA CORRECTIONAL
CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Charles Downes, failed to prove that he sustained a work-related accident arising out of and in the course of his employment on February 27, 2016. Petitioner's claim for compensation is, therefore, denied.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Petitioner, Charles Downes, filed an Application for Adjustment for Claim on May 16, 2016. Petitioner alleged injury to his left ankle while playing basketball during his lunch break on February 27, 2016.

2. Charles Downes has been employed as a correctional officer for 15 years. He is a salaried employee and gets a 30-minute, unpaid lunch break during his shift. T.12. Downes testified that he is not he is not allowed to leave the facility for any reason as the facility has to have adequate staff in case of an emergency. *Id.* He is allowed to take his lunch break in the multi-purpose building, the staff dining room, the roll call room, or the smoking area. T.13.

3. On February 27, 2016, Petitioner was playing basketball during his lunch break when he heard a pop in his ankle as he went up for a jump shot. He fell straight to the ground and could not get up. T.17.

4. Downes testified that he would play basketball in the multi-purpose room during his unpaid lunch break, and he plays basketball to "stay in shape." Downes testified that it is a benefit to both himself and his employer for him to be in good shape. T.14. He has played basketball during his lunch break from the start of his employment. He stated that officers, lieutenants, and majors have all participated in the basketball games, and his employer has acquiesced to the games. T.15. He stated that his witness, Major Ted McAbee, also played basketball. He has not been told that he could not play basketball and there is no prohibition against playing basketball. *Id.*

5. During cross-examination, Downes testified that there is no official mandate asking that the correctional officers play basketball. T.24. He took a physical when he was first hired, but has not taken once since. T.25. He does not receive a monetary bonus to stay in shape and there is no incentive to play basketball. *Id.* The facility does not care if he is working out, eating, or reading a book during his break. T.26. The basketball courts are provided for the inmates and the facility allows the officers to use them as a courtesy. T.27.

6. Petitioner's witness, Theodore McAbee, is a Major and testified that he agreed with petitioner's testimony. T.32. He has also played basketball during his lunch break. There is no ban on playing basketball. T.33. He stated no one is permitted to leave the facility during their lunch break. *Id.* The prison does benefit from the officers staying in shape. T.27. On cross-examination, he stated that there is no mandate that officers stay in shape, and it is up to the officers to stay in shape. T.36.

7. Following the accident, Petitioner underwent an MRI of the left ankle without contrast on March 16, 2016. The MRI revealed a calcaneal spur-Achilles insertion avulsion involving the central dorsal 50% of the Achilles tendon. The avulsed portion of the

tendon and the associated ossicle were retracted from the dorsal Achilles by 4.3 cm, with laxity of the torn portion of the tendon above the avulsed bony fragment. PX.7.

8. Dr. Corey Solman of Tenet Health System performed repair of the left Achilles tendon on March 24, 2016. The post-operative diagnosis was left Achilles tendon rupture with partial bony avulsion. PX.6.

9. Petitioner followed-up with Dr. Solman on July 6, 2016. He was 3 months post left Achilles repair. He reported no pain and he had progressed well in physical therapy without any difficulty. Examination revealed that his range of motion and strength was equal to the uninvolved side. He was released to full duty work, and was to follow-up in 6 weeks for a final visit. PX.6.

10. Petitioner testified that he received non-occupational disability benefits while off work. T.19. He now walks with a limp. The surgical area is sensitive to the touch and throbs if he is on his feet for long periods of time. T.21. He is on his feet 70 percent of the day and is extremely sore at the end of his shift and takes Ibuprofen or Motrin. T.23.

To recover under the Act, the claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "In the course of employment" refers to the time, place and circumstances surrounding the injury, and the "arising out of" component refers to a causal connection between the injury and the employment. *Id.*

Section 11 of the Act, however, states that "[a]ccidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of the employment even though the employer pays some or all of the cost thereof." 820 ILCS 305/11. An exception contained in section 11 of the Act provides that the "exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program." 820 ILCS 305/11. This provision has been consistently interpreted to mean that "[e]xcept to the extent that an employee is ordered or assigned by the employer to participate in the program, injuries occurring during the course of recreational events are simply not compensable irrespective of whether it may be [otherwise] said they arise out of and in the course of employment." *Kozak v. Industrial Comm'n*, 219 Ill. App. 3d 629, 633, 579 N.E.2d 921, 162 Ill. Dec. 107 (1991). In other words, if the claimant was injured while "participating in a voluntary recreational program" section 11 of the Act bars compensation and it does not matter that compensation may have been appropriate under some other theory such as the "personal comfort doctrine." *Id.*

Here, it is undisputed that Downes' participation in basketball, which gave rise to his injury, was voluntary. While the Respondent was aware that employees would play basketball during their lunch break, no evidence was offered establishing that the employees were required

to play basketball. Rather, the evidence establishes that employees were allowed to take their breaks in any one of 4 areas of the facility. Further, they were not given physical fitness examinations as part of their job requirement and Major McAbee testified that there was no mandate that the officers stay in shape. The record lacks sufficient evidence that establishes that playing basketball was anything but voluntary.

The dispositive question is whether the basketball game Downes was participating in was a *recreational program* covered by section 11 of the Act.

Section 11 of the Act does not define "recreational programs," although it provides general examples of such: athletic events, parties, picnics. In *Elmhurst Park District*, the court observed that, using the plain and ordinary meaning of the concept "recreation," section 11 of the Act encompassed any "act of recreating or the state of being recreated: refreshment of the strength and spirits after toil: DIVERSION, PLAY." *Elmhurst Park District*, 395 Ill. App. 3d at 409. Thus, the *recreational* nature of the activity (refreshing strength and spirit, diversion, play) and not the location or frequency of that activity will determine whether an activity constitutes a "recreational program" under section 11 of the Act. *Id.* The extent to which the employer benefits from an employee's participation in the activity, the extent to which the employer actively organizes and runs the recreational event, and the extent to which the employer sponsors or compels attendance in the event are legitimate inquiries, but are only important insofar as a question arises as to whether the activity is voluntary, and not as to whether the activity is a recreational program as encompassed under section 11 of the Act. *Kozak*, 219 Ill. App. 3d at 633.

Here there is no question that the Downes' participation in the basketball game was voluntary. The employer did not organize or sponsor the basketball game. They did not require their employees to play basketball. And, there is no mandate requiring the employees stay in shape.

At issue, therefore, is whether playing basketball during his lunch break was a "recreational program" for which section 11 of the Act precludes compensation. Clearly, playing basketball during Petitioner's lunch break was a recreational activity, thus excluded from compensation under Section 11 of the Act.

Petitioner argues that the Appellate Court upheld the Commission's decision in *Campbell v. Taylorville*, 13 I.W.C.C. 0574 (2013), *aff'd* by 2014 IL App (5th) 140010WC-U, which stated:

> The mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases as noted in Eagle Discount...Section 11 of the Act is intended to apply to situations where there are recreational programs such as employer sport teams or employer picnics where the employer may have organized or contributed to the formation of the teams or events...

The Commission notes that the above case cited by Petitioner was filed under Illinois Supreme Court Rule 23. Pursuant to Illinois Supreme Court Rule 23(e)(1), an order entered under subpart (b) or (c) of this rule is not precedential and may not be cited by any party except to support contentions of double jeopardy, *res judicata*, collateral estoppel or law of the case. As none of the stated exceptions are at issue, Petitioner's reliance on *Campbell* is misplaced. Assuming, however, that *Campbell* was not a Rule 23 order and could properly be cited by Petitioner, the Commission is still not persuaded by their argument. The Court noted that the claimant in *Campbell* was asked to participate in the basketball game by his shift supervisor and the game occurred while the claimant was on-duty and unable to leave the premises. Further, the court noted that Taylorville encouraged fitness and sports activities during work hours and provided a fitness room and basketball hoops for its staff to utilize during their shift. The court found that the basketball game was part of his normal activities. Whereas in the present case, there is no indication Petitioner was asked to participate in a basketball game. Rather, the employees were free to take their lunch break in any one of the 4 break rooms. The game occurred during his unpaid lunch break. And, the Respondent did not have a mandate requiring their employees to be in shape.

The Commission also notes that the Arbitrator erred in his analysis of *Eagle Discount Supermarket v. Industrial Commission*, 82 ILL.2d 331 (1980) and the personal comfort doctrine. *Eagle Discount* was decided prior to the enactment of Section 11 of the Act. Under the current Act, the first question to be determined is whether the claimant was engaged in a voluntary recreational program or activity. If so, then the injuries resulting from those activities are not compensable, regardless of any other theory of compensation. *Kozak v. Industrial Comm'n*, 219 Ill. App. 3d 629, 633, 579 N.E.2d 921, 162 Ill. Dec. 107 (1991). Here, having found that the Petitioner was engaged in a voluntary recreational program as encompassed under section 11 of the Act, the Commission finds that the Petitioner is precluded from receiving compensation for his injuries. His claim for compensation is, therefore, denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 21, 2017, is hereby reversed for the reasons stated above, and Petitioner's claim for compensation is hereby denied.

DATED: AUG 15 2018

Michael J. Brennan

Kevin W. Lamborn

MJB/tdm
O: 7/16/18
052

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Arbitrator's Decision. I believe Petitioner met his burden of proving by a preponderance of the evidence that he suffered an accident arising out of and in the course of his employment.

Petitioner has worked as a corrections officer at Centralia Correctional Center for 15 years. During that time, he has routinely played basketball with other employees during his lunch break. It is undisputed that Respondent prohibited its employees from leaving the premises during lunch breaks. While Respondent did not mandate how Petitioner could spend his break, the facility did restrict its employees to the following four areas during their breaks: 1) the multi-purpose room; 2) the staff dining room; 3) the roll call room; or 4) the designated smoking area. Respondent knows many employees engage in activities such as playing basketball during their lunch breaks; in fact, Respondent allows employees to use the multi-purpose room for that purpose. While Petitioner testified that Respondent does not require its employees participate in basketball games during their lunch breaks, it is undisputed that Respondent has acquiesced to its employees' engagement in activities such as playing basketball during their lunch breaks. In fact, employees' participation in these physical activities is so widespread that even high-ranking officials like Major McAbee regularly participate during their lunch break.

After considering the totality of the evidence, I believe Petitioner proved his ankle injury was the result of a compensable work accident. Respondent does not mandate its employees play basketball at lunch, but the evidence shows Respondent strongly supports its workers' participation in the activity. Respondent benefits from its employees staying healthy and in shape because being a correctional officer is a physically demanding job. While Respondent does not conduct ongoing physicals after the hiring process, Major McAbee confirmed that Respondent directly benefits from its employees staying in shape. Based on the evidence that Respondent exercised a level of control over Petitioner during his unpaid lunch, Respondent's longstanding tacit approval of its employees playing basketball in the multi-purposed room during the lunch break, and the benefit Respondent derives from its employees staying fit, I believe Petitioner's injury did not occur during a voluntary recreational activity or program. Thus, the majority erroneously analyzed this case under §11 of the Act.

For the forgoing reasons, I would affirm and adopt the Arbitrator's Decision in its entirety.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOWNES, CHARLES
Employee/Petitioner

Case# **16WC008645**

CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

18IWCC0508

On 11/21/2017, 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 1.41% 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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1350 CENTRAL MANAGEMENT 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

NOV 21 2017

Ronald A. Rascia, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHARLES DOWNES
Employee/Petitioner

v.

CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

Case # 16 WC 08645

Consolidated cases: _____

18IWCC0508

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 **Mt. Vernon**, on **November 3, 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 27, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$64,858.90**; the average weekly wage was **$1,247.29**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **1** dependent child.

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

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

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

Respondent is entitled to a credit for any awarded medical expenses which were paid prior to hearing via group health coverage under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner sustained accidental injuries arising out of and in the course of his employment on February 27, 2016, and sustained a left Achilles tendon injury which is causally related to the February 27, 2016 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$831.53 per week** for **19 weeks**, commencing **February 28, 2016 through July 10, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay the **reasonable and necessary causally related medical expenses contained within Petitioner's Exhibit 1**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all awarded medical benefits that have been previously paid by Respondent pursuant to Sections 8(a), 8.2 and 8(j) of the Act, 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 **$748.37 per week** for **29.225 weeks**, because the injuries sustained caused the **17.5% loss of use of the right foot**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **July 6, 2016** through **November 3, 2016**, 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

November 13, 2017
Date

STATEMENT OF FACTS

Petitioner works for Respondent as a full-time Correctional Officer (CO) at its Centralia Correctional Center facility, and has been employed in this capacity for 15 years. He works 37.5 hours per week, and gets one 30 minute unpaid lunch break each shift. Petitioner testified that he is not allowed to leave Respondent's premises during his lunch break because he must be available to answer and respond to any code or riot calls. During the lunch break, there are only four areas of the facility he can go to: the multipurpose building, the staff dining room, the roll call room, and the smoking area.

On 2/27/16, Petitioner testified he was playing basketball with other COs in the multipurpose building during his lunch period. He testified that he plays basketball to stay in shape because his job can be physically demanding, especially given he has to respond to altercations or interventions with inmates, and that staying in good shape is a benefit to both himself and to the Respondent. Supervisors as well as COs play basketball during lunch in the multipurpose room, including Major McAbee. He testified that testified there is no official mandate or memorandum indicating COs can or cannot play ball or work out during lunch, but that the Respondent acquiesced in allowing the activity. Petitioner testified he had been playing basketball during his lunch break since he started with the Respondent at the Centralia facility.

The Petitioner testified that he was playing basketball in the multipurpose room during his lunch break on 2/27/16, went up for a jump shot, felt a pop in his left ankle area and it felt like someone had punched him in the calf. When he was unable to get up, he realizing he had significantly injured his left calf. Petitioner testified that he had no prior injuries, treatment or workers' compensation claims related to the left calf/foot prior to this injury.

An Employee's Notice of Injury, dated 2/28/16, states that the Petitioner was injured the day before when he jumped while playing basketball with several other COs during lunch in the multipurpose building, and multiple witness statements were provided by the COs who were present which give a consistent history of what occurred on 2/27/16. (Rx2, Rx4 & Rx5).

The Petitioner's testimony was generally corroborated Respondent's representative, Major Ted McAbee, who was called to testify by the Petitioner. Major McAbee testified that he has also played basketball in the

multipurpose room during his lunch break, and that there was no prohibition or ban on COs performing this activity. He also confirmed that COs cannot leave the facility during lunch due to the potential of having to respond to an altercation, and that he keeps track of where each staff member is at all times to account for their well-being. He testified that he had worked with the Petitioner and that he is a good employee. Major McAbee testified that the basketballs used by COs during lunch, as well as the inmates, in the multipurpose room were provided by Respondent through an inmate benefit fund. He agreed that some COs are in good shape and others are not, as there is no requirement that they be in shape, but also agreed on redirect that physically fit COs benefit the Respondent.

After the injury, Petitioner testified he had severe pain and was unable to bear weight. He said he was told that he had one of the worst Achilles tendon tears the doctor had ever seen and that surgery needed to be performed as soon as possible.

On 2/27/16, Petitioner presented to the emergency department at St. Mary's Good Samaritan. He reported he was playing basketball at work when he took a jump shot and felt a pop in his calf. Petitioner described the pain as if someone kicked him. His symptoms included swelling and deformity, and he had difficulty walking. X-rays of Petitioner's ankle and foot were taken, and he was diagnosed with injury to left ankle, Achilles' tendon injury, and calcific tendonitis of the ankle or foot. Petitioner was given pain medication and crutches and was to stay off of work until he was evaluated by an orthopedic physician. (Px3).

The impression from the 2/27/16 x-rays of the left ankle included: 1) no acute fracture or dislocation; 2) old non-united chip fractures off the inferior aspect of the lateral malleolus; 3) thickened Achilles tendon distally could represent Achilles tendinopathy; 4) other calcifications noted at the Achilles tendon insertion may be due to prior trauma, moderate sized plantar calcaneal spur; and 5) follow up with outpatient MRI. Left foot x-rays indicated no gross acute fracture or dislocation and no radiopaque foreign bodies or soft tissue abnormalities. (Px4).

On 3/1/16, the Petitioner presented to Dr. Houle at the Orthopaedic Center of Southern Illinois. He reported that he injured his left ankle/Achilles tendon during his break at work when he jumped to shoot a basketball, felt a pop in his left lower calf region and fell when he landed. It was noted that Petitioner had a history of chronic ankle sprains as a child that required bracing. Following physical examination, Dr. Houle's impression was an acute left ankle injury, and he was unable to rule out a partial or complete tear of the Achilles tendon, with possible chronic Achilles tendon tendinitis, and history of chronic ankle sprains with underlying arthritic changes to the ankle. Petitioner was given sedentary work restrictions and an MRI was recommended. (Px5).

On 3/4/16, Petitioner presented to Dr. Solman at the Orthopedic Sports Medicine & Spine Care Institute for his left ankle. He had been referred by Dr. Raskas, who was treating Petitioner for an unrelated issue. Petitioner indicated he injured his ankle while playing basketball at work. He was wearing a boot to ambulate and had not returned to work since the injury. Dr. Solman's impression was status post left ankle injury with likely full or near full thickness Achilles tendon rupture. Dr. Solman discussed the possibility of surgery and recommended an MRI, noting it would be 6 to 8 months post-surgery before Petitioner would reach maximum medical improvement. (Px6). A 3/7/16 note from Dr. Houle's office indicated they called Petitioner to set up the MRI, and he advised that since he hadn't heard back from them he saw another physician, who had scheduled him for surgery. A separate phone note indicated that Respondent had denied the claim and would not authorize the MRI. (Px5).

On 3/16/16, Petitioner underwent the left ankle MRI, and this reportedly reflected: calcaneal spur-Achilles insertional avulsion involving the central dorsal 50% of the Achilles tendon; the avulsed portion of the tendon

and the associated ossicle are retracted from the dorsal Achilles by 4.3 cm, with laxity of the torn portion of the tendon above the bony fragment; the anterior, medial, and lateral margins of the Achilles remain intact, however, there is marked tendinopathy of these portions of tendon above this level which likely constitutes a high grade partial Achilles tendinous/osseous avulsion. (Px7).

When Dr. Solman reviewed the MRI with Petitioner on 3/16/16, his impression was that the films showed an avulsion of the posterior portion of the left Achilles tendon along with a fragment of bone from the calcaneus. The diagnosis was partial thickness Achilles avulsion of posterior portion, and Petitioner expressed his desire to undergo surgical intervention. (Px6).

Dr. Solman performed surgery on 3/24/16 involving repair of Petitioner's left Achilles tendon The report noted a large piece of avulsed bone from the central posterior calcaneus was identified, while the entire lateral half of the Achilles was intact, while the medial portion had about 2.5 cm of attachment distally and the avulsed portion was retracted about 4 cm. The bone fragment was excised, and suturing and an anchor were utilized to perform the Achilles repair. (Px6, Px8). At a 4/1/16 follow up, Dr. Solman noted Petitioner reported some ongoing pain, but was doing well overall. He was placed in a boot and was advised to remain non weight-bearing. On 4/29/16, Petitioner indicated he had some mild soreness, but overall was doing well. He was to start ambulating in his boot and begin gentle strengthening in physical therapy. (Px6).

On 6/3/16, the Petitioner reported to Dr. Solman that he was walking some without the boot at home. On physical examination, Petitioner had a well healed incision and was able to dorsiflex and plantarflex the foot without pain with good range of motion. Mild swelling of the peroneal tendons and posterior tibial tendons was noted. There was no indication that Petitioner was limping or had an altered gait. Petitioner was advised that he could wear regular footwear and was to continue physical therapy. On 7/6/16, Petitioner reported no pain, and he had progressed will in physical therapy without disability. Petitioner indicated he was ready to go back to work. On physical examination, Petitioner's left ankle range of motion and strength were equal to the right side. Again, there was no indication of Petitioner having an abnormal gait. Petitioner was to begin a home exercise program and return to work full duty, and was to follow up in 6 weeks for a final visit. (Px6). Petitioner testified he did not return to Dr. Solman after the 7/6/16 visit.

Petitioner testified that surgery helped, and he was able to return to work at full duty. Currently, he testified he still has a limp, especially after getting up from prolonged sitting, but it improves after he walks around a bit. The Achilles area is sensitive to touch, and he has severe pain if he hits it at all. He believed his left ankle area is somewhat larger than the right side. When he is on his feet for a long time, noting he could be on his feet as much as 70% of his shift at work, it throbs and hurts. The floor surfaces are concrete, and at the end of the day he is very sore. He takes ibuprofen and Aleve. Petitioner received non-occupational disability benefits, and if awarded temporary total disability in this case, he understands he has to repay the occupational disability benefits pursuant to his union contract.

On cross examination, Petitioner he had to take a physical to get his job, but hasn't had to undergo another one since. He receives no wages, monetary benefit or work incentives to work out or play ball during lunch. He doesn't report his lunch period activities to anyone at the Respondent, including whether he is playing ball. He agreed the inmate fund provides the basketballs for the inmates, and that the court and facility also are provided for the inmates, so it is a courtesy for COs to use it.

Petitioner agrees he reported spraining his ankle playing ball in the past, "but nothing chronic that I can remember." He is working full duty, has ended treatment and is not taking any prescribed medications. Following his 7/5/16 visit with Dr. Solman, when he was released to return to work, Petitioner agreed he was

supposed to follow up, but testified he did not do so because the doctor said "unless I was feeling immense pain or I felt something pop or snap" he would not need to return. He agreed he was advised to return if he had any additional problems, and he has not done so. He does not use a brace or any other protective devices on his ankle, and agreed he can do his job sufficiently.

The parties noted at hearing that the records and medical expenses from St. Mary's physical therapy would be admitted at the hearing and that agreed copies of these records would subsequently be provided to the Arbitrator to be added to the record. This was done by the parties, and the medical expenses were added to Px1, while the progress notes were admitted as Px9.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that the facts of this case involve the interaction of Section 11 of the Act, and the "personal comfort doctrine."

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase 'arising out of the employment' refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Discount Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" may apply. Acts of "personal comfort," including engaging in sports activities, may be "incidental to employment" and satisfy the "arising out of" requirement. So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* at 496-497.

However, subsequent to the decision in *Eagle Discount Supermarket*, the Illinois legislature enacted a specific portion of Section 11 of the Act, which states as follows:

"Accidental injuries incurred while participating in voluntary recreational programs including but not limited to athletic events, parties and picnics do not arise out of and in the course of employment even though the employer pays some or all of the cost thereof. This exclusion shall not apply in the event that the injured employee was ordered or assigned by his employer to participate in the program." 820 ILCS 305/11.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Eagle Discount Supermarket* at 496.

In *Eagle Discount*, the claimant was on lunch break, without pay, when he tripped and was injured on the employer's parking lot while playing Frisbee. Although the employees were not restricted to the employer's

premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. The manager would also turn on the parking lot lights so that the employees would have light in which to play. The employer argued that the claimant's injuries were non-compensable for four (4) reasons: (1) The claimant's "parking lot" injury is noncompensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a noncompensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980).

The Supreme Court determined that the personal comfort doctrine was applicable in the case, and gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* at 496-97. Consequently, Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises. the claimant did not expose himself to an unnecessary or unreasonable risk, and the employer acquiesced to the activity. *Id.*

This Arbitrator believes that comparison to the *Eagle Discount Supermarket* case is applicable here, and that the personal comfort doctrine is applicable here. In Petitioner's case, the relevant factors are undisputed. The injury occurred on Respondent's premises, and the employer, pursuant to the testimony of Major McAbee, appears to have acquiesced in allowing COs and supervisors to play basketball in the multipurpose room during lunch. The evidence supports that this was a common activity for a number of COs to stay in shape. There was no evidence presented that the Petitioner was participating in basketball in an unreasonable manner when he was injured. The fact that COs were not permitted to leave Respondent's premises during their lunch period factors significantly into the Arbitrator's determination in this case. While playing basketball may not be something that would typically occur during a typical employee's work day, and thus not a more "common" personal comfort activity such as eating or using the restroom, the Arbitrator notes that the job of a CO involves having to keep order and deal with inmate attacks and other similar behavior that requires a physical response. It seems to be common sense that being in the best possible physical condition would be in the best interests of both a CO as well as the Respondent. Our Supreme Court has previously found that an activity, playing Frisbee, which does not specifically appear to promote the duties of a stock worker constituted a personal comfort for the stock worker. Here, the inability to leave the prison premises and the physically enhancing activity of playing basketball would comparatively involve personal comfort of a CO while more directly impact the job in a positive way. The Arbitrator finds that Petitioner's accidental injuries arose out of and in the course of his employment with Respondent on 2/27/16 when he was injured playing basketball during his lunch period.

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 Petitioner's left ankle injury, in the view of the Arbitrator, can be determined to be causally related to the 2/27/16 accident via a chain of events analysis. While the x-rays and MRI reflect what appears to be a prior injury to the left ankle, it is abundantly clear that the Achilles tear occurred while he was playing basketball on 2/27/16. He had been working and ambulating prior to the accident, and obviously had been able to play basketball prior to the injury. He subsequently was unable to do so, and the incident was witnessed by multiple co-workers. The Arbitrator finds that the evidence strongly supports that the Petitioner's left Achilles tear is causally related to the 2/27/16 accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings (above) with regard to the issues of accident and causation, the Arbitrator finds that the Petitioner is entitled to, and Respondent is liable for, the medical expenses contained in Px1. A review of these expenses indicates all are related to the Petitioner's left ankle/Achilles treatment, the treatment appears to have been reasonable and necessary pursuant to Section 8(a) of the Act, and the Respondent has not submitted evidence disputing the reasonableness and necessity of the treatment. The Respondent is entitled to credit for any of these awarded expenses which were paid prior to the hearing pursuant to Sections 8(a), 8(j) and 8.2 of the Act. Additionally, the parties have stipulated that any outstanding awarded medical expenses may be paid by the Respondent directly to the applicable providers.

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 evidence indicates that the Petitioner was held off work due to his left Achilles injury from 2/28/16 through 7/10/16. The Arbitrator finds that the Petitioner is entitled to TTD during this noted period of time. Additionally, the Arbitrator notes that the Petitioner has acknowledged that based on this award, his union contract indicates he is to repay the occupational disability benefits he received for this period of time.

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);

(ii) the occupation of the injured employee;

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

(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an AMA permanent partial impairment report or opinion into evidence. As such, this factor carries no weight in the permanency determination.

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 correctional officer at the time of the accident, and has returned to his full work duties for the Respondent. This tends to show a lesser degree of permanent partial disability than would have been the case had he not been able to return to his regular job. At the same time, the Petitioner testified that upwards of 70% of his job is spent on his feet, and thus his job requires a significant use of the lower extremities. This tends to show a somewhat greater degree of permanent partial disability, in the Arbitrator's view, than the average worker.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. Neither party presented any specific evidence with regard to the impact of the Petitioner's age on his permanent partial disability. Thus, this factor carries no significant weight in the Arbitrator's permanency determination.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented to indicate that such capacity has been negatively impacted by the Petitioner's injury. As such, this factor tends to show a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner testified to ongoing complaints of some ongoing pain and a limp. The last report of Dr. Solman, on the other hand, indicates on 7/6/16 the Petitioner had no pain and had progressed without disability. The Arbitrator does note this was prior to the Petitioner's return to work, so he may not have been on his feet yet as often as he would have to be at work. At the same time, he agreed he hasn't sought further treatment with Dr. Solman due to ongoing pain. The Arbitrator notes that the diagnostic testing in this case appears to show the Petitioner has had some level of prior injury to the left ankle, while he initially testified he had no such prior injuries. As noted above, the Petitioner does appear to be on his feet for significant portions of his regular workdays.

The Arbitrator notes with interest the following Commission decisions: 14 IWCC 134 (*Bone*); 14 IWCC 805 (*Green*); 14 IWCC 1005 (*Geist*); 13 IWCC 204 (*Schmitt*).

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17.5% loss of use of the left foot 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 SANGAMON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timmy J. Brown,
Petitioner,

18IWCC0509

vs.

NO: 16 WC 36911

Dynegy Midwest Generation Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue 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 January 30, 2018, is hereby affirmed and adopted.

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

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

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

DATED: AUG 15 2018
o7/26/18
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 ARBITRATOR DECISION

18IWCC0509

BROWN, TIMMY J Case# **16WC036911**
Employee/Petitioner

DYNEGY MIDWEST GENERATION INC
Employer/Respondent

On 1/30/2018, 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 1.62% 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:

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

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

TIMMY J.BROWN,
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

Case # **16** WC **36911**

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 **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/12/18**. By stipulation, the parties agree:

On the date of accident, **9/12/16**, 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 **$108,680.00**, and the average weekly wage was **$2,090.00**.

At the time of injury, Petitioner was **48** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$22,382.55** for nonoccupational indemnity disability benefits, for a total credit of **$22,382.55**.

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 $775.18/week for a further period of 106 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **petitioner a 12.5% loss of use of the right hand, a 10% loss of use of the left hand, a 12.5% loss of use of the right arm, and a 12.5% loss of use of the left arm.**

Respondent shall pay Petitioner compensation that has accrued from **9/12/16** through **1/12/18**, 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.

Maureen P. Pulia

Signature of Arbitrator

1/26/18
Date

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Petitioner, a 48 year old mechanical maintenance worker, sustained an accidental injury to his bilateral hands and arms due to repetitive work activities, that arose out of and in the course of his employment and manifested itself on 9/12/16. Petitioner performed millwright, and iron and boiler maker work; tied rebar; tightened bolts that weighed thousands of pounds; and used impact wrenches, jackhammers, and pneumatic tools. He performed this work for approximately 18 years. Prior to the injury, petitioner was experiencing numbness in his hands, especially at night, and would often drop things. Petitioner is right hand dominant.

Petitioner sought treatment from his primary care physician for these complaints and was eventually referred to Dr. Trudeau for testing. On 9/8/16 petitioner underwent an EMG/NCV of his bilateral upper extremities performed by Dr. Trudeau. The results revealed bilateral cubital tunnel syndrome, and bilateral carpal tunnel syndrome.

On 11/2/16 petitioner presented to Dr. Christopher Meander, at Orthopedic Center of Illinois with chief complaints of elbow problems and wrist pain. Petitioner reported pain, stiffness and tenderness, as well as numbness and weakness of the hand. He reported his exacerbating factors as use of the thumb, hand, and wrist, repetitive use, and gripping. Petitioner reported that his symptoms began roughly a year and a half ago, with his numbness beginning in his right hand. He reported that he then increased his activities on the left to protect the right, and then developed numbness and pain in the ulnar nerve distribution. Following an examination and imaging, Dr. Meander assessed left and right elbow pain, and right and left wrist pain. His impression was bilateral moderate carpal tunnel syndrome, bilateral moderate cubital syndrome, and early mild thumb CMC and ST-T joint primary osteoarthritis. Dr. Meander recommended carpal tunnel release and in situ ulnar nerve release, bilaterally. Dr. Meander was of the opinion that given petitioner's job and his description of his typical daily activities involving heavy and repetitive gripping and lifting, that petitioner's carpal tunnel syndrome and cubital tunnel syndrome were caused in part by his work activities.

On 1/17/17 petitioner underwent a left carpal tunnel release and in-situ ulnar nerve release, performed by Dr. Meander. His post-operative diagnosis was left carpal tunnel syndrome and cubital tunnel syndrome. Petitioner followed-up post-operatively with Dr. Meander.

On 2/21/17 petitioner underwent a right carpal tunnel release and in-situ ulnar nerve release, performed by Dr. Meander. His post-operative diagnosis was right carpal tunnel syndrome and cubital tunnel syndrome. Petitioner followed-up post-operatively with Dr. Meander on 3/6/17 and 4/12/17. On 4/12/17 petitioner's sensation was improving, but he still had soreness, especially over his carpal tunnels. He also reported some soreness at his right medial epicondylitis. Dr. Meander noted that these symptoms were slowly improving and he expected them to continue to improve with time. Dr. Meander released petitioner to full duty work on

4/24/17. He told petitioner that if he was not able to tolerate his work activities that he should let him know and they could adjust plans, if needed. He told petitioner to contact him if he did not progress as expected.

Respondent's attorney Neil Giffhorn indicated that respondent would not be taking a credit for any overpayment of nonoccupational indemnity disability benefits. He further indicated that all medical bills that have not been paid, would be paid pursuant to Sections 8(a) and 8.2 of the Act. He also stated that respondent would hold petitioner harmless from any group payments made.

Petitioner testified that he still has weakness in his bilateral hands and elbows, especially on the right. He also reported some numbness in his hands. He stated that he feels things, but it feels like he is wearing gloves. Petitioner complained of fatigue in his hands when gripping and holding things. He testified that when he loosens bolts with an 8 pound sledge hammer, he gets a shock up to his elbow upon impact. He also testified that after 8-10 blows with a hammer he needs to shake things out. Petitioner complained of pain after gripping something tight for less than 2 minutes. Petitioner also complained of shocking pain up his hand to his elbow when he hits the ground with a golf club. Petitioner reported more pain in his right hand, and shocks up his left hand. Petitioner complained of fatigue and weakness in his hands, and difficulty opening jars and bottles. Petitioner also reported numbness by his right elbow when brushing his teeth, and a shock in his elbow when "breaking" when playing pool.

Petitioner testified that he and his co-workers, who are all getting older, help each other out. Petitioner also testified that he no longer takes divots when golfing. Petitioner used to compete in archery for several years, but as a result of his weakness and pain in his arms, he got a release from his doctor that allows him to use a crossbar. Petitioner no longer competes. Petitioner is also an avid hunter.

Petitioner testified that he has returned to full duty work and performs his regular duty job. He stated that his hourly rate is about the same. Petitioner does work overtime. Petitioner has not been disciplined for any inability to do his job. Petitioner has not returned to Dr. Meander or anyone else for additional treatment to his bilateral hands and arms. Petitioner testified that he has not returned because he is only feeling what Dr. Meander told him to feel. Petitioner does not believe there is anything else they can do to help him. He stated that everything he experiences is within what Dr. Meander told him to expect.

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 mechanical maintenance worker at the time of the accident and

returned to his regular duty job on 4/24/17 and continues in that capacity as of the trial date. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. Because of this, the fact that petitioner is currently working the same job he was working prior to the injury, and the fact that he has many possible work years ahead of him if he planned on working to retirement age, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the petitioner testified that his wages have not decreased as a result of his injury since he continues to work in the same capacity. Additionally, the petitioner testified that he also continues to work overtime. 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 the last credible treating record offered into evidence was 4/12/17. On that date, petitioner reported that his sensation was improving, but he still had soreness, especially over his carpal tunnels. He also reported some soreness at his right medial epicondylitis. Dr. Meander noted that these symptoms were slowly improving and he expected them to continue to improve with time. Dr. Meander released petitioner to full duty work on 4/24/17. He told petitioner that if he is not able to tolerate his work activities that he should let him know and they could adjust plans, if needed. He told petitioner to contact him if he did not progress as expected. Petitioner did not return to Dr. Meander or seek any other treatment after 4/12/17.

At trial, petitioner testified that he still has weakness in his bilateral hands and elbows, especially on the right. He also reported some numbness in his hands. He stated that he feels things, but it feels like he is wearing gloves. Petitioner complained of fatigue in his hands when gripping and holding things. He testified that when he loosens bolts with an 8 pound sledge hammer, he gets a shock up to his elbow upon impact. He also testified that after 8-10 blows with a hammer he needs to shake things out. Petitioner complained of pain after gripping something tight for less than 2 minutes. Petitioner also complained of shocking pain up his hand to his elbow when he hits the ground with a golf club. Petitioner reported more pain in his right hand, and shocks up his left hand. Petitioner complained of fatigue and weakness in his hands, and difficulty opening jars and bottles. Petitioner also reported numbness by his right elbow when brushing his teeth, and a shock in his elbow when "breaking" when playing pool.

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 petitioner's left hand, 12.5% loss of petitioner's right hand,12.5 % loss of petitioner's left arm, and 12.5% loss of petitioner's right arm 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Wooten,
Petitioner,

18IWCC0510

vs.

NO: 12 WC 44372

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent 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 9, 2018, 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:
o7/26/18
DLS/rm
046

AUG 15 2018

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

18IWCC0510

WOOTEN, JERRY
Employee/Petitioner

Case# **12WC044372**

CITY OF CHICAGO
Employer/Respondent

On 3/9/2018, 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 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

18IWCC0510

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jerry Wooten
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **044372**

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 **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **January 23, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **12/10/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,856.00**; the average weekly wage was **$1,228.00**.

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

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

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

Respondent shall be given a credit of **$12,163.69** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$12,163.69**.

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 $818.66/week for the period of time between December 11, 2012 and March 24, 2013. Respondent shall be given a credit of $12,163.69 for benefits that have been paid.

Based on the following factors, and the record taken as a whole, this Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the right hand pursuant to Section 8(e) of the Act.

With regard to subsection (i) of Section 8.1b(b), this Arbitrator notes that no opinion comporting with the specific requirements of Section 8.1b(b)(a) was submitted into evidence. However, this Arbitrator has considered the comments of Dr. Fernandez as a factor in the evaluation of petitioner's permanent partial disability as required by section 8.1b(b)(i). The doctor noted a weakness to pinch and grip with a loss of 30-40%. Because of that, this Arbitrator gives greater weight to this factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, this Arbitrator notes that the record reveals Petitioner was employed as a truck driver at the time of the accident and is able to return to work in his prior capacity a result of the injury. I give greater weight to this factor.

With regard to subsection (iii) of Section 8.1b(b) this Arbitrator notes Petitioner was 62 years old at the time of the accident. Because of that age I give greater weight to that factor.

With regard to subsection (iv) of section 8.1b(b), Petitioner's future earnings capacity, this Arbitrator notes no testimony or evidence on this issue was offered. Because of this, I give no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, this Arbitrator notes Petitioner works with difficulty as borne out by the records and has lost significant ability to pinch and grip. Because of this, I give greater weight to this factor.

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

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

Signature of Arbitrator

3/9/18
Date

MAR 9 - 2018

Findings of Fact

Jerry Wooten (Petitioner), a 62 year old male, was working as a truck driver for the City of Chicago (Respondent) on December 10, 2012. He had done so for well over 25 years. Petitioner testified (no transcript of Proceedings on Arbitration was provided to the Arbitrator) he was picking up debris, operating a dump truck, and while attempting to dump debris from the truck, a chain caught in the gate. Petitioner tried to free up the chain and his right little finger caught in the back of the gate, and was crushed. Petitioner testified he reported the accident to his foreman who called an ambulance. See Respondent's Exhibit 1 at 1; Petitioner's Exhibit 4 (none of Petitioner's exhibits are paginated).

Petitioner was taken by ambulance to St. Mary of Nazareth Hospital. There he was diagnosed with a crush evulsion injury requiring reconstruction. An x-ray was done of Petitioner's right hand, indicating a comminuted, displaced and intra-articular fracture through the distal phalanx of the fifth digit extending into the interphalangeal joint space. Also indicated was significant associated soft tissue injury and evidence of an old healed fracture involving the fifth metacarpal. Petitioner's Exhibit 1; Petitioner's Exhibit 2.

Petitioner testified he had surgery the day of the accident, December 10, 2012. The post-operative diagnosis in the operative report indicated: a right small finger crush injury reconstructed; right small finger crush injury with closed reduction of distal phalanx finger; complex repair and advancement flap closure of right small finger injury, 2cm x 1cm; repair of right small finger nail bed; repair of terminal extensor tendon of right small finger. Petitioner's Exhibit 2.

Petitioner had follow up visits with his surgeon, Dr. Mark Grevious, through April 11, 2013. During those visits, Dr. Grevious noted Petitioner had a near complete amputation. He also noted Petitioner's complaints of pain and swelling during those visits. Petitioner was returned to full duty March 22, 2013. Petitioner's Exhibit 2.

Petitioner also participated in therapy, referred by Dr. Grevious, at Accelerated Rehabilitation Center. He had eight visits from February 25, 2013, through March 19, 2013, with treatments including: AAROM; AROM; strengthening; manual therapy; functional activities; therapeutic exercises; scar management; fluido therapy; hot and cold packs; and stretching. During those visits, Petitioner told staff he had difficulty lifting, driving, dressing, cooking, and climbing stairs. He said he had a difficult time bending and grasping. Petitioner's Exhibit 3.

On January 29, 2013, Petitioner submitted to an independent medical examination by Dr. Mark Gonzalez. There was no evidence submitted as to the qualifications of Dr. Gonzalez. On physical examination of Petitioner, Gonzalez found exquisite tenderness about the distal phalanx, bruising at the nail, which he found to have been crushed. He thought the nail was going to fall

off. He found significant tenderness and pain when Petitioner moved his finger. Gonzalez noted, in a review of an x-ray, a comminuted fracture of the distal ½ of the distal phalanx, incompletely united. He assessed Petitioner with a crush injury to the distal phalanx, not completely healed, exquisitely tender. Gonzalez thought Petitioner could return to duty in six to eight weeks, and would be at MMI by March 29, 2013. Respondent's Exhibit 1.

On May 19, 2015, Petitioner submitted to yet another independent medical examination, by Dr. John Fernandez, a Board Certified Orthopedic Surgeon. Fernandez noted that although Petitioner was discharged back to work, he continued to work with difficulties. There were significant residual complaints of right small finger pain, sensitivity and discoloration, specifically, exposure to cold. Petitioner complained of swelling and deformity. His major complaint was stiffness to terminal flexion and closing the hand and associated weakness to grasping and pinching. Fernandez found residual nail deformity and discoloration of the skin, coldness to the digits and weakness to the pinch and grip of 30-40%. X-rays revealed a severe malunion of the distal phalanx. While the fracture had healed, it did so, said Fernandez, in a less than optimal position. Fernandez said Petitioner's condition was causally related to the work injury and was caused by the injury. Petitioner was at MMI, said Fernandez, but not normal, and limited to light to medium use of the right hand. Petitioner's Exhibit 4.

Petitioner testified he is right hand dominant, and he tries not to put any pressure on the finger, which cannot be straightened. He has difficulty grasping and holding things tight. This Arbitrator viewed the finger, at the hearing, finding it bent, shriveled, and discolored. It was severely malformed.

Conclusions of Law

As to disputed issue F, is Petitioner's current condition of ill-being causally related to the injury, this Arbitrator makes the following conclusion of law: this Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the injury.

In support of this conclusion, I rely on the testimony of Petitioner, as well as the IME by Dr. John Fernandez in which he states unequivocally that "Within a reasonable degree of medical and surgical certainty Mr. Wooten's conditions are causally related to the work injury. These are not idiopathic or degenerative in nature and were caused by the injury. There was no preexisting status or treatment for similar problems in the past. His current condition is directly related to that injury that he sustained at work on 12/10/2012."

It is extremely troublesome that when the Request for Hearing was tendered before trial, Respondent modified paragraph 4 to dispute whether the current condition of ill-being was causally connected to the injury. Arbitrator's Exhibit 1. Yet Respondent offered no evidence whatsoever contrary to Petitioner's claim it was, nor even cross examined Petitioner on that issue. Respondent disputed the issue even though its own selected orthopedic surgeon performed an examination on Petitioner over two years before hearing, and told Respondent, in no uncertain

terms, there was a causal connection. It is worth noting it was Petitioner who brought that IME to light.

Section 16 of the Act states that when the Commission finds that the employer has engaged in a frivolous defense which does not present a real controversy within the purview of the provisions of paragraph (k) of section 19 of the Act, the Commission may assess all or part of the attorney's fees and costs against such employer. Section 19(k) states, in a case where proceedings have been carried on by the one liable to pay compensation, which does not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of that amount, payable at the time of such award. 820 ILCS 305/19(k). Yet, because no penalty petition was filed, at this time, this Arbitrator does not reach a conclusion on this issue.

As to disputed issue K, TTD in dispute, while in the Request for Hearing (Arbitrator's Exhibit 1) Respondent inexplicably disputed Petitioner's claim that all TTD was paid by Respondent from December 11, 2012 through March 24, 2013. That is, disputed the fact they **had** provided TTD payments from injury to MMI. While there was scant direct evidence in this issue, there is enough to determine Petitioner entitled to TTD benefits of $818.66 per week and Respondent receiving a credit of $12,163.69 for TTD paid.

With regard to disputed issue L, what is the nature and extent of the injury, this Arbitrator makes the following conclusions of law: this Arbitrator concludes that Petitioner sustained, as a result of the accident, a crush injury to the right small finger, requiring complex reconstruction.

In support of this conclusion, I rely on the testimony of Petitioner; the records of St. Mary of Nazareth Hospital; Dr. Mark Grevious; and Dr. John Fernandez. Petitioner's Exhibit 1; Petitioner's Exhibit 2; Petitioner's Exhibit 4.

As to permanent partial disability, I view this as an injury to the hand. I do so because of the evidence presented and the testimony of Petitioner in addition to my view of the injury. In sum, there is significant deformity affecting the full use of the hand, significant weakness affecting the use of the hand, and continued difficulties at work because of the condition of the hand. Petitioner's Exhibit 2; Petitioner's Exhibit 4.

As to permanent disability, I consider the factors found in Section 8.1b(b) of the Act and find as follows.

With regard to subsection (i) of Section 8.1b(b), this Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. However, this Arbitrator has considered the IME by Dr. Fernandez as a factor in the evaluation of Petitioner's permanent partial disability as required by section 8.1b(b)(i). Fernandez noted a residual weakness to pinch and grip with a loss of about 30-40% compared to the contralateral side. Because of this finding, this Arbitrator gives greater weight to this factor.

With regard to subsection (ii) of Section 8.1b(b), the occupation of the employee, this Arbitrator notes, by testimony and by medical records, that although Petitioner returned to work,

the injury still affects the way he can work. His work is physically demanding. I give greater weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), this Arbitrator notes that Petitioner was 62 years old at the time of the accident. Because he faces a slower healing process at that age, I give greater weight to that factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earning capacity, this Arbitrator notes no testimony was offered as to this factor. Petitioner returned to work presumably at no loss of wage. Because of this, I give no weight to this factor.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, this Arbitrator notes that Petitioner testified he tries not to put pressure on the finger, which cannot be straightened, and the records are clear he works with difficulty, and has lost significant ability to pinch and grip. Because of this, I give greater weight to this factor.

Based on the above factors, and the record taken as a whole, this Arbitrator finds the Petitioner sustained permanent partial disability to the extent of 20% loss of the right hand as a result of the injury.

Arbitrator

3/9/18
Date

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

Joseph Hall,
Petitioner,

vs.

NO: 17WC 1121

18IWCC0511

Illinois Department of Corrections,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent 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 28, 2018, 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 2018
o080118
LEC/jrc
043

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HALL, JOSEPH
Employee/Petitioner

Case# **17WC001121**

17WC000206

ILLINOIS DEPARTMENT OF CORRECTIONS
Employer/Respondent

18IWCC0511

On 2/28/2018, 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 1.83% 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:

1974 LAWLER & LAWLER
MICHAEL SINNEN
1129 N CARBON ST
MARION, IL 62959

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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

FEB 28 2018

DANIELA A. RASCIA, ACTING SECRETARY
Illinois Workers' Compensation Commission

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
NATURE AND EXTENT ONLY

JOSEPH HALL
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF CORRECTIONS
Employer/Respondent

Case # **17** WC **01121**

Consolidated cases: **17 WC 00206**

18IWCC0511

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **December 15, 2017**. By stipulation, the parties agree:

On the date of accident, **September 9, 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 $**90,935.25**, and the average weekly wage was $**1,748.75**.

At the time of injury, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

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

18IWCC0511

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$755.22 per week**, the maximum allowable statutory rate, for **43 weeks**, because the injuries sustained caused the **20% loss of use of the right leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **December 22, 2015** through **December 15, 2017**, 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

February 27, 2018
Date

FEB 28 2018

STATEMENT OF FACTS and CONCLUSIONS OF LAW

The Petitioner testified that, as of his 9/9/15 accident date, he had worked for the Respondent as an electrician for 17 years. He testified the job involved any electrical work at his assigned prison, including changing lights, switches, outlets, performing new construction, equipment repair some fiber wiring.

He was working at Respondent's Menard facility on 9/9/15. He testified that his tools and parts are kept in the back of a cargo truck. It was raining that day, and as he was climbing into the truck bed to get tools, he stepped up on the bumper (about 3.5 feet up), his boot slipped and he fell forward into the truck, injuring his right knee.
He testified went to see the facility nurse, notified the Respondent of the incident and completed accident paperwork. (See PxC and Rx1 in 17 WC 1121).

Petitioner initially sought treatment at the Orthopaedic Institute on 9/11/15 for right knee pain. Following examination, Dr. Wood diagnosed a likely medial meniscus tear, restricted Petitioner to light duty and prescribed a right knee MRI.

The 9/21/15 MRI showed a complex medial meniscus tear of the posterior horn and body. There also was a small mid-body portion of meniscal tissue that was flipped into the superior medial recess. Free meniscal tissue was also noted in the central knee joint that the radiologist indicated was likely sequelae of the meniscal tear. The MRI also reflected a Grade 1 MCL sprain, small to moderate joint effusion, and mild patellar tendinopathy that was likely chronic. After reviewing the MRI on 9/25/15, Dr. Wood diagnosed an acute meniscus tear and prescribed arthroscopic surgery. (PxA1; Rx5).

Dr. Wood performed a right partial medial meniscectomy surgery on 10/29/15. Post-operative diagnoses included: 1) Grade III chondromalacia of the medial femoral condyle (primary degenerative arthritis), 2) acute medial meniscus tear and 3) Grade II chondromalacia of the patellofemoral joint. Dr. Wood noted the meniscus had both acute and chronic findings, but that the large bucket handle tear was clearly acute. (PxA1; Rx5).

Petitioner testified surgery was followed by about 5 weeks of therapy at the Orthopedic Center in Herrin. He testified he went back to light duty about two weeks after the surgery, and was released to return to regular work on 12/22/15.

The medical records reflect an 11/11/15 light duty release and prescription for 4 weeks of physical therapy. On 11/19/15, Dr. Wood issued a release for Petitioner to return to full duty as of 11/23/15. The therapy note from that date indicated the Petitioner had returned to work earlier that day. By 12/7/15, Petitioner was reporting no complaints, that work was going well, but he had some minor muscle soreness following treatments. It appears that he had met all of his short and long-term goals. (PxA1; Rx5).

The Petitioner testified that the surgery provided significant improvement, but he continued to have ongoing right knee pain, so he followed up with Dr. Wood in December 2016 and March 2017 because to make sure nothing else was wrong.

On 12/12/16, Petitioner reported pain and stiffness: "He states that the symptoms have been chronic non-traumatic." He noted the symptoms fluctuated intermittently and were mild but aching. Symptoms occurred with continuous activity. X-rays showed moderate degenerative changes in the right patellofemoral and medial compartments, with mild degenerative findings in the left knee. Dr. Wood diagnosed primary osteoarthritis of the right knee, noting Petitioner was "very heavy", and that he had done well until recently, noting increased pain, particularly with extensive activity. Dr. Wood indicated the first step would to treatment would be Meloxicam and weight loss, and if this didn't work Visco supplementation. Dr. Wood determined on 12/22/15 that the Petitioner had reached maximum medical improvement. (PxA1; Rx5).

On 3/15/17, Petitioner presented to Dr. Wood with right knee pain, swelling, stiffness and weakness. He reported this was a mild to moderate aching that occurs with activity. Dr. Wood noted that the initial 9/11/15 x-rays showed minimal degenerative joint disease, which were moderate on 12/12/16 films. Exam noted a slow but steady gait, good alignment, no significant swelling and no instability. Petitioner asked him about the causality of his arthritis, and Dr. Wood stated: "The natural history of arthritis is that it will get worse over time however his meniscal tear may have patient [sic] the natural history of arthritis for him." Dr. Wood also stated: "His injury did aggravate pre-existing arthritis. He is injury [sic] may have a second natural history of arthritis. At some point in his future he may need a total knee." Petitioner felt like anti-inflammatory medication helped him, and therefore declined attempting viscosupplementation injections. He was to continue working full duty and again was discharged from care at MMI. (PxA1; Rx5).

Petitioner testified that the knee injury impacts his job duties, such as any climbing, crawling, kneeling and stooping. On or about 12/16/15, Petitioner testified that he transferred to Respondent's Big Muddy facility. He testified he made the

move because he had moved and not because of his knee injury. He continues to work at Big Muddy as an electrician performing the same duties he did at Menard. The location of his pain has remained the same in the knee, and it hasn't changed much since post-surgery therapy ended.

On cross examination, the Petitioner reiterated that he returned to light duty two weeks post-surgery, and agreed he was released to full duty as of 11/23/15. The Petitioner agreed that, as an electrician, he has inmate helpers who, at times, carry tools for him, and who sometimes perform electrical work under his instructions. While he has ongoing problems with stairs, climbing and working on the floor due to his knee, Petitioner agreed that he has been able to do his job and his supervisor doesn't have any problems with his job performance.

Petitioner agreed that he is making the same or higher wages than at the time of his injuries, and the injuries have not impacted his income. He still takes Meloxicam daily for his knee as prescribed by Dr. Wood, and testified that it does help. He has had refills since March 2017.

The Respondent obtained an American Medical Association (AMA) impairment rating from Dr. Katz for the right knee injury on 9/29/17. Petitioner reported persistent aching and pain since the surgery, with sharp pains in the medial right knee and popping. He did not indicate instability. Petitioner reported mild pain at the time of the exam, but that it increases with heavy lifting and prolonged walking or standing. It appears that Dr. Katz' exam was relatively normal other than noting HS and quadriceps strength could be improved. His diagnosis was severe right medial meniscus tear on top of preexisting degenerative changes. He noted Petitioner is overweight and on a slow path to severe arthritis and possible knee replacement. Based on his review of the 6th edition AMA guide, Dr. Katz determined that the Petitioner was at the default lower extremity impairment rating for his meniscal tear of 2%. (Rx3).

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 2% of the right lower extremity as determined by Dr. Katz pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (Rx3). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. In the present case, Dr. Katz' report notes that the Petitioner had some ongoing knee ache but no evidence of instability, and found that the AMA guide would put the Petitioner at the default rating for a medial meniscus tear. The Arbitrator puts some weight on this determination of Dr. Katz.

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 prison electrician at the time of the accident and that he has been able to return to his regular work duties in that capacity. He testified that he has been able to complete all his job duties, though some, such as climbing and working at floor level, can be difficult. Given that these activities are part of the Petitioner's job, as well as periods of higher activity which impacts his pain levels, the Arbitrator notes that lower extremity use is significantly involved in performing the work. The Arbitrator gives this factor medium weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. The parties did not submit evidence in this case with regard to how the Petitioner's age may impact his right knee condition. Dr. Wood did note that the Petitioner's knee would likely continue to degenerate over time, however it is unclear to the Arbitrator exactly how the Petitioner's age makes his permanent condition worse or better. The Arbitrator gives this factor no weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner testified that, because he has continued to do the same job, the right knee injury has not impacted his future earning capacity. The Arbitrator gives this factor some weight.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the records of Dr. Wood are consistent with the testimony of the Petitioner. He has an ongoing right knee ache with periods of increased pain with certain activities and/or prolonged standing, walking or other activities. He continues to take Meloxicam. There is a strong inference that the Petitioner's ongoing symptoms are significantly due to his degenerative condition as opposed to specifically the medial meniscus tear. However, Dr. Wood also has pointed out that x-rays taken after the accident but prior to the surgery reflect a worsening of the degenerative conditions in the right knee, and he opined that the accident aggravated the preexisting right knee arthritis. While he noted it only as a possibility, Dr. Wood indicated that the Petitioner could ultimately be a total knee replacement candidate in the future. The Arbitrator gives this factor significant weight.

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

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

☐ 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

Michelle Morales,

Petitioner,

vs. NO: 15 WC 16623

Epsilon,

Respondent.

18IWCC0512

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 permanent partial disability (PPD) nature & extent only, 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

- The parties stipulated to accident and causal connection.

- Petitioner testified that prior to May 6, 2015 she had never injured her right arm or hand before. Petitioner is right hand dominant. Petitioner had been diagnosed and treated for multiple sclerosis (MS) but she testified that that had no effect on her upper extremities. Petitioner was taking Gabapentin, Tysabri, and Baclafen for her MS. It was noted that the parties stipulated that Petitioner suffered an accident at work. On the date of accident, May 6, 2015, Petitioner testified that she was in the conference room setting up a presentation for the team. Petitioner testified that she had her computer out and as she was leaving the room she caught her foot on an Ethernet cord that went across the carpet (that powered the table) and fell. Petitioner testified that she fell, Superman like, face down on the floor.

Petitioner stated that she could not get up and she noticed that her entire right arm felt like a lead weight. Petitioner stated that she felt significant pain from the top to bottom of her right arm. Petitioner was seen at Central Du Page Hospital shortly after the accident. Petitioner had x-rays taken and was told that she had a fracture in her right elbow. Petitioner's arm was placed in a sling. Petitioner was given pain medication and told to follow up with an orthopedic doctor/surgeon for casting. Petitioner was seen two days later by Dr. Paul Prinz at Special Care Orthopedics, on referral from her primary care physician (PCP), Dr. Hannon. Petitioner first saw Dr. Prinz May 8, 2015 and told the doctor what happened. Dr. Prinz examined Petitioner and reviewed the x-rays. The doctor put Petitioner's right arm/elbow in a mold and sling and told her to continue wearing the cast and to follow up in a week. Petitioner saw Dr. Prinz again May 14, 2015. Petitioner was still wearing the cast and taking Tramadol for pain. Dr. Prinz examined her again and recommended outpatient therapy for her fingers and elbow. Petitioner underwent x-rays again May 21, 2015 and was placed in a posterior mold and told to start gentle range of motion exercises June 4, 2015 in occupational therapy. Petitioner was again examined June 11, 2015 and told to continue the therapy. Petitioner testified that around that time she began to notice her body was reacting in convulsions; the pain caused her whole arm to rise up in pain and then subside, but there was ongoing pain in her arm. Petitioner stated they call it CRPS, but they did not know for sure at that time; it just started with the bursts of pain. Petitioner testified that she reported the problem to Dr. Prinz June 23, 2015 and she also complained of swelling and discoloration of her right hand. Petitioner was referred to Dr. Saltzman, an orthopedic surgeon who referred her to a pain specialist but the appointment was far out. Dr. Prinz then referred Petitioner to Dr. Konowitz, a pain doctor she first saw June 29, 2015. Petitioner underwent a Doppler study of her right arm prior to that. Dr. Konowitz performed blood tests and prescribed Gabapentin, Lidoderm, and Pennsaid and Mobic for Petitioner. Petitioner saw Dr. Konowitz on July 9, 2015 who scheduled a stellate ganglion block for July 10, 2015 at Gottlieb Hospital. Petitioner stated that she saw Dr. Konowitz or the nurse practitioner, Ms. Iontorno, July 28 and August 3, 2015. Petitioner had a second stellate ganglion block on August 14, 2015 and returned to Dr. Prinz on August 20, 2015. Dr. Prinz examined Petitioner at that time and referred her to Dr. Mark Cohen at Midwest Orthopedics at Rush. Petitioner stated that she was unable to see Dr. Cohen as he was not interested examining her because he was not the treating doctor. Petitioner returned to Dr. Konowitz on September 10, 2015. Dr. Konowitz scheduled Petitioner for another injection. Petitioner returned for follow up on October 20, 2015. Petitioner saw Dr. Prinz sometime around September 17, 2015 and told him what she was noticing about herself. Dr. Prinz referred Petitioner to Dr. Schiffman at Loyola. Dr. Schiffman told Petitioner to undergo hand therapy only until cleared for surgery. Petitioner saw Dr. Konowitz on October 29, 2015 and he cleared her for the elbow surgery which was performed by Dr. Schiffman on November 4, 2015. Dr. Schiffman released Petitioner for light duty on November 23, 2015. Petitioner had been off work from November 6 through November 23, 2015 when she was released to light duty. Petitioner worked at home at that time. Petitioner saw Schiffman on January 4, 2016 and he prescribed 2 more months of occupational therapy. Petitioner again saw Dr. Schiffman on February 25, 2016 and reported what she noticed about herself. Dr. Schiffman examined Petitioner and advised her to discontinue therapy; Petitioner had been in therapy more than 6 months. Dr. Schiffman discharged Petitioner from care regarding her elbow and advised

her to return as needed. Petitioner testified that she has not been back to Dr. Schiffman since but she continued seeing Dr. Konowitz.

The Commission finds that Petitioner had no prior right arm issue. She has MS, but, that did not affect her right arm and she had been performing her job duties without prior issues. Petitioner suffered a comminuted and impacted fracture of the radius. Petitioner underwent a contracture release surgery, and per Dr. Coe, her right arm is about a half inch shorter. Petitioner developed CRPS which really isn't a condition taken into consideration under the AMA guidelines. Petitioner, who is right hand dominant (also not considered under AMA guidelines), has noted limited range of motion with her right elbow. Dr. Coe's AMA rating was at 5% impairment of the arm (maximum amount). Dr. Coe clearly noted the causal relationship between the accident, the fractures and the development of CRPS. Petitioner was 50 years old and she remains working in her same position. Petitioner has subsequently received pay increases; her future earnings do not appear to be impacted in any way. Petitioner's job is not physically demanding as to lifting and things like that, but she uses her right hand/arm for drawing, using the computer, and working on an easel. Petitioner's use of her arm does have an effect over the course of her day and her daily living is affected with dressing and getting up from a seated position, like from the floor when playing with the kids.

The Commission finds the evidence and unrebutted and supported testimony supports a higher permanent partial disability (PPD) award of 30% loss of use of her right dominant arm, given the fractures, shortening of the arm, restricted range of motion, weakness, and CRPS which all resulted from the accident. Petitioner met the burden of proving an increase of the PPD award. The Commission finds the decision of the Arbitrator as not totally contrary to the weight of the evidence, but inadequate, and, herein, modifies to increase to a 30% loss of use of her right arm. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,289.43 per week for a period of 25-4/7 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 $755.22 per week for a period of 75.9 weeks, as provided in §8(e)(10) of the Act, for the reason that the injuries sustained caused the 30% loss of use of Petitioner's right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,461.17 for medical expenses under §8(a) of the Act.

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

18IWCC0512

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 $61,700.00. 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:
d-7/26/18
DLG/jsf
045

AUG 17 2018

David S. Gore

Stephen Mathis

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORALES, MICHELLE
Employee/Petitioner

Case# **15WC016623**

EPSILON
Employer/Respondent

18IWCC0512

On 2/8/2018, 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 1.65% 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:

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

2837 LAW OFFICES JOSEPH MARCINIAK
BRENT W HALBLEIB
200 W MADISON ST SUITE 501
CHICAGO, IL 60606

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

Michelle Morales
Employee/Petitioner

v.

Epsilon
Employer/Respondent

Case # **15** WC **16623**

Consolidated cases: **N/A**

18IWCC0512

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **December 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 _____

18IWCC0512

FINDINGS

On **May 6, 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 **$100,575.80**; the average weekly wage was **$1934.15**.

On the date of accident, Petitioner was **50** 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 **$29,656.89** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,569.31** for other benefits, for a total credit of **$31,226.20**.

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

ORDER

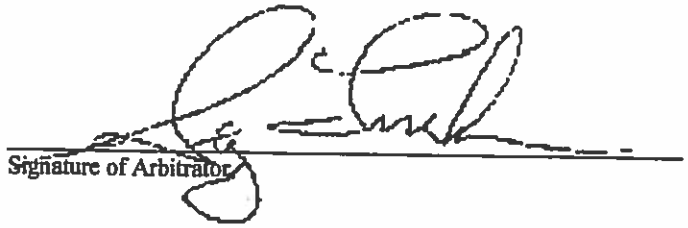
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,289.47 to Midwest Commercial Medical and $171.70 to DuPage Medical Group, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,289.43/week for 25 4/7 weeks, commencing May 16, 2015 through October 23, 2015 and November 6, 2015 through November 23, 2015, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$29,656.89** for TTD and **$1,569.31** for other benefits, for a total credit of **$31,226.20**.

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 63.25 weeks, because the injuries sustained caused the 25% loss of the Right Arm, 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

February 2, 2018
Date

FEB 8 - 2018

Statement of Facts

Prior to trial, the Parties stipulated as to the period of temporary compensation and credit for benefits paid. The Parties also stipulated to the outstanding medical bills (PX 7 and PX 8) and agreed that Respondent would make payment directly to the providers as provided in Sections 8(a) and 8.2 of the Act. The Arbitrator has awarded these agreed benefits in the Order but makes no further findings on these undisputed issues.

Petitioner Michelle Morales testified that on May 6, 2015, she was employed by Respondent Epsilon as a creative director for 4 years. Her job responsibilities included the design, formatting and production of artwork for promotional material. She sketched artwork on paper with a pen or pencil held in her right hand. Petitioner would also draw using a computer keyboard and a mouse held in her right hand. Petitioner testified that her job duties required the use of her hands 100% of the time. Petitioner is right arm dominant.

Petitioner testified that she had no prior injuries to her right hand or wrist. She had been diagnosed with multiple sclerosis prior to her work injury. She was taking three daily medications for the multiple sclerosis which included one or two gabapentin pills. She testified that the multiple sclerosis did not affect her ability to use her arms and hands.

On May 6, 2015, while setting up for a meeting, Petitioner tripped on a computer cord and fell to the floor. She noted immediate pain in her right arm. She was unable to get up due to severe pain in the entire length of her right arm. Petitioner was seen that day at Central DuPage Hospital. She provided a consistent history of a trip and fall over a cord at work and complained of mild right wrist pain and significant right elbow pain. X-rays showed a fracture of the right radial head with associated intra-articular extension and mild impaction. Petitioner was given pain medication, a long arm splint, a sling and an orthopedic referral (PX 1).

Petitioner began treatment Dr. Paul Prinz at Special Care Orthopedics and Hand Surgery on May 8, 2015 (PX 2). Petitioner reported significant pain in the lateral aspect of the right elbow. Updated x-rays showed adequate alignment of the proximal radial fracture with an intra-articular extension. Dr. Prinz recommended nonsurgical management of the fracture. The right arm was placed in a long arm cast and Petitioner was advised to keep her right arm elevated (PX 2). On May 14, 2015, Petitioner noted finger stiffness. She was to remain in the cast for another week. On May 21, 2015, Dr. Prinz removed Petitioner's cast but notes that she was unable to cooperate with the exam because she was anxious. Dr. Prinz notes x-rays show some angulation of the radial head. He expressed a concern for stiffness, and recommended a posterior mold and the start of some gentle range of motion (PX 2). On June 4, 2015, Dr. Prinz noted Petitioner was doing fairly well and ordered occupational therapy. Petitioner was to begin weaning the splint (PX 2).

On June 22, 2015 Petitioner called Dr. Prinz complaining of severe elbow pains in bursts lasting 10 to 15 seconds. Petitioner declined his suggestion to seek treatment at the ER. On June 23, 2015, Petitioner complained of severe 10 to 15 second bursts of pain, decreased right elbow motion with pain, swelling and discoloration of the right hand with stiffness in the fingers. Physical examination showed decreased range of motion of the right elbow with pain out of proportion to her injury. Dr. Prinz suspected a complex regional pain syndrome. Dr. Prinz recommended that Petitioner see a pain management specialist and also obtain a second opinion with an elbow expert (PX 2).

Petitioner saw Dr. Martin Salzman, an orthopedic surgeon, on June 25, 2015. His examination noted swelling with her fingers stiff and swollen. They were shiny. She had hypersensitivity. She had limited painful range of motion in the elbow. Dr. Salzman found that the fracture appeared healed and recommended range of motion. He stated that of more concern was the extreme pain and hypersensitivity in the right forearm. Dr. Salzman referred her to a pain physician at Northwestern for evaluation (PX 4). Petitioner testified that she could not obtain an appointment in the near future with a pain physician at Northwestern so Dr. Prinz referred her to Dr. Konowitz.

Dr. Konowitz, a pain physician, examined Petitioner on June 29, 2015 for her complaints of pain in the right elbow and pain radiating in the right deltoid as well as the right forearm with symptoms of swelling, discoloration and decreased motility of the fingers of the right hand (PX 6). Dr. Konowitz assessed chronic pain due to trauma in the right arm and hand and injury to the radial nerve. He prescribed an increased dose of gabapentin, a Lidoderm patch, pain medication, and Mobic (PX 6, p 19-26). On July 9, 2015, Dr. Konowitz noted that Petitioner had decreased pain and swelling in her right arm and hand. She reported the cramping and dysesthesias have resolved. He ordered stellate ganglion blocks (PX 6, p 46-53).

Dr. Konowitz administered the first stellate ganglion blocks on July 10, 2015 at Gottlieb Hospital (PX 5). On July 28, 2015, Petitioner reported that the block had greatly reduced the pain. The physical examination notes no hyperalgesias nor tactile allodynia. There is mild edema but equal color of both hands, no trophic changes or sweating. Dr. Konowitz ordered a repeat stellate ganglion block (PX 6, p 89-94). Dr. Konowitz administered an additional stellate ganglion block on August 14, 2015 (PX 5).

Petitioner returned to Dr. Prinz on August 20, 2015 complaining of a limited range of right elbow motion and diminished grip strength despite occupational therapy. She noted that her pain specialist recommended manipulation under anesthesia. Dr. Prinz disagreed with the recommendation until the CRPS is better controlled. He discussed having Petitioner see an elbow expert for a second opinion on arthroscopy. On August 27, 2017, Dr. Prinz advised Petitioner against having a manipulation of the right elbow due to the risk of refracture (PX 1). Petitioner testified that Dr. Prinz referred her to Dr. Kenneth Schiffman, an orthopedic surgeon for consideration of arthroscopic surgery. Dr. Schiffman saw Petitioner on September 3, 2015. Dr. Schiffman stated that it is likely Petitioner will require a surgical release of the right elbow contracture. He recommended only gentle range of motion in therapy at that time (PX 3). On September 10, 2015, Petitioner told Dr. Konowitz that her pain was markedly decreased since Dr. Schiffman made changes to her occupational therapy. On September 24, 2015, Petitioner reported tingling in her legs but stated she has felt this before related to her MS. Dr. Konowitz noted ongoing numbness and dusky color but no allodynia or hyperalgesia and equal temperature (PX 5). On October 19, 2015, Petitioner advised Dr. Schiffman that she was doing better with less pain. He scheduled her surgery (PX 3). On October 29, 2015, Dr. Konowitz notes Petitioner is scheduled for surgery. He notes there are no symptoms reported of tactile allodynia, hyperalgesia, edema, sweating, trophic changes or color changes. He notes Petitioner is working 5 days per week at full duty. She is able to work at home for part of it (PX 5).

Dr. Schiffman performed surgery on November 6, 2015 for an open release of the right elbow contracture (PX 3). Petitioner testified that Dr. Schiffman sent her to physical therapy which she attended three times per week beginning November 27, 2015 through February 2016. On February 25, 2016, Petitioner advised Dr. Schiffman that she was functioning well although she still had waxing and waning of her pain. Her physical examination noted extension lacking 40 degrees with flexion to 130 degrees. Pronation and supination were full. Dr. Schiffman suggested Petitioner shift to a home exercise program. She was to return as needed (PX 3). Petitioner testified she has not returned to Dr. Schiffman since the release.

Petitioner also saw Dr. Konowitz on February 25, 2016 complaining of increased pain and numbness in her right hand and fingers, especially the middle and ring fingers, which increased with repetitive use of a computer mouse. Dr. Konowitz found no evidence of CRPS on examination. He considered additional stellate ganglion blocks. On Dr. Konowitz scheduled additional blocks for March 25, 2016, but they were not approved. On May 26, 2016, Dr. Konowitz noted that Petitioner had quiescent right elbow and hand symptoms. She is using the mouse at work. He placed Petitioner at maximum medical improvement and advised her to return as needed (PX 6).

Petitioner returned to Dr. Konowitz on December 29, 2016 with a two-month history of tingling in her right hand that began in her right shoulder and went into her forearm and right lateral arm. She can reproduce the symptoms with her head in extension. Dr. Konowitz impression was cervical radiculopathy Dr. Konowitz increased the gabapentin to 1200 mg daily and ordered an MRI of the cervical spine and an EMG of the upper extremities. The EMG was not authorized by Respondent according to Dr. Konowitz. The cervical MRI performed January 14, 2017 noted likely demyelinating plaques C6-7 and mild/moderate right foraminal stenosis at C6-7 from uncinate hypertrophy. Petitioner last saw Dr. Konowitz on January 26, 2017 stating her pain in the right arm has improved with the gabapentin increased dose. She complained of mainly of pain in her right elbow radiating to the middle and ring fingers of her right hand. Dr. Konowitz advised Petitioner to continue the gabapentin 1200 mg daily and start turmeric and yoga (PX 6).

Dr. Jeffery Coe examined Petitioner on November 22, 2016 at Respondent's request for purposes of an impairment rating (RX 1, Ex 3). Dr. Coe testified by evidence deposition taken October 2, 2017 (RX 1). He testified to Petitioner's accident and medical history. He noted that Petitioner had been diagnosed with multiple sclerosis prior to the accident. Dr. Coe opined that the multiple sclerosis is completely unrelated to the acute injury and its recovery. Dr. Coe testified that Petitioner complained of pain in the flexor or bending surface of the right elbow which occasionally radiated into the right upper arm and forearm. Petitioner complained of stiffness, occasional tingling in the right arm and weakness in the right arm and hand. Dr. Coe opined that the subjective complaints were consistent with the medical records.

On examination, Dr. Coe found a 4 inch hypopigmented surgical scar along the lateral border of the right elbow. There was tenderness to palpation at the radial head fracture site. Extension at the right elbow was 160 degrees as opposed to 180 degrees on the left side. Flexion was 130 degrees right, 140 degrees left, Petitioner had 70 degrees of supination, on the right as opposed to 90 degrees on the left. Dr. Coe found no evidence of any nerve abnormality in pronation and supination (RX 1).

Dr. Coe testified that Petitioner had reached maximum medical improvement for her two diagnoses which consisted of a fracture of the right elbow with some residuals and a specific and independent, though related, diagnosis of a pain syndrome. Dr. Coe opined that there is a causal connection between the accident and the right radial head fracture and the CRPS (RX 1).

Dr. Coe testified to the calculations performed in preparing the AMA impairment rating. He explained the use of the Quick Dash report and the pain questionnaire. He opined that Petitioner had a 5% upper extremity impairment for her right elbow fracture according to the AMA Guide. The 5% rating is the highest allowable by the AMA Guide for an elbow fracture. Dr. Coe testified that since pain is subjective, the AMA Guide rating for complex regional pain syndrome is based on responses on a questionnaire. Petitioner had a self-reported score of 33 which, according to Table 3-1, is related to a mild degree of pain impairment. Per the AMA Guide, Petitioner had a 0% whole person impairment for the CRPS.

Petitioner testified that she has numbness and pain in her right arm and fingers daily, greater on workdays. Petitioner testified that she cannot fully flex or extend her right arm. She notes that her work sketches are not as fluid or organic as prior to the accident. When sketching, her right hand does not rotate as it did before the accident. Her grip on the pen or pencil has changed. She notices increased flexion of her right wrist as the day wears on. When drawing with a computer, she cannot use a tracking pad because she does not have the necessary finger function. When using a computer mouse to draw, she has difficulty gripping the mouse and constantly changes hand position. She also works more slowly since the accident. In her personal life, Petitioner testified that she has trouble grabbing objects and drops things due to stiffness in her right hand and fingers. Ordinary tasks such as buttoning her clothes are difficult due to stiffness in her fingers. She has trouble with any activity requiring pushing such as getting up off the floor.

Petitioner testified that she was taking gabapentin for her multiple sclerosis prior to the accident and now takes an increased dose as prescribed by Dr. Konowitz. Her multiple sclerosis has never affected her ability to perform her job. She is still employed in the same capacity by Respondent. She has received pay raises since the accident and has received no complaints about the quality of her work.

Conclusions of Law

In support of the Arbitrator's decision with respect to (L) Nature & Extent, the Arbitrator finds as follows:

Petitioner's date of accident is after September 1, 2011 and therefore the provisions of Section 8.1b of the Act are applicable to the assessment of partial permanent disability in this matter.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that the record contains an impairment rating of 5% of the right upper extremity for the fractured elbow and 0% of the whole person for the CRPS as determined by Dr. Coe, pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. (RX 1). The Arbitrator notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. The doctor noted the methodology he used in reaching the impairment rating, Petitioner's response to the pain questionnaires and his physical examination findings. He noted Petitioner had received the maximum rating available for the elbow fracture. Because of this, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a creative director at the time of the accident and that she is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes that Petitioner has been back to her regular job for over a year without seeking medical attention. Her job is not heavy or physical but does require extensive use of the right arm and hand. The medical records confirm her use of a computer and computer mouse for the majority of her work day. Petitioner testified to the difficulties she notices in performing her regular duty tasks. Because of these facts, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Petitioner would not be considered either a younger or older worker but she would be expected to remain in the workforce for an extended period. There was no evidence presented to indicate that her

unrelated condition of multiple sclerosis would shorten her expected work life. Because of this, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner remains in her regular duty position with Respondent. She has not received any complaints about her work performance and testified she has received pay raises. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered a fracture of the right radial head with associated intra-articular extension and mild impaction. Her treatment included medication, physical therapy and the November 6, 2015 surgical release of the right elbow contracture. Petitioner also developed CRPS and was treatment with stellate ganglion blocks, therapy and medications. The medical records document continued loss of range of motion in the right elbow and strength. She continued with pain complaints. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

Petitioner was treated for both causally related conditions of ill-being, but the Arbitrator notes that Petitioner's CRPS symptoms only were manifested in the right arm and hand. Her current complaints are localized only in the right arm and hand. The Arbitrator also notes that Petitioner advanced complaints related to her MS in her lower extremities, and that the 2017 visits with Dr. Konowitz were diagnosed as cervical radiculopathy related to foraminal stenosis or demyelinating plaques. The Arbitrator finds that Petitioner's permanent partial disability should therefore be properly assessed as a partial loss of use of the right arm. The Arbitrator finds instructive the Commission decisions in *Ruth Reames v. Friendship Care Nursing Home,* 09 IWCC 1075 (30% loss of use of the arm for a pre-AMA case involving a 55-year-old employee with a radial head fracture with surgery for a radial head implant, the development of radial nerve palsy and resultant loss of motion and strength); and *Charles Strobel v. State of Illinois-IDOT*, 17 IWCC 0196 (17.5% loss of use of the arm awarded to 56 year old employee with radial head fracture and epicondylitis).

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 Right Arm pursuant to §8(e)10 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Russell Stevens,

Petitioner,

vs. NO: 15 WC 42401

Panel's Plus,

Respondent.

18IWCC0513

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, benefit rates and vocational rehabilitation, 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. On November 11, 2015 Petitioner was putting an addition onto the back of an existing building at a General Mills plant. He was 25 feet in the air on a roof, kneeling on corrugated metal. He was to cut a thermal break into the top of the standing walls surrounding the perimeter of the building. He was cutting with a Skilsaw sideways. Due to all of the crawling, he felt some twisting, popping, pain and swelling in his knees.

2. The next day work was rained out, but Petitioner told his supervisor he would not have been able to work anyway. The day after, Petitioner visited the ER at Northwest Community Hospital.

3. On November 17, 2015 Dr. Grear reviewed x-rays taken four days prior, and diagnosed left knee effusion and right knee capsulitis. He drained Petitioner's left knee, took him off work and prescribed pain medication.

4. On December 1, 2015 Dr. Grear found bilateral patellofemoral crepitation and trace ligament effusion. He diagnosed Petitioner with bilateral internal derangement of the knees and recommended bilateral knee MRI's.

5. After reviewing the bilateral MRI's, Dr. Grear diagnosed a torn right lateral meniscus and recurrent tear of the left medial meniscus with a possible loose body. He recommended arthroscopic knee surgery.

6. Right knee surgery was performed March 14, 2016, during which Dr. Grear also found chondromalacia of the undersurface of the patella and a horizontal tear of the undersurface of the lateral meniscus and peripheral beak tear of the midbody of the lateral meniscus. Therapy was recommended.

7. Dr. Grear opined that Petitioner's right knee reached maximum medical improvement (MMI) on June 17, 2016. However, Petitioner was still kept off work while awaiting left knee surgery, which was performed on September 12, 2016.

8. Petitioner continued complaining of pain throughout the remainder of 2016. On January 20, 2017 Dr. Grear notes that no significant improvement has been made with physical therapy. He recommended the completion of the most recent pain medication refill, and estimates that Petitioner will be unable to return to work in construction in the near future.

9. On February 3, 2017 Dr. Grear found Petitioner had reached MMI and placed him on permanent work restrictions of no crawling, stooping, climbing ladders, frequent position changes or lifting over twenty pounds. Petitioner requested light duty from Respondent, but it was never offered.

10. Petitioner then began looking for work elsewhere. He applied for 10 jobs per week from February through the November 14, 2017.

11. On May 12, 2017 Dr. Grear opined that Petitioner was clearly employable, just not as a Union Carpenter any longer.

12. Dr. Levin performed several Independent Medical Examinations (IME) on Petitioner. On January 26, 2016 he diagnosed Petitioner with a symptomatic right lateral meniscus tear and a left medial meniscus tear, both causally related to the November 11, 2015 accident. However, by March 22, 2017, after another examination, Dr. Levin opined that Petitioner's subjective complaints were inconsistent with his objective condition.

13. Dr. Levin opined that Petitioner should have been able to return to work without restrictions in relation to his left knee forty-two days after the left knee surgery of September 12, 2016, based on the *Official Disability Guidelines Return-to-Work "Best Practices Guidelines"*. This return to work date would be October 24, 2016.

14. On July 24, 2017 Petitioner met with Kari Stafseth at Vocomotive. Ms. Stafseth noted that Petitioner worked for Respondent for ten years at forty hours per week. (*Trial testimony revealed that he only worked for Respondent for eight years intermittently*). She opined that Petitioner could not return to work as a Finish Carpenter based on Dr. Grear's permanent restrictions. She also opined that vocational services would assist Petitioner in securing a new job. He has been working in Carpentry for over twenty years, and thus has no recent interviewing experience. Accordingly, he requires assistance in learning how to answer questions regarding his inability to return to his previous line of work.

15. At the time of trial, Petitioner's knees were still stiff and in pain. He stated that he did not benefit from therapy after his bilateral knee surgeries, as the ongoing pain did not allow him to graduate to work hardening therapy. He used a four-point cane to navigate 2 flights of stairs in his condominium. He takes pain medication but would like to find work, stating that he is bored.

16. Prior to the accident on November 11, 2015, Petitioner stated that his knees would occasionally swell, but he had no popping sensations or severe pain.

The Commission affirms the Arbitrator's rulings on accident, causal connection vocational rehabilitation. However, the Commission modifies the Arbitrator's award regarding the temporary total disability (TTD) period. Petitioner was awarded TTD benefits for a period of 49-3/7 weeks (November 12, 2015 through October 23, 2016), with the termination date based on the opinion of Dr. Levin. The Commission views the evidence slightly different, noting that Dr. Grear examined Petitioner on several occasions between October 23, 2016 and February 3, 2017. During this time period, Dr. Grear continued to recommend therapy and pain medications in an attempt to improve Petitioner's condition. Clearly, Dr. Grear believed that Petitioner was still capable of improvement during that time frame, which extended well past the October 24, 2016 return to work date suggested by Dr. Levin. The Commission places more weight on the more informed opinion of Dr. Grear than that of Dr. Levin.

18IWCC0513

Accordingly, the Commission modifies the TTD period, and extends it to a termination date of February 3, 2017 (64-1/7 weeks), when Dr. Grear placed Petitioner at MMI.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner suffered bilateral knee injuries arising out of and in the course of his employment with Respondent on the date in question.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's bilateral knee conditions were causally related to his work duties.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,037.00 per week for a period of 64-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $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 17 2018
O: 6/28/18
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

STEVENS, RUSSELL
Employee/Petitioner

Case# **15WC042401**

13WC022633

PANEL'S PLUS
Employer/Respondent

18IWCC0513

On 12/5/2017, 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 1.45% 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:

0700 GREGORIO & MARCO
SEAN STEC
2 N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
EVAN KLUG
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RUSSELL STEVENS
Employee/Petitioner

v.

PANEL'S PLUS
Employer/Respondent

Case # **15** WC **42401**

Consolidated cases: **13 WC 22633**

18IWCC0513

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **11/21/2017**. 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. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Vocational Rehabilitation**

FINDINGS

On the date of accident, **11/11/2015**, 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 **$80,886.00**; the average weekly wage was **$1,555.50**.

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

Respondent shall be given a credit of **$79,428.55** for TTD, **$0** for TPD, **$0** for maintenance, and $ **0** for other benefits, for a total credit of **$79,428.55**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,037.00/week for 49 and 3/7 weeks, commencing November 12, 2015 through October 23, 2016, as provided in Section 8(a) of the Act.

Respondent shall receive credit for $79,428.55 in temporary benefits paid to date.

Petitioner is not entitled to vocational rehabilitation or maintenance benefits as a result of November 11, 2015 accident.

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

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

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

David A. Kane
Signature of Arbitrator

December 5, 2017
Date

ICArbDec19(b)

DEC 5 - 2017

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

RUSSELL STEVENS, Petitioner, vs. PANELS PLUS, INC., Respondent.	)	No. 15 WC 42401 Consol. 13 WC 22633

18IWCC0513

STATEMENT OF FACTS

The instant matter involves consolidated Applications for Adjustment of Claim filed by Mr. Russell Stevens (*hereinafter* "Petitioner"), against Panels Plus, Inc. (*hereinafter* "Respondent"). Case Number 13 WC 22633 involves allegation of injury to the left knee on July 1, 2013, while Case Number 15 WC 42401 involves allegation of injury to the bilateral knees on November 11, 2015.

The matter was set for trial on petitioner's Request for Immediate Hearing under Section 19(b) of the Act, seeking a determination regarding entitlement to vocational rehabilitation benefits and weekly maintenance payments. Placed at issue at hearing were accident, causation, entitlement to weekly benefits for TTD and Maintenance, as well as entitlement to vocational rehabilitation services under the Act.

Petitioner testified that he worked as a union carpenter as a member of Carpenter's Local 181 for approximately 28 years. He testified that this was a "hiring hall." He initially testified that he worked respondent for approximately eight years, though on cross-examination admitted that this employment was not continuous. He instead worked for respondent for some months in 2008 and 2009, before briefly returning in 2011. He thereafter worked with various

employers between late 2011 and late 2012 before once again returning to work for respondent.

Petitioner testified he first saw Dr. Michael Grear, an orthopedic surgeon, for residual right knee pain and swelling on October 19, 2005. Petitioner underwent right knee MRI. He received prescription narcotic medication and endorsed receipt of a cortisone injection in 2006 in order to help relieve right knee pain. He continued to treat with Dr. Grear for the right knee between 2005 and 2007. Petitioner testified that he then did not seek medical treatment for knee complaints from late 2007 before returning to Dr. Grear in 2011.

On September 19, 2011, petitioner returned to Dr. Grear and complained of internal derangement of both the right *and* left knees. (Petitioner's Exhibit 3, *hereinafter* "Px 3") Dr. Grear's written history indicates that petitioner had "gotten back to work as a union carpenter" and complained of bilateral knee pain. Petitioner then underwent an MRI of left knee at MRI of Arlington Heights on November 11, 2011, which the interpreting radiologist indicated showed degenerative changes, fraying, and possible degenerative tear or tears of the lateral meniscus. (Id.) He testified that he experienced generalized pain and swelling between December of 2011 and February of 2013, though denied that Dr. Grear recommended any additional left knee treatment.

Petitioner testified he worked regular duty as a carpenter from October of 2005 through June of 2013, and denied missing any time within that period as a result of knee pain. However, Dr. Grear's records of September 19, 2011 indicate that petitioner returned to union carpentry work, and December 15, 2011 records indicate that although working in union carpentry, petitioner did not have enough hours yet at that point for insurance and he elected not to pursue a recommended left knee injection. (Px 3) He then admitted on cross-examination to absence from work due to economic downturn in approximately 2011.

Petitioner then testified regarding allegation of July 1, 2013 accident. He noted work for respondent at a commercial building project, beginning at approximately 6 a.m. He was tasked with removal of a large standing metal barrier that was fixed to the ground on either end by four bolts. Upon barrier removal, he was also required to grind away the remaining bolts, which extended approximately 2.5 to 3 inches from the ground. Petitioner testified that he was kneeling, grinding one bolt, and that as he repositioned on his knees he knelt on another bolt nearby.

Petitioner testified that following this incident he felt pain in his left knee, swelling, and popping. He identified the location of the pain at the very front of his knee at the bottom of the kneecap. The job required approximately four hours in total to complete, and the incident occurred with perhaps 25 minutes of additional work remaining. Petitioner testified he completed his work and reported the incident to his employer via telephone. Petitioner then saw Dr. Grear for evaluation later on the same date.

A review of Dr. Grear's notes shows a slightly different account of injury. While petitioner complained of a contusion at the time of trial and pain centrally located below the kneecap, Dr. Grear noted that kneeling on a bolt "caused [petitioner] to stand erect twisting his knee" and examination showed mild tenderness at the "mid medial joint line." (Px 3) Dr. Grear placed petitioner off work and ordered MRI. He diagnosed lateral and medial meniscal tears, ultimately performing arthroscopic surgery on October 14, 2013. However, the surgery notably revealed a pristine medial meniscus, while a lateral meniscal tear was addressed. (Id.)

On February 3, 2014, petitioner was examined by Dr. Jay Levin, an orthopedic surgeon, at respondent's request under Section 12 of the Act. (Respondent's Exhibit 1, *hereinafter* "Rx 1") Notably, at the time of examination petitioner *denied* any history of prior left knee injuries, complaints, x-rays, or MRIs prior to

the July 1, 2013 incident. (Id.) At hearing, petitioner claimed he misunderstood the question when explaining his failure to admit to prior use of medication, regular followup, MRI, and diagnosed lateral meniscus tear. Upon later examining petitioner's preinjury medical records, and specifically comparing pre and post-injury MRI findings, Dr. Levin updated his opinion in a written report dated April 22, 2014. He noted that left knee MRI from November 11, 2011 showed anatomical findings consistent with MRI of July 5, 2013, immediately post-dating the alleged accident, and opined that petitioner's activity could have resulted in a manifestation of a preexisting condition without any specific injury. (Id.)

Petitioner testified that he completed postoperative care following left knee arthroscopy and returned to work with respondent without work restriction on April 4, 2014. He thereafter continued to work for respondent without incident until November 11, 2015. Regarding interval treatment, petitioner indicated he indeed saw Dr. Grear over this period, though that this was for "back stuff" and not in relation to care for the knees.

It was stipulated by the parties that respondent paid $39,927.43 in disputed TTD benefits while petitioner remained off work.

Petitioner next testified that on November 11, 2015, he once again began work for respondent at approximately 6 a.m. Work on that date was completed at a General Motors plant and involved an addition to an existing building. Petitioner was engaged in cutting thermal breaks in standing walls, which required kneeling and crawling on a corrugated metal surface. Petitioner testified that while working he felt twisting, popping, and pain in the knees, followed by bilateral knee swelling. He testified that he finished work for the day around 1:30 p.m., approximately 50 minutes after the onset of these symptoms. He testified that he thereafter had knee pain that was possibly greater on the left, though that was effectively equal on both sides.

Petitioner reported alerting his foreman of the knee injury the following morning while seated in their respective cars at the job site. Although work was scheduled on November 12, 2013, petitioner testified it was ultimately a "rain out" and that no one from respondent worked at the job site on that date. Petitioner testified he thereafter sought emergency care November 13, 2013, and followed up with Dr. Grear on November 17, 2013.

Petitioner completed a course of treatment involving MRI and consideration of knee surgery. He was then once again seen by Dr. Levin for repeat Section 12 Examination on January 7, 2016. Petitioner claimed to not have remembered 2011 left knee MRI at the time of prior 2014 examination, and merely reported "prior soreness in the right knee in the past." (Rx1) However, contrary to trial testimony and Dr. Grear's records, petitioner once again reported to Dr. Levin having "no real workup" and "denie[d] any MRIs, x-rays, cortisone injections, or need to see a physician regarding his right knee in the past." (Id.)

Dr. Levin then once again review prior records and authored a report dated January 26, 2016. He credibly considered all available objective evidence and concluded, notwithstanding petitioner's failure to disclose preexisting care, that petitioner's right and left knee conditions were causally related to the alleged November 11, 2015 occurrence. (Rx 1) Petitioner thereafter underwent right knee arthroscopy on March 14, 2016, and left knee arthroscopy on September 12, 2016. Both procedures were performed by Dr. Grear. (Px 3)

Petitioner testified that both procedures were followed by courses of postoperative therapy at Midwest Physical Therapy, though he admitted that he performed no work conditioning or functional capacity evaluation. Petitioner testified that on February 3, 2017, he received permanent work restrictions from Dr. Grear including no crawling, no stooping, no ladders, no lifting greater than 20 pounds, and frequent position changes.

Petitioner testified he contacted respondent seeking work within these restrictions, and that he thereafter began a job search in February of 2017. However, he also admitted on cross-examination to having applied for Social Security Disability even *before* receiving these restrictions from Dr. Grear.

(While petitioner claimed at hearing he could not return to carpentry, and therefore filed for disability, Dr. Grear instead testified that petitioner could work within restrictions if allowed by the union, further emphasizing "there's no doubt that there are aspects of carpentry [petitioner] is capable of doing." (Px 7))

Petitioner testified that he initially looked for work in-person, though that his job search now consists of completing online applications. He testified to completion of job search logs and receipt of a "couple of calls," though no offers of work.

Petitioner thereafter testified that, following February 2017 work release and placement at maximum medical improvement, he continued with regular monthly visits to Dr. Grear for a refill of prescription medications and "basic checkup." Petitioner arrived at the hearing with a 4-point cane, and testified to its use predominantly for stairs or long periods of ambulation, though admitted on cross-examination that the cane was never prescribed for him.

Petitioner returned once again to Dr. Levin for Section 12 reexamination on March 22, 2017. In a prepared report and later in testimony, Dr. Levin opined that petitioner's subjective complaints were inconsistent with his objective condition, and that petitioner should have been capable of returning to work without restrictions. Dr. Levin explained that this opinion was supported by the nature of petitioner's diagnosis, postoperative course, and general medical condition, and was based upon Official Disability Guidelines and the recommendations of the American Academy of Orthopedic Surgery. (Rx 1)

On July 24, 2017, petitioner saw Ms. Kari Stafseth of Vocamotive, who completed an assessment and proposed rehabilitation plan. (Px 8) Ms. Stafseth's vocational history quite incorrectly notes petitioner worked for respondent for *ten* years at forty hours per week from January 2005 to November of 2015. Petitioner instead notably testified to work for respondent for *eight* years, though even this was shown to be incorrect on cross-examination. Petitioner ultimately admitted that work for respondent only began in 2008, and was thereafter intermittent and punctuated by varied work for multiple additional employers before injury in 2013. Petitioner also testified at hearing to prior experience as a working foreman for an earlier employer, Facilities Resource, though no mention of this leadership experience was made by Ms. Stafseth in discussing petitioner's background, skills, or appropriate positions. Petitioner nevertheless testified that he requested implementation of Ms. Stafseth's vocational rehabilitation plan.

On October 13, 2017, Ms. Julie Bose of MedVoc Rehabilitation, LTD., completed Vocational Rehabilitation File Review and Opinion. (Rx 2) Ms. Bose's report disagrees with the Vocamotive assessment of employability only in entry-level, unskilled positions and its recommendations for suggested services. Ms. Bose noted petitioner is a skilled worker, that he would be provided on-the-job training in appropriate positions should he require alternative work, and that he does not require placement services in order to find a job. (Rx 2)

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "C" (DID ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony, deposition testimony, and consideration of submitted written evidence, the Arbitrator finds that petitioner experienced an accident on November 11, 2015 that arose out of and occurred in the course of his employment. The Arbitrator notes that at the time of alleged accident, petitioner was cutting thermal breaks in standing walls, which required working from a kneeling position on a corrugated surface. Petitioner testified he experienced pain and swelling in the bilateral knees approximately fifty minutes before the conclusion of his designated shift.

Because petitioner was performing his assigned work for respondent at the time of alleged accident, the Arbitrator finds petitioner has demonstrated accident "in the course of" employment. Although the records once again establish that petitioner possessed significant preexisting medical conditions involving both the left and the right knees, the Arbitrator nevertheless relies on the opinions of both Dr. Michael Grear and Dr. Jay Levin (Px 7, Rx1) in concluding that petitioner's described kneeling activity on November 11, 2015 was a competent mechanism of injury. Because this kneeling was required to accomplish petitioner's work tasks, the Arbitrator therefore finds that petitioner has demonstrated an accident arising out of employment with respondent.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE ACCIDENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony, deposition testimony, and consideration of submitted written evidence, the Arbitrator finds that petitioner's current condition of ill-being is causally related to alleged November 11, 2015 work accident. The Arbitrator notes that despite the presence of preexisting medical conditions, petitioner worked without restriction between approximately April of 2014 and November 11, 2015 accident.

The Arbitrator finds that petitioner possessed a right knee lateral meniscal tear addressed with partial lateral meniscectomy on March 24, 2016, and left knee lateral meniscus tear addressed with partial lateral meniscectomy on September 1, 2016. The Arbitrator once again relies on the opinions of Dr. Grear and Dr. Levin in finding that a sufficient causative link exists between petitioner's work activities on November 11, 2015 and his subsequently diagnosed conditions. (Px 7, Rx 1) The Arbitrator further notes no claims of intervening accident or other change sufficient to sever the causal relation between petitioner's present condition and the November 11, 2015 occurrence.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (TEMPORARY BENEFIT ENTITLEMENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony, deposition testimony, and consideration of submitted written evidence, the Arbitrator finds that petitioner completed his regular work on the date of November 11, 2015 accident, though thereafter remained off work under physician restriction while pursuing medical treatment. The Arbitrator notes petitioner was placed at Maximum Medical Improvement by Dr. Grear on February 3, 2017, (Px 3) though that Dr. Levin has opined petitioner should have been capable of returning to work without restriction forty-two days following September 12, 2016 surgery by October 24, 2016. (Rx 1)

The Arbitrator notes that Dr. Grear has not identified any failure of the surgical interventions or other personal medical conditions to suggest that petitioner should not be capable of an unrestricted return to work, instead relying on petitioner's subjective complaints to support the need of work restriction. Dr. Grear also wrote restrictions prohibiting return to work "as a union carpenter," though later testified that he believed petitioner could work as a carpenter "under restrictions," stating that "there's no doubt that there are aspects of carpentry [petitioner] is capable of doing." (Px 7)

Dr. Levin, by contrast, has credibly described as inconsistent petitioner's objective medical condition and his ongoing subjective complaints. (Rx1) The Arbitrator also finds significant the fact that petitioner's complaints of substantial pain and functional disability, and his use of a non-prescribed assistive device come in the context of an application for Social Security Disability claiming a complete inability for perform gainful employment. (Px 8)

The Arbitrator notes that he is not required to give more weight to a treating physician's opinion over another examining physician's opinion. Prairie *Farms Dairy v. The Industrial Commission*, 279 Ill.App.3d 546 (5th Dist. Ind. Comm. Div. 1996). To the extent that the medical testimony might be construed as conflicting, it is well established that resolution of such conflicts falls within the province of the Commission *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 206, 797 N.E.2d 665, 673 (2003) (citing *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill.2d at 37, 65 Ill.Dec. 6, 440 N.E.2d 861)

In this context, the Arbitrator finds Dr. Levin's objective reliance on Official Disability Guidelines Return-to-Work Best Practice Guidelines and recommendations of the American Academy of Orthopedic Surgery more convincing that Dr. Grear's reliance on petitioner's subjective complaints. The Arbitrator therefore finds petitioner was under work restriction precluding return to full-duty employment from November 12, 2015 through October 23, 2016, a

period of 49 and 3/7 weeks. The Arbitrator finds petitioner entitled to Temporary Total Disability payments for this period.

Because the Arbitrator has found petitioner capable of returning to work without limitation attributable to November 11, 2015 work accident effective October 24, 2016, the Arbitrator accordingly finds that petitioner is not entitled to maintenance benefits. vocational rehabilitation benefits.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "N" (CREDIT DUE RESPONDENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony and Request for Hearing stipulations, the Arbitrator finds that respondent paid to petitioner the sum of $79,428.55 for disputed benefits in connection with allegation of November 11, 2015 accident. Respondent shall receive credit for this amount.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "O" (PETITIONER'S ENTITLEMENT TO VOCATIONAL REHABILITATION), THE ARBITRATOR FINDS THE FOLLOWING:

Because the Arbitrator has found petitioner capable of returning to work without limitation attributable to November 11, 2015 work accident effective October 24, 2016, the Arbitrator accordingly finds that petitioner is not entitled to vocational rehabilitation.

If, however, the Arbitrator found petitioner required work restrictions as alleged by Dr. Grear, the Arbitrator would nevertheless still conclude that petitioner does not require vocational rehabilitation and has failed to demonstrate the reasonableness of the proposed Vocamotive Rehabilitation Plan.

The Arbitrator notes that Ms. Kari Stafseth of Vocamotive, authored a plan proposing provision of extensive training and assistance with the stated end of obtaining petitioner entry-level, unskilled work. The recommendations for services thus appear inconsistent with the stated aim of unskilled employment and thus unreasonable.

The Arbitrator next notes that Ms. Stafseth's report almost entirely fails to properly address petitioner's vocational history. Also, Ms. Stafseth appears to have based her assessment of petitioner's skills and experience, and more importantly her recommendations for target employment, on what can be most charitably described as an incorrect work history. While Petitioner testified to experience involving rather varied job duties with multiple companies between 2008 and 2012, and earlier leadership experience as a foreman with another employer, Facilities Resource, Ms. Stafseth's history reflects and proposed rehabilitation plan reflect none of this basic background. (Px 8)

The Arbitrator instead finds more credible the opinion of Ms. Julie Bose of MedVoc Rehabilitation LTD indicating that although petitioner could benefit from placement service these are not necessary for an individual of his skill and experience. (Rx 2)

STATE OF ILLINOIS)
) SS.
COUNTY OF **COOK**)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Russell Stevens,

Petitioner,

vs. NO: 13 WC 22633

Panel's Plus,

Respondent.

18IWCC0514

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, benefit rates and vocational rehabilitation, 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 has been a Union Carpenter for 28 years. A brief history of Petitioner's medical care reveals that on October 19, 2005 he visited Dr. Grear complaining of residual right knee pain and swelling. He underwent an MRI and continued treating for his knee through July 2007.

18IWCC0514

2. From July 9, 2007 through September 16, 2011 Petitioner did not treat with Dr. Grear, as he had no knee pain.

3. On September 17, 2011 Petitioner returned to Dr. Grear due to bilateral knee pain. He also treated bilaterally in September and October, but only treated for left knee pain in December 2011.

4. Petitioner's left knee treatment continued through February 21, 2013.

5. Petitioner did not miss any time off work between 2005 and 2013 due to knee problems.

6. On July 1, 2013 Petitioner was working on a construction rehab. He removed a steel barrier that was anchored by four bolts sticking up from the cement, grounded the bolts down and then put insulated panel walls into the remaining opening. While grinding the bolts down he knelt on one of them with his left knee. His knee began to swell up and he felt popping and pain at the bottom of his kneecap.

7. Petitioner's knee pain prior to this was just general soreness. The accident in question led to increased pain and swelling. He immediately returned to Dr. Grear for treatment.

8. Dr. Grear took Petitioner off work and prescribed pain medication, beginning July 2, 2013.

9. After a left knee MRI on July 5, 2013 which revealed findings compatible with a complex tear at the posterior horn of the medial meniscus, Petitioner was advised to undergo arthroscopic knee surgery, which was performed October 14, 2013.

10. On April 8, 2014 Dr. Grear's partner, Dr. Komnick, released Petitioner back to work with no restrictions, effective April 14, 2014. He worked full duty from April 8, 2014 through November 11, 2015.

The Commission affirms the Arbitrator's rulings on accident, causal connection and the temporary total disability (TTD) rate awarded by the Arbitrator. However, the Commission modifies the Arbitrator's award regarding the TTD period. Petitioner was awarded TTD benefits for a period of 39-3/7 weeks (July 2, 2013 through April 3, 2014). While there is evidence in the medical records corroborating the beginning TTD date of July 2, 2013, the termination date of April 3, 2014 seems to be in error. Evidence provided shows that Petitioner was released back to work beginning April 14, 2014. This increases the TTD period up to 40-6/7 weeks.

Accordingly, the Commission hereby modifies the Arbitrator's finding of TTD period, and modifies it as stated above.

18IWCC0514

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner suffered a left knee injury arising out of and in the course of his employment with Respondent on the date in question.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's left knee condition was causally related to his work duties.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $936.04 per week for a period of 40-6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $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:
O: 6/28/18 AUG 17 2018
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

STEVENS, RUSSELL
Employee/Petitioner

Case# **13WC022633**

15WC042401

PANEL'S PLUS
Employer/Respondent

18IWCC0514

On 12/5/2017, 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 1.45% 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:

0700 GREGORIO & MARCO
SEAN STEC
2 N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
EVAN KLUG
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RUSSELL STEVENS
Employee/Petitioner

v.

PANEL'S PLUS
Employer/Respondent

Case # 13 WC 22633

Consolidated cases: 15 WC 42401

18IWCC0514

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **11/21/2017**. 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. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Vocational Rehabilitation**

FINDINGS

On the date of accident, **7/1/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,001.96**; the average weekly wage was **$1,405.46**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$39,927.43** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$39,927.43**.

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 $936.04/week for 39 and 3/7 weeks, commencing July 2, 2013 through April 3, 2014, as provided in Section 8(a) of the Act.

Respondent shall receive credit for $39,927.43 in temporary benefits paid to date.

Petitioner is not entitled to vocational rehabilitation as a result of July 1, 2013 accident.

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

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

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

David A. Kane
Signature of Arbitrator

December 5, 2017
Date

ICArbDec19(b)

DEC 5 - 2017

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION

RUSSELL STEVENS, Petitioner, vs. PANELS PLUS, INC., Respondent.	)	No. 13 WC 22633 Consol. 15 WC 42401

18IWCC0514

STATEMENT OF FACTS

The instant matter involves consolidated Applications for Adjustment of Claim filed by Mr. Russell Stevens (*hereinafter* "Petitioner"), against Panels Plus, Inc. (*hereinafter* "Respondent"). Case Number 13 WC 22633 involves allegation of injury to the left knee on July 1, 2013, while Case Number 15 WC 42401 involves allegation of injury to the bilateral knees on November 11, 2015.

The matter was set for trial on petitioner's Request for Immediate Hearing under Section 19(b) of the Act, seeking a determination regarding entitlement to vocational rehabilitation benefits and weekly maintenance payments. Placed at issue at hearing were accident, causation, entitlement to weekly benefits for TTD and Maintenance, as well as entitlement to vocational rehabilitation services under the Act.

Petitioner testified that he worked as a union carpenter as a member of Carpenter's Local 181 for approximately 28 years. He testified that this was a "hiring hall." He initially testified that he worked respondent for approximately eight years, though on cross-examination admitted that this employment was not continuous. He instead worked for respondent for some months in 2008 and 2009, before briefly returning in 2011. He thereafter worked with various

employers between late 2011 and late 2012 before once again returning to work for respondent.

Petitioner testified he first saw Dr. Michael Grear, an orthopedic surgeon, for residual right knee pain and swelling on October 19, 2005. Petitioner underwent right knee MRI. He received prescription narcotic medication and endorsed receipt of a cortisone injection in 2006 in order to help relieve right knee pain. He continued to treat with Dr. Grear for the right knee between 2005 and 2007. Petitioner testified that he then did not seek medical treatment for knee complaints from late 2007 before returning to Dr. Grear in 2011.

On September 19, 2011, petitioner returned to Dr. Grear and complained of internal derangement of both the right *and* left knees. (Petitioner's Exhibit 3, *hereinafter* "Px 3") Dr. Grear's written history indicates that petitioner had "gotten back to work as a union carpenter" and complained of bilateral knee pain. Petitioner then underwent an MRI of left knee at MRI of Arlington Heights on November 11, 2011, which the interpreting radiologist indicated showed degenerative changes, fraying, and possible degenerative tear or tears of the lateral meniscus. (Id.) He testified that he experienced generalized pain and swelling between December of 2011 and February of 2013, though denied that Dr. Grear recommended any additional left knee treatment.

Petitioner testified he worked regular duty as a carpenter from October of 2005 through June of 2013, and denied missing any time within that period as a result of knee pain. However, Dr. Grear's records of September 19, 2011 indicate that petitioner returned to union carpentry work, and December 15, 2011 records indicate that although working in union carpentry, petitioner did not have enough hours yet at that point for insurance and he elected not to pursue a recommended left knee injection. (Px 3) He then admitted on cross-examination to absence from work due to economic downturn in approximately 2011.

Petitioner then testified regarding allegation of July 1, 2013 accident. He noted work for respondent at a commercial building project, beginning at approximately 6 a.m. He was tasked with removal of a large standing metal barrier that was fixed to the ground on either end by four bolts. Upon barrier removal, he was also required to grind away the remaining bolts, which extended approximately 2.5 to 3 inches from the ground. Petitioner testified that he was kneeling, grinding one bolt, and that as he repositioned on his knees he knelt on another bolt nearby.

Petitioner testified that following this incident he felt pain in his left knee, swelling, and popping. He identified the location of the pain at the very front of his knee at the bottom of the kneecap. The job required approximately four hours in total to complete, and the incident occurred with perhaps 25 minutes of additional work remaining. Petitioner testified he completed his work and reported the incident to his employer via telephone. Petitioner then saw Dr. Grear for evaluation later on the same date.

A review of Dr. Grear's notes shows a slightly different account of injury. While petitioner complained of a contusion at the time of trial and pain centrally located below the kneecap, Dr. Grear noted that kneeling on a bolt "caused [petitioner] to stand erect twisting his knee" and examination showed mild tenderness at the "mid medial joint line." (Px 3) Dr. Grear placed petitioner off work and ordered MRI. He diagnosed lateral and medial meniscal tears, ultimately performing arthroscopic surgery on October 14, 2013. However, the surgery notably revealed a pristine medial meniscus, while a lateral meniscal tear was addressed. (Id.)

On February 3, 2014, petitioner was examined by Dr. Jay Levin, an orthopedic surgeon, at respondent's request under Section 12 of the Act. (Respondent's Exhibit 1, *hereinafter* "Rx 1") Notably, at the time of examination petitioner *denied* any history of prior left knee injuries, complaints, x-rays, or MRIs prior to

the July 1, 2013 incident. (Id.) At hearing, petitioner claimed he misunderstood the question when explaining his failure to admit to prior use of medication, regular followup, MRI, and diagnosed lateral meniscus tear. Upon later examining petitioner's preinjury medical records, and specifically comparing pre and post-injury MRI findings, Dr. Levin updated his opinion in a written report dated April 22, 2014. He noted that left knee MRI from November 11, 2011 showed anatomical findings consistent with MRI of July 5, 2013, immediately post-dating the alleged accident, and opined that petitioner's activity could have resulted in a manifestation of a preexisting condition without any specific injury. (Id.)

Petitioner testified that he completed postoperative care following left knee arthroscopy and returned to work with respondent without work restriction on April 4, 2014. He thereafter continued to work for respondent without incident until November 11, 2015. Regarding interval treatment, petitioner indicated he indeed saw Dr. Grear over this period, though that this was for "back stuff" and not in relation to care for the knees.

It was stipulated by the parties that respondent paid $39,927.43 in disputed TTD benefits while petitioner remained off work.

Petitioner next testified that on November 11, 2015, he once again began work for respondent at approximately 6 a.m. Work on that date was completed at a General Motors plant and involved an addition to an existing building. Petitioner was engaged in cutting thermal breaks in standing walls, which required kneeling and crawling on a corrugated metal surface. Petitioner testified that while working he felt twisting, popping, and pain in the knees, followed by bilateral knee swelling. He testified that he finished work for the day around 1:30 p.m., approximately 50 minutes after the onset of these symptoms. He testified that he thereafter had knee pain that was possibly greater on the left, though that was effectively equal on both sides.

Petitioner reported alerting his foreman of the knee injury the following morning while seated in their respective cars at the job site. Although work was scheduled on November 12, 2013, petitioner testified it was ultimately a "rain out" and that no one from respondent worked at the job site on that date. Petitioner testified he thereafter sought emergency care November 13, 2013, and followed up with Dr. Grear on November 17, 2013.

Petitioner completed a course of treatment involving MRI and consideration of knee surgery. He was then once again seen by Dr. Levin for repeat Section 12 Examination on January 7, 2016. Petitioner claimed to not have remembered 2011 left knee MRI at the time of prior 2014 examination, and merely reported "prior soreness in the right knee in the past." (Rx1) However, contrary to trial testimony and Dr. Grear's records, petitioner once again reported to Dr. Levin having "no real workup" and "denie[d] any MRIs, x-rays, cortisone injections, or need to see a physician regarding his right knee in the past." (Id.)

Dr. Levin then once again review prior records and authored a report dated January 26, 2016. He credibly considered all available objective evidence and concluded, notwithstanding petitioner's failure to disclose preexisting care, that petitioner's right and left knee conditions were causally related to the alleged November 11, 2015 occurrence. (Rx 1) Petitioner thereafter underwent right knee arthroscopy on March 14, 2016, and left knee arthroscopy on September 12, 2016. Both procedures were performed by Dr. Grear. (Px 3)

Petitioner testified that both procedures were followed by courses of postoperative therapy at Midwest Physical Therapy, though he admitted that he performed no work conditioning or functional capacity evaluation. Petitioner testified that on February 3, 2017, he received permanent work restrictions from Dr. Grear including no crawling, no stooping, no ladders, no lifting greater than 20 pounds, and frequent position changes.

Petitioner testified he contacted respondent seeking work within these restrictions, and that he thereafter began a job search in February of 2017. However, he also admitted on cross-examination to having applied for Social Security Disability even *before* receiving these restrictions from Dr. Grear.

(While petitioner claimed at hearing he could not return to carpentry, and therefore filed for disability, Dr. Grear instead testified that petitioner could work within restrictions if allowed by the union, further emphasizing "there's no doubt that there are aspects of carpentry [petitioner] is capable of doing." (Px 7))

Petitioner testified that he initially looked for work in-person, though that his job search now consists of completing online applications. He testified to completion of job search logs and receipt of a "couple of calls," though no offers of work.

Petitioner thereafter testified that, following February 2017 work release and placement at maximum medical improvement, he continued with regular monthly visits to Dr. Grear for a refill of prescription medications and "basic checkup." Petitioner arrived at the hearing with a 4-point cane, and testified to its use predominantly for stairs or long periods of ambulation, though admitted on cross-examination that the cane was never prescribed for him.

Petitioner returned once again to Dr. Levin for Section 12 reexamination on March 22, 2017. In a prepared report and later in testimony, Dr. Levin opined that petitioner's subjective complaints were inconsistent with his objective condition, and that petitioner should have been capable of returning to work without restrictions. Dr. Levin explained that this opinion was supported by the nature of petitioner's diagnosis, postoperative course, and general medical condition, and was based upon Official Disability Guidelines and the recommendations of the American Academy of Orthopedic Surgery. (Rx 1)

On July 24, 2017, petitioner saw Ms. Kari Stafseth of Vocamotive, who completed an assessment and proposed rehabilitation plan. (Px 8) Ms. Stafseth's vocational history quite incorrectly notes petitioner worked for respondent for *ten* years at forty hours per week from January 2005 to November of 2015. Petitioner instead notably testified to work for respondent for *eight* years, though even this was shown to be incorrect on cross-examination. Petitioner ultimately admitted that work for respondent only began in 2008, and was thereafter intermittent and punctuated by varied work for multiple additional employers before injury in 2013. Petitioner also testified at hearing to prior experience as a working foreman for an earlier employer, Facilities Resource, though no mention of this leadership experience was made by Ms. Stafseth in discussing petitioner's background, skills, or appropriate positions. Petitioner nevertheless testified that he requested implementation of Ms. Stafseth's vocational rehabilitation plan.

On October 13, 2017, Ms. Julie Bose of MedVoc Rehabilitation, LTD., completed Vocational Rehabilitation File Review and Opinion. (Rx 2) Ms. Bose's report disagrees with the Vocamotive assessment of employability only in entry-level, unskilled positions and its recommendations for suggested services. Ms. Bose noted petitioner is a skilled worker, that he would be provided on-the-job training in appropriate positions should he require alternative work, and that he does not require placement services in order to find a job. (Rx 2)

CONCLUSIONS OF LAW

In a workers' compensation case, the claimant has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Comm'n,* 79 Ill.2d 249, 253, 38 Ill.Dec. 133, 403 N.E.2d 221 (1980).

In resolving disputed issues of fact, including issues related to causation, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence. (*see Id.* citing *Hosteny v. Illinois Workers' Compensation Comm'n,* 397 Ill.App.3d 665, 675, 340 Ill.Dec. 475, 928 N.E.2d 474 (2009); *Fickas v. Industrial Comm'n,* 308 Ill.App.3d 1037, 1041, 242 Ill.Dec. 634, 721 N.E.2d 1165 (1999).)

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "C" (DID ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony, deposition testimony, and consideration of submitted written evidence, the Arbitrator finds that petitioner experienced an accident on July 1, 2013 that arose out of and occurred in the course of his employment. The Arbitrator notes that at the time of accident, petitioner was specifically tasked with grinding away of bolts extending from the ground in connection with removal of a fixed barrier. This grinding required petitioner to move about on his hands and knees. The alleged accident involved petitioner's repositioning and kneeling with his left knee on an existing bolt, precisely the material he was tasked with removing.

Because petitioner was performing his assigned work for respondent at the time of alleged accident, the Arbitrator finds petitioner has demonstrated accident "in the course of" employment. Although the records later establish that petitioner possessed a significant preexisting medical condition involving the left knee, the Arbitrator nevertheless also finds support for the conclusion that petitioner indeed knelt on a bolt while at work and thereafter experienced increased pain and other symptoms. As accident involved contact with material on which petitioner was directly working, the Arbitrator finds that there is sufficient connection to petitioner's duties to find accident "arising out of" employment with respondent.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "F" (IS PETITIONER'S CURRENT CONDITION OF ILL BEING CAUSALLY RELATED TO THE ACCIDENT), THE ARBITRATOR FINDS THE FOLLOWING:

Petitioner has filed two separate Applications for Adjustment of Claim with the Illinois Workers' Compensation Commission. The records reflect that, with respect to the instant claim for benefits relating to July 1, 2013 accident, petitioner completed medical treatment with Dr. Grear, was released to return to work without restriction attributable to the left knee condition, and so returned to work with respondent.

Petitioner thereafter alleged an accident involving the bilateral knees on November 11, 2015, and at the time of November 21, 2017 hearing complained of ongoing pain, limitation, and disability. The Arbitrator locates no opinion in the supplied evidence causally relating petitioner's 2017 condition to 2013 injury, and it appears to be petitioner's testimony that his existing condition is the result instead of 2015 accident. In this context, the Arbitrator does not find that that petitioner's current condition of ill-being related to July 1, 2013 accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (TEMPORARY BENEFIT ENTITLEMENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony, deposition testimony, and consideration of submitted written evidence, the Arbitrator finds that petitioner completed his regular work on the date of July 1, 2013 accident, though thereafter remained off work under physician restriction while pursuing medical treatment from July 2, 2013 until release at Maximum Medical Improvement and return to work April 4, 2014, a period of 39 and 3/7 weeks. The Arbitrator finds petitioner entitled to Temporary Total Disability payments for this period.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "N" (CREDIT DUE RESPONDENT), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony and Request for Hearing stipulations, the Arbitrator finds that respondent paid to petitioner the sum of $39,927.43 for disputed Temporary Total Disability benefits in connection with allegation of July 1, 2013 accident. Respondent shall receive credit for this amount.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "O" (PETITIONER'S ENTITLEMENT TO VOCATIONAL REHABILITATION), THE ARBITRATOR FINDS THE FOLLOWING:

Based upon hearing testimony, deposition testimony, and consideration of submitted written evidence, the Arbitrator finds that petitioner was released to return to work without restriction following July 1, 2013 accident, and that he indeed so returned. Petitioner presented no evidence of entitlement to vocational rehabilitation as a result of July 1, 2013 accident. The Arbitrator therefore accordingly finds petitioner was not entitled to vocational rehabilitation.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Felipe Ayala,

Petitioner,

vs. NO: 10 WC 29579

18IWCC0515

Green Scene and the Illinois State Treasurer
as ex-officio custodian of the Injured Workers' Benefit Fund,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent (IWBF) herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability and nature and extent, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes, as stated below, and otherwise adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes several errors and/or inconsistencies in the Arbitrator's decision.

In the Order section on p.2 of her form decision, the Arbitrator awarded 10% person-as-a-whole, while on p.8 of her addendum she found that Petitioner was permanently partially disabled to the extent of 7.5% person-as-a-whole. The Commission hereby corrects this inconsistency and finds that Petitioner suffered permanent partial disability to the extent of 7.5% person-as-a-whole pursuant to §8(d)2 of the Act, or the percentage loss of use cited in the body of her decision and for which she provided a basis (i.e. explanation) for her award.

Furthermore, also on p.2 of the form portion of her decision, the Arbitrator incorrectly noted that Petitioner was single at the time of the accident. The Commission notes that the Application for Adjustment of Claim alleges, and Petitioner testified [T.14], that he was married with no children at the time of the accident. As a result, a minimum PPD rate of $245.33 would

apply, given one dependent and a date of accident of 7/2/10. The Commission notes the TTD rate awarded by the Arbitrator would not be affected by the applicable minimum rate ($245.33) and would remain at $266.67.

In addition, the Commission notes that on p.1 of her addendum the Arbitrator mistakenly referenced that Petitioner "... claims that he was injured while working for Green Scene (Respondent) on August 20, 2010." The Commission notes that the alleged date of accident is actually July 2, 2010, and the Arbitrator's decision is corrected to reflect as much.

Finally, in response to Respondent's claim of error with respect to the Arbitrator's award of temporary total disability benefits, the Commission wishes to point out that the Arbitrator's Order, at p.2 of her form decision, did not make two different TTD awards. Instead, the Arbitrator awarded TTD from July 3, 2010 through October 29, 2010, for a period of 17 weeks, and then went on to note that Respondent was liable for benefits that had ***accrued*** from the date of accident (7/2/10) through the hearing date (3/11/16), a period that would include the dates for which TTD was awarded. This accrual language, which is included in the Commission's standard decision forms and approved paragraphs, in no way represents an additional period of TTD, and should not be construed as such.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 3/31/16 is affirmed with changes, as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $266.67 per week for a period of 17 weeks, from 7/3/10 through 10/29/10, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses as set forth in PX9, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 7.5% 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.

18IWCC0515

The Commission notes that the Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act.

Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

DATED:
o:6/26/18
TJT/pmo
51

AUG 17 2018

Thomas J. Tyrrell

Stephen J. Mathis

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AYALA, FELIPE
Employee/Petitioner

Case# **10WC029579**

GREEN SCENE & INJURED WORKERS' BENEFIT FUND
Employer/Respondent

18IWCC0515

On 3/31/2016, 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 0.47% 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:

1427 BERG & BERG
JASON R COAKLEY
2100 W 35TH ST
CHICAGO, IL 60609

0000 GREEN SCENE
3515 STERN AVE
ST CHARLES, IL 60174

5462 ASSISTANT ATTORNEY GENERAL
MAGGIE TIMLIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Felipe Ayala
Employee/Petitioner

v.

Green Scene & Injured Workers' Benefit Fund
Employer/Respondent

Case # **10** WC **29579**

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 **Geneva**, on **March 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 **July 2, 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 this accident.

In the year preceding the injury, Petitioner earned **$20,800.00**; the average weekly wage was **$400.00**.

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

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

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

Respondent shall be given a credit of **$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

Injured Workers' Benefit Fund

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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $266.67/week for 17 weeks, commencing July 3, 2010 through October 29, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from July 2, 2010 through March 11, 2016, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay the outstanding reasonable and necessary medical services incurred by Petitioner and submitted into evidence as PX9 pursuant to Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $245.33/week for 50 weeks, because the injuries sustained caused Petitioner 10% loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

March 30, 2016
Date

MAR 31 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Felipe Ayala
Employee/Petitioner

v.

Green Scene & Injured Workers' Benefit Fund
Employer/Respondent

Case # 10 WC 29579

Consolidated cases: N/A

FINDINGS OF FACT

Felipe Ayala (Petitioner) claims that he was injured while working for Green Scene (Respondent) on August 20, 2010. Arbitrator's Exhibit[1] ("AX") 1. Respondent was served proper notice of the hearing and failed to appear at the hearing.

Petitioner submitted a copy of notice served on Respondent via certified mail dated February 8, 2016. PX2. The return receipt from the U.S. Postal Service indicates that Mr. Jeffrey Lemke on behalf of Respondent received the notice on February 12, 2016 as indicated by his signature on the return receipt. *Id.* No one appeared on Respondent's behalf at the hearing.

Petitioner also submitted certification from the Illinois Workers' Compensation Commission's Insurance Compliance Department affirming that there is no insurance coverage according to the National Council on Compensation Insurance (NCCI) in a letter dated October 15, 2012. PX8. Mr. Shelton Wilson confirmed that there were no records of policy information showing proof of workers' compensation insurance on the date of July 2, 2010 for Respondent. Id.

Petitioner named the Injured Workers' Benefit Fund (IWBF) as an additional respondent in this matter. Counsel for the IWBF appeared at the hearing and disputes Petitioner's claims regarding employer/employee relationship, accident, notice, causal connection, earnings, age, marital status, dependency, unpaid medical bills, and the nature and extent of Petitioner's injury. AX1.

Background

Petitioner testified that he was born on December 15, 1947 and was 62 years old on the date of accident. He explained that he has been married for 49 years and has 11 children, but none were dependents on July 2, 2010.

Petitioner testified that he was employed by Respondent performing maintenance services, trimming trees and doing "construction." He explained that he would use all sorts of trimming tools, a lawnmower and a ladder, which were all owned by Respondent. Petitioner had been employed by Respondent for approximately four years at the time of his injury and worked with other employees at that time. He explained that he would go to the "shop" and was then driven to and from various work sites by Respondent's trucks. A supervisor, Sergio Ojeda (Mr. Ojeda), worked with Petitioner and oversaw his work. Petitioner testified that Mr. Ojeda would send him to work as indicated by the owner of the company. Petitioner testified that the owner would give him his work schedule.

[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 provided pay stubs issued by "Green Scene, Inc." for certain periods from April 8, 2010 through July 3, 2010. PX10. When the weather was bad in the winter from December up to March, Petitioner did not work. Petitioner testified that he did not work for other employers during the winter months. Petitioner testified that he usually worked 40 hours per week, but he did not have a set schedule. Petitioner testified that taxes were withheld from his checks, which is reflected in Petitioner's Exhibit 10. He also received yearly W-2 forms.

July 2, 2010

On July 2, 2010, Petitioner testified that he was injured at work when he fell from a tree. He was cutting branches from the tree and standing on a ladder at the time that was held by Mr. Ojeda. Petitioner explained that while he was cutting a branch it made him fall down and he lost consciousness. Petitioner also explained that he was instructed to trim the branches on the tree from which he fell by Respondent's owner.

Petitioner reported his accident to Mr. Ojeda and understood that Mr. Ojeda spoke with the owner of the company about the injury. When Petitioner regained consciousness, he testified that he experienced pain in his low back due to a fracture on the right side.

Medical Treatment

Petitioner testified that Mr. Ojeda then took him to a clinic for treatment and he underwent tests for the fracture. He testified that he was in a lot of pain at this time and

Petitioner testified that in the days following the accident he went to the office and was attended by the owner's secretary. He also testified that he spoke to the owner's daughter about the accident so he could get his benefits for medicine.

Petitioner testified that he remained in the hospital for several days. Petitioner was on crutches for three months and he did not work during these months.

The medical records reflect that Petitioner presented at the emergency room at St. Alexius Medical Center on July 2, 2010. PX1. Dr. Jonathan Dunn, noted Petitioner's report that he "was at work on a ladder approximately 10 feet off the ground, trimming a tree. He sustained a fall off the ladder and landed on his right side. He sustained a laceration to his right elbow, landed on his right hip and also does admit to a loss of consciousness." Id. Petitioner underwent a diagnostic testing including a CT scan and x-rays as well as various consultations to assess his condition. Id. Petitioner's x-rays showed a fracture of the right iliac wing, which was confirmed by CT scans of his abdomen and pelvis. Id. Dr. Tina Bhargava also noted that there was "likely hemorrhage into the quadratus lumborum. The patient also had a contusion to the right side of his head." Id.

Petitioner was admitted and remained at St. Alexius Medical Center for three days. Id. He developed a urinary retention problem and was told to see Dr. Ramarao at Clinical Associates the day after he was discharged. Id. Petitioner was discharged on July 5, 2010 with prescriptions for Metoprolol and Norco as well as instructions for follow up medical care. Id.

Petitioner saw Dr. Ramareo on July 6, 2010 for right flank pain and a urinary problem. PX2. Dr. Ramarao ordered Metoprolol, hydrocodone and docusate sodium noting an observation plan and instructions to follow up as needed. Id.

Petitioner then followed up on July 15, 2010 Barrington Orthopedic Specialists with Dr. Dunn for orthopedic care. PX3. Petitioner presented for symptoms in his right hip related to his right iliac wing fracture. Id. He reported using crutches to protect weight bearing. Id. Dr. Dunn noted diffuse posterior swelling and marked posterior ecchymosis on the right hip. Id. He diagnosed Petitioner with a right iliac wing fracture and right elbow laceration. Id. Dr. Dunn ordered physical therapy and pain medication as needed. Id. Dr. Dunn also noted that Petitioner was currently off work, kept him off work and anticipated that he would reach maximum medical improvement in two-to-six months. Id.

On July 23, 2010, Petitioner then followed up with a chiropractor, Dr. Ruben Bermudez, at Herron Medical Center/Alevio Physical Therapy and Chiropractic. PX4. He reported back pain radiating into his right flank area and into his right buttocks related to a work accident on July 2, 2010. Id. Petitioner also reported that he was working for Green Scene located in St. Charles, Illinois at the time of his accident and provided a consistent mechanism of injury (i.e., on July 2, 2010 he was cutting tree branches from a ladder when he fell, lost consciousness and injured his back with right sided pain). Id. Petitioner further reported that sitting, coughing, or sneezing increased his pain and that he had no prior low back problems. Id. On examination, Dr. Bermudez noted ecchymosis and edema through the lumbar area into the right gluteus maximus and right flank with painful and limited range of motion of the lumbar spine. Id. He prescribed nonsteroidal anti-inflammatory medication, a muscle relaxant, gastroprotective medication, an analgesic balm and a lumbar spine MRI. Id. Dr. Bermudez maintained Petitioner's off work restrictions. Id.

Petitioner underwent the recommended MRI on June 24, 2010. PX4. The interpreting radiologist noted some mild bulges at the L2-3, L3-4, and L4-5 levels and a "broad based posterior bulging disc with a more focal protrusion in the left paracentral and left foraminal region" at the L5-S1 level. Id.

On July 27, 2010, Petitioner saw Dr. Edward Sclamberg as referred by Dr. Bermudez for a consultation regarding his pelvic fracture. PX5. Petitioner provided a consistent mechanism of injury at work and reported that he was still using crutches. Id. Dr. Sclamberg diagnosed Petitioner with a right iliac bone fracture and recommended that Petitioner remain weight-bearing as tolerated with continued use the crutches. Id. He ordered repeat radiographs in three weeks and a follow up visit. Dr. Sclamberg indicated that he would likely begin formal physical therapy at that time. Id.

Petitioner then followed up with Dr. Suneela Harsoor, a pain management specialist, through the Herron Medical Center on July 29, 2010. PX6. Petitioner reported a consistent mechanism of injury and continued low back pain at its worst "is 8/10, at its least it is 5/10, on an average about 7/10" and use of crutches for ambulation. Id. Dr. Harsoor reviewed Petitioner's lumbar MRI and images of the pelvic fracture. Id. She diagnosed Petitioner with lumbar spine radiculopathy, pelvic/thigh/hip pain and myofascial pain. Id. Dr. Harsoor maintained Petitioner's off work restrictions due to his significant pain and recommended continued physical therapy and medications. Id. She noted that further options included medications, epidural steroid injections, physical therapy and surgery after his response to the current treatment plan. Id.

Petitioner returned to Dr. Bermudez on August 6, 2010 and August 11, 2010 for physical therapy to treat his low back pain. PX4. Dr. Bermudez indicated that Petitioner should then follow up with Dr. Harsoor. Id. Petitioner did so and saw Dr. Harsoor on August 6, 2010. PX6. She noted Petitioner's continued significant pain and

scheduled a lumbar epidural steroid injection along with trigger point injections at three levels which took place on August 17, 2010. Id. Petitioner returned to Dr. Harsoor on September 2, 2010 and reported that he had experienced relief from the lumbar injection. Id. Dr. Harsoor ordered continued physical therapy and kept Petitioner off work. Id.

On October 10, 2010, Dr. Harsoor recommended continued physical therapy, medication management and released Petitioner to light duty work with a 15 pound lifting restriction. PX6. Petitioner was able to begin physical therapy at Elgin Physical Health Center on October 8, 2010. PX7. He returned to Dr. Harsoor on October 29, 2010 at which time she released him back to full duty work. PX6. Petitioner completed a course of physical therapy at Elgin Physical Health Center on November 5, 2010 at which point he was placed at maximum medical improvement. PX7. Petitioner's last visit with any physician was on November 30, 2010 when he saw Dr. Harsoor. PX6. At this visit, Dr. Harsoor noted Petitioner's report that there was no work available with his old employer. Id.

Additional Information

Regarding his current condition, Petitioner testified that he cannot lift heavy items as he did before. He is bothered when walking a lot and explained that he feels more or less able to go to work, but it is different now because he cannot do what he did before including climbing trees. Petitioner testified that he is currently working temporary jobs, but the landscaping work is different than that which he could do before his accident.

Petitioner also testified that his daily life is different. He cannot walk very much and if it is very cold he feels pain. Petitioner explained that he did not have these issues before his accident. He also explained that he had no prior back treatment or symptoms before his accident at work. He was never off work for low back pain or symptoms.

As of the date of the hearing, Petitioner testified that his medical bills had not paid and he requested payment of temporary total disability benefits.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are hereby made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (A), whether Respondent was operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds the following:

The Illinois Workers' Compensation Act ("Act") defines those businesses that are considered "employers" and, thus, come under its jurisdiction. Under Section 3, various types of businesses automatically come under the Act's jurisdiction due to their extra-hazardous activities including "[a]ny business ... in which electric, gasoline, or other power driven equipment is used in the operation thereof." 820 ILCS 305/3 (LEXIS 2005).

Petitioner gave credible and unrebutted testimony that Respondent's business involved use of such electric, gasoline, and power-driven equipment including lawnmowers and tree trimmers. Thus, the Arbitrator finds that Respondent was operating as an employer on the claimed date of accident under and subject to the Act.

In support of the Arbitrator's decision relating to Issue (B), whether there was an employee-employer relationship on the claimed dates of accident, the Arbitrator finds the following:

The existence of an employer-employee relationship between Petitioner and Respondent is a prerequisite to determining further compensability of his claim. The Illinois Supreme Court has articulated various factors to be considered in determining whether a claimant is an employee under the Act including: "whether the employer may control the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from the person's compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment." *Roberson v. Industrial Comm'n*, 225 Ill.2d 159, 175 (2007) (*citing Wenholdt v. Industrial Commission*, 95 Ill. 2d 76, 81 (1983), *quoting Morgan Cab Co. v. Industrial Comm'n*, 60 Ill. 2d 92, 97 (1975)). Determination of the existence of an employer-employee relationship rests on the totality of the circumstances in each case; however, the "right to control the manner in which work is performed is the most important consideration, among others, in determining whether an employer/employee relationship existed." *Roberson*, 225 Ill.2d at 175.

Petitioner gave credible and unrebutted testimony that he was hired by Respondent as an employee approximately four years before his injury at work. He received daily work instructions and assignments from Mr. Ojeda and Respondent's owner directly. Mr. Ojeda supervised Petitioner each day and worked along side Petitioner on occasion, including on the date of accident when he held the ladder on which Petitioner was perched trimming a tree branch. Respondent also provided all of the tools used by Petitioner and drove Petitioner along with other employees to and from various work sites each day. While Petitioner did not work a set schedule, he testified that he worked 40 hours per week, which is corroborated by his pay stubs showing such regular work. Moreover, Petitioner's paystubs reflect that Respondent withheld taxes and made deductions from his paychecks. Based on all of the foregoing, the Arbitrator finds that an employee-employer relationship existed on the claimed date of accident.

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 as claimed and the date of such accident, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2010). 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 his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

Petitioner credibly testified, and the medical records reflect, that he was working for Respondent when on July 2, 2010 he fell while cutting a tree branch causing him to lose consciousness and requiring emergency care. In addition, the medical records from St. Alexius Medical Center and Petitioner's treating physicians, Drs. Ramareo, Dunn, Bermudez, Sclamberg and Harsoor, corroborate his testimony about the mechanism of injury and subsequent onset of symptoms. No evidence was submitted to the contrary. Based on all of the foregoing, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment with Respondent on July 2, 2010 as claimed.

In support of the Arbitrator's decision relating to Issue (E), whether timely notice of the accident given to Respondent, the Arbitrator finds the following:

Section 6(c) of the Act provides that notice of an accident must be provided to the employer not later than 45 days after the accident. 820 ILCS 305/6 (LEXIS 2005). Proper notice is a prerequisite to maintain a right of action under the Act. *Lambert v. Industrial Comm'n*, 79 Ill.2d 243, 247 (1980).

Petitioner credibly testified that Mr. Ojeda, his supervisor, was present at the time of his injury and drove him to the hospital for emergency care. Petitioner also gave unrebutted testimony that several days later he went to report the accident to Respondent's owner and spoke with both the owner's secretary and daughter, who spoke Spanish. Thus, the Arbitrator finds that Petitioner gave timely notice of the accident to Respondent pursuant to the Act and that Respondent was aware of Petitioner's work accident.

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:

After carefully observing the Petitioner at trial and reviewing all evidence proffered at the hearing, the Arbitrator finds that Petitioner credibly testified about his injury and presented a consistent sequence of events corroborated by contemporaneous medical records reflecting that Petitioner sustained an injury necessitating medical treatment after his accident. The record is devoid of evidence that Petitioner had any history of injury, symptomatology or medical treatment to the low back before July 2, 2010. Indeed, the medical records support Petitioner's testimony at the hearing. Thus, the Arbitrator finds that Petitioner's claimed current condition of ill-being is causally related to his injury at work.

In support of the Arbitrator's decision relating to Issue (G), what Petitioner's earnings were, the Arbitrator finds the following:

The paystubs submitted into evidence show that Petitioner worked 40 hours per week, but sometimes worked less hours. However, Petitioner testified that he worked for Respondent an average of 40 hours per week. Petitioner's testimony is unrebutted and credible. Thus, the Arbitrator finds that Petitioner earned $20,800.00 annually and that his average weekly wage was $400.00 as claimed.

In support of the Arbitrator's decision relating to Issues (H) and (I), Petitioner's age, martial status and dependency, the Arbitrator finds the following:

Petitioner testified that his date of birth is December 15, 1947 and on the date of the accident, he was married with no dependent children. The medical records corroborate Petitioner's testimony. Thus, the Arbitrator finds that Petitioner was 62 years old and single with no dependants under the age of 21 at the time of his injury at work.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after his accident at work. The medical bills submitted into evidence relate to emergency room care, hospital services, diagnostic testing, physicians' services, physical therapy, chiropractic treatment, and prescription medications prescribed as a direct result of his injury at work. Based on a thorough review of the medical records and bills submitted into evidence, in conjunction with Petitioner's testimony at trial, the Arbitrator finds that Petitioner's medical bills are for reasonable and necessary medical care to alleviate him of the effects of his injury at work. Based on all of the foregoing, the Arbitrator awards the outstanding medical bills admitted into evidence as Petitioner's Exhibit 9 and orders Respondent to pay Petitioner these bills pursuant to Section 8(a) and Section 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:

Petitioner requests temporary total disability benefits from July 3, 2010 through October 29, 2010. "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 (June 26, 2014, Opinion Filed); *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 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

The record reflects that Respondent did not accommodate any light duty work restrictions, pay temporary total disability benefits or accept Petitioner back to work when he was released from medical care. Thus, the Arbitrator finds that Petitioner has established that he is entitled to temporary total disability benefits as claimed.

In support of the Arbitrator's decision relating to Issue (L), what is the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Based on the record as a whole—which reflects credible and unrebutted evidence that Petitioner sustained a low back injury resulting in physical therapy and several injections with minimal continuing symptomatology—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 7.5% 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 WINNEBAGO)

☐ 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 Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James R. Metz,

Petitioner,

vs. NO: 12 WC 3744

State of IL, Dept. of Transportation,

Respondent.

18IWCC0516

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 issue of accident, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

Findings of Fact

Petitioner has worked for Respondent since 2001. (Tr. at 11). On November 8, 2011, Petitioner worked as a highway maintenance worker for Respondent. His duties included plowing snow, mowing ditches, patching holes, removing debris from roads, and conducting traffic control for construction projects. *Id.* Petitioner testified his normal work hours were from 7:00 a.m. until 3:30 p.m. *Id.* Petitioner testified that the IDOT facility is located on approximately two or three acres and a fence encloses the property. *Id.* at 12. Petitioner testified that he drove to work every day and parked in the parking lot. *Id.* at 13. He testified that Respondent designated certain areas for employee parking. *Id.* at 13-14. He testified that IDOT is responsible for maintaining the parking lot. *Id.* at 29.

Petitioner testified that it was raining on November 8, 2011. *Id.* at 14. He drove his normal vehicle (a Ford F-150 truck) and parked in the usual area. *Id.* at 15. He testified, "I was getting out of my vehicle. It was raining hard, and I was in a hurry and slipped on the surface and went down and injured my ankle." *Id.* He testified that he fell to the ground and used his hand to prevent falling on his face. *Id.* Petitioner testified that he was carrying his lunch box and thermos when he fell. *Id.* He immediately felt pain in his left ankle, but thought it was only a sprain. *Id.* at 16. He reported his fall to his lead worker, Craig Cowin, and began his work day. *Id.* at 16, 18. He testified that he told Mr. Cowin that he fell while exiting his truck when he arrived at work and thought he

sprained his ankle. He tried to work that day and rode with a "snow bird" to show the employee his route. Petitioner did not drive and noticed that his ankle was not improving. *Id.* at 18-19. He called his wife and decided to seek medical care. *Id.* at 19. He left work around 11 a.m. Petitioner testified that he punches a time clock when his shift starts at 7 a.m. On the date of accident, Petitioner arrived approximately 20 minutes early per his usual routine. *Id.* at 20.

Petitioner visited the ER that day and the doctors diagnosed a left ankle fracture. *Id.* at 21. Petitioner began treatment with Dr. Brinkman, an orthopedic surgeon, the next day. *Id.* at 23. Petitioner testified that the doctor kept him off work until the new year. *Id.* at 23-24. Petitioner returned to work on or around January 2, 2012. Petitioner testified that his ankle improved prior to his return to work; however, following his return to work it was initially hard for him to walk on the ankle because the tendons were stiff. *Id.* at 26. Petitioner testified that the discomfort lasted only a few months and that his home exercise program helped. *Id.* When asked how his ankle felt, Petitioner testified, "It feels great." *Id.* Petitioner testified that he re-injured his left ankle in May 2013 while attending a heavy metal concert with his son. *Id.* at 27. He testified that although that injury hurt worse than his ankle fracture, the doctors only diagnosed a sprain. *Id.*

He had no prior injuries to the left ankle. *Id.* at 33. Petitioner testified that he did not receive any workers' compensation benefits while off work. *Id.* at 28. Instead, Petitioner used his sick time to cover his time off work. He testified that his left ankle does not impact his ability to perform his work duties. *Id.* at 29. He continues to work in his original position as a highway maintainer and has no difficulty performing his job. *Id.* at 34-35. Petitioner testified that his group insurance paid his medical bills and if he paid anything out-of-pocket, it was very little. *Id.* at 30.

Medical Treatment

At the ER, Petitioner told medical personnel that he rolled his left ankle that morning and complained of pain radiating up his left leg with weight-bearing. (PX 2). Medical personnel noted swelling and discoloration of the left ankle. Petitioner reported feeling a pop when he fell. X-rays of the left ankle revealed a fracture above the ankle mortise in the lateral malleolus with no evidence of dislocation. The doctor diagnosed a possible left ankle distal fibular fracture.

Dr. Brinkman first examined Petitioner the day after his fall. (PX 1). Dr. Brinkman interpreted the x-rays as showing the ankle mortise to be intact with very minimal displacement of the lateral malleolus. He placed Petitioner in a short leg non-weight bearing cast and told Petitioner to use crutches. On November 16, 2011, Dr. Brinkman noted that x-rays of the left ankle showed the ankle mortise to be intact and the alignment of the fracture was nearly anatomic. On December 11, 2011, the updated x-rays revealed near anatomic fracture alignment and no shift of the talus.

On December 21, 2011, the updated x-rays revealed a healed fracture. Dr. Brinkman removed Petitioner's cast and prescribed physical therapy. Petitioner returned to work full duty on January 1, 2012. On January 9, 2012, Petitioner told Dr. Brinkman that he was doing fine after his return to work. The doctor noted some restriction of plantar flexion and good dorsiflexion of the ankle. Petitioner denied any significant pain. Dr. Brinkman placed Petitioner at MMI and released him from his care. Petitioner's final physical therapy session occurred on January 20, 2012. On that day, Petitioner reported work was "okay." The therapist noted Petitioner met all the identified

goals except for achieving left ankle range of motion within five degrees of the right ankle range of motion. The therapist discharged Petitioner with a home exercise program.

Petitioner reinjured his left ankle on May 3, 2013. (PX 2). Petitioner reported someone stepped on his left ankle the night before while he attended a concert. X-rays of the left ankle revealed minimal soft tissue swelling of the lateral ankle and resolution of the previously demonstrated fracture deformity of the distal fibula. There was no evidence of a new fracture or deformity. The ER doctor diagnosed a left ankle contusion.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). He must show by a preponderance of the evidence that he suffered a disabling injury which arose out of and in the course of his employment. *Id.* The phrase "in the course of employment" refers to the time, place and circumstances surrounding the injury. *Id.* To satisfy the "arising out of" prong, Petitioner must show that the injury "had its origin in some risk connected with, or incidental to, the employment." *Id.* The compensability of Petitioner's claim rests on the question of whether he suffered an accident arising out of his employment. After carefully considering all the evidence, the Commission finds Petitioner did not meet his burden of proving his injury arose out of his employment.

The first step of the Commission's analysis of the arising out of prong requires determining the category of risk to which Petitioner's employment exposed him. *See Dukich v. Ill. Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31. Illinois courts have identified three categories of risk to which an employee may be exposed: "1) risks that are distinctly associated with one's employment; 2) risks that are personal to the employee, such as idiopathic falls; and 3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed." *Id.* On the date of accident, Petitioner slipped and fell on wet pavement in the parking lot at work. Thus, his injury is not the result of a personal risk. Likewise, his injury was not the result of a risk distinctly associated with his employment. After all, Petitioner fell after arriving at the facility to begin his work day. There is no evidence that any aspect of his employment enhanced his risk in some way. Notably, Petitioner does not allege that his fall was due to a defect in the parking lot such as a pothole, loose gravel, or an uneven surface. Consequently, Petitioner may only prevail if his work injury is the result of a qualifying neutral risk.

Generally, injuries resulting from a neutral risk do not arise out of the employment and are compensable only when the employee was exposed to the risk to a greater degree than the public. *Id.* The Commission finds the *Dukich* opinion most instructive. *Id.* The relevant facts in *Dukich* are strikingly similar to those in this current case. In *Dukich*, the claimant slipped and fell on wet pavement while on her employer's premises. *Id.* at ¶ 35. It was undisputed that there were no defects on the paved surface where the claimant fell such as holes, uneven surfaces, depressions, or loose gravel. Like Petitioner, the claimant in *Dukich* was not carrying anything required for her job and was not rushing to complete a work task when she fell. Instead, the *Dukich* claimant simply slipped on wet pavement. The Appellate Court identified the risk to the claimant as "the risk of

18IWCC0516

walking on wet pavement in the rain on property owned and controlled by her employer." *Id.* In its analysis, the Appellate Court opined,

> "The dangers created by rainfall are dangers to which all members of the public are exposed on a regular basis. These dangers, unlike defects or particular hazardous conditions located at a particular worksite, are not risks distinctly associated with one's employment. Accordingly…recovery should be allowed only if the claimant can establish that she was exposed to the risks of injury from rainfall to a greater degree than the general public by virtue of her employment."

Id. at ¶ 36. Like the claimant in *Dukich*, Petitioner has presented no evidence that the wet pavement he encountered on Respondent's property was any different or more dangerous than any other wet pavement the public encounters on a regular basis.

For the foregoing reasons, the Commission denies benefits to Petitioner because he did not suffer an injury arising out of and in the course of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated June 16, 2016, is reversed in its entirety and all benefits are denied.

DATED: AUG 17 2018

o: 7/10/2018
TJT/jds
51

David L. Gore

Michael J. Brennan

Kevin W. Lamborn

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Frye,

Petitioner,

vs.

NO: 17 WC 12293

18IWCC0517

Flex-N-Gate Logistics,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability and medical expenses, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Commission modifies the decision of the Arbitrator to find that Petitioner was a traveling employee, and that as such his claim is compensable pursuant to the traveling employee doctrine and not the neutral risk analysis effectively performed by the Arbitrator.

The Commission notes that "[c]ourts generally regard employees whose duties require them to travel away from their employer's premises (traveling employees) differently from other employees when considering whether an injury arose out of and in the course of employment." *Venture-Newberg-Perini v. Ill. Workers' Compensation Commission*, 1 N.E.3d 535, 539 (Ill. 2013), citing *Wright v. Industrial Commission*, 62 Ill. 2d 65, 68, 338 N.E.2d 379 (1975); *Hoffman v. Industrial Commission*, 109 Ill. 2d 194, 199, 486 N.E.2d 889, 93 Ill. Dec. 356 (1985).

A traveling employee is any employee for whom travel is an essential element of his employment. *Urban v. Industrial Commission*, 34 Ill. 2d 159, 163 (1966). An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable, i.e. conduct that "might normally be anticipated or foreseen by the employer." *Robinson v. Industrial Commission*, 96 Ill. 2d 87, 92 (1983).

The courts have also found that injuries arising from three categories of acts are compensable: (1) acts the employer instructs the employee to perform; (2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; (3) acts which the employee might be reasonably expected to perform incident to his assigned duties. In making this decision, the courts consider the reasonableness of the act and whether it might have reasonably been foreseen by the employer. *Venture-Newberg-Perini*, 1 N.E.3d at 540.

In the present case, Petitioner was most assuredly engaged in an activity at the time of the accident that his employer could reasonably have expected him to perform incident to his assigned duties – namely, walking up steps to the receiving office at Flex-N-Gate's Danville facility after dropping off a trailer, one of many trips he would regularly make between Respondent's multiple locations during the course of any given shift. Furthermore, there is also no question that this activity was both reasonable and foreseeable.

In addition, the Commission finds that contrary to Respondent's contention, Petitioner did not somehow lose his status as a traveling employee merely because the incident happened to have occurred on stairs located in one of Respondent's facilities. The Commission notes that a traveling employee is deemed to be in the course of his employment from the time he leaves home until he returns. *Cox v. Illinois Workers' Compensation Commission*, 406 Ill. App. 3d 541, 545 (2010). As such, Petitioner was still a traveling employee, and still very much in the course of his employment when the incident took place, especially since Petitioner's job required nothing but traveling between the various sites owned and operated by Respondent.

Thus, the Commission finds that Petitioner was a traveling employee, and that as a result he sustained accidental injuries arising out of and in the course of his employment on 12/6/16.

In addition, the Commission corrects a clerical error in the decision of the Arbitrator. In the Order section of his decision, the Arbitrator awarded TTD from 12/7/16 through 4/26/17 for a period he found to be 35-4/7 weeks. The Commission notes that this period is actually 20-1/7 weeks. The Arbitrator's decision is hereby corrected accordingly.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 9/8/17 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $444.34 per week for a period of 20-1/7 weeks, from 12/7/16 through 4/26/17, that being the period of temporary total incapacity for work under §8(b) of the Act.

18IWCC0517

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses as set forth in PX8-13, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical treatment as prescribed by his treating physicians, and that Respondent shall pay to Petitioner the reasonable and necessary medical expenses associated therewith, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that 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.

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

DATED:
o:7/16/18
TJT/pmo
51

AUG 17 2018

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

FRYE, JAMES
Employee/Petitioner

Case# **17WC012293**

FLEX-N-GATE LOGISTICS
Employer/Respondent

18IWCC0517

On 9/8/2017, 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 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1937 TUGGLE SCHIRO LICHTENBERGER
TODD D LICHTENBERGER
510 N VERMILION
DANVILLE, IL 61832

0522 THOMAS MAMER & HAUGHEY LLP
JOHN M STURMANIS
30 E MAIN ST SUITE 500
CHAMPAIGN, IL 61820

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Frye
Employee/Petitioner

v.

Flex-N-Gate Logistics
Employer/Respondent

Case # 17 WC 12293

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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana, Illinois**, on **August 17, 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. ☒ 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 6, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**34,658.52**; the average weekly wage was $**666.51**.

On the date of accident, Petitioner was **55** 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 $**9,140.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,140.72**.

Respondent is entitled to a credit of $**medical bills paid by group insurance** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's exhibits 8, 9, 10, 11, 12, 13, and 14 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given 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 $444.34 per week for 35-4/7 weeks, commencing December 7, 2016, through April 26, 2017.

Petitioner's claim for temporary total disability benefits from May 2, 2017 through the date of arbitration is denied.

Respondent shall be given credit of $9,140.72 for TTD, $0 for TPD, and $0 for maintenance benefits, for a total credit of $9,140.72.

Respondent shall pay reasonable and necessary medical expenses for prospective medical care as prescribed by Petitioner's treating physicians.

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

9/5/2017
Date

ICArbDec19(b)

SEP - 8 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged that he sustained accidental injuries arising out of and in the course of his employment for Respondent on December 6, 2016. The Application alleges that Petitioner sustained injuries to his whole body when he fell while trying to climb steps.

This case was tried on a 19(b) proceeding and Petitioner seeks an order for payment of temporary total disability benefits, reasonable and necessary medical expenses, and prospective medical treatment. Respondent disputes liability on the basis of accident. Although Respondent indicated on the Request for Hearing it is disputing causal connection, it was stipulated by the parties at the time of trial that Respondent did not dispute causal connection with regards to claimed injuries regarding the right upper extremity and cervical spine.

Petitioner worked for Respondent as a truck driver. His job involved moving trailers between various locations, in various cities, owned and operated by Respondent. Petitioner testified that he reported to work in Covington, IN, on December 5, 2017, when his shift began at 11:00 pm Indiana time. Petitioner testified he went to the dispatch office where he received his orders and went down the steps at the loading dock to get his truck.

Petitioner testified he then transported a trailer to Respondent's plant in Danville, IL. Petitioner testified he unhooked that trailer at the dock, went up the steps to the shipping/receiving desk, got new orders, and went back down the same steps to return to his truck. The stairway at the Danville, IL plant is concrete with metal handrails and consists of seven (7) steps (Rx. 1).

Petitioner testified he then transported a different trailer to Respondent's plant in Urbana, IL. Petitioner testified he unhooked that trailer in Urbana, IL and hooked to a different trailer. Petitioner testified he went up the steps at the Urbana, IL plant to the shipping receiving office, turned in his paperwork, got new paperwork for the outgoing trailer, and went back down the same steps to return to his truck. Petitioner testified there are approximately six (6) steps at the Urbana, IL plant, made of concrete, and generally the same as the steps at the plant in Danville, IL,

Petitioner testified he then transported a different trailer back to Respondent's plant in Danville, IL. Petitioner testified that when he got back to the Danville, IL plant he parked his truck and started to climb the steps again. Petitioner testified he fell while climbing those steps. Petitioner testified he did not know what caused him to fall but he may have missed a step. Petitioner testified he was carrying paperwork at the time. Petitioner testified he was in a hurry because he had additional trips to other locations which needed to be completed during his shift. Petitioner testified that in addition to transporting trailers to other plants, the Respondent wanted him to move other trailers between the dock and the parking lot at the Danville, IL location.

Petitioner testified his shift that day was typical of an average day. Petitioner testified that had he not fallen that day he would have continued working and moved three (3) trailers in the Danville, IL parking lot, transported a trailer back to the Urbana, IL location and repeated the earlier process at that plant, including going up and down the steps at the loading dock. Petitioner testified he then would have transported a trailer back to the Danville, IL plant and repeated the process there, including going up and down the steps at the loading dock. Petitioner testified he then would have transported a trailer to the Respondent's plant in Veedersburg, IN. There he would have used either a ramp or stairs consisting of five (5) steps, depending on which dock they sent him to. Petitioner testified he would end his shift back

at the Covington, IN plant where he would climb the steps again to turn in his final paperwork at the dispatch office.

Petitioner testified that the schedule for that day was typical of an average day and that he was required to go up and down these stairways, located at various loading docks, eight (8) to ten (10) times per day.

Petitioner testified that soon after his fall an ambulance arrived to transport him to the hospital. Petitioner was transported by Arrow Ambulance to Presence United Samaritans Medical Center in Danville, IL (Px. 1).

Petitioner presented at the United Samaritans Medical Center Emergency Department complaining of right shoulder and left knee pain (Px. 2).

Petitioner testified he was directed by Respondent to treat at Carle Occupational Medicine and was first seen by Dr. Scott on December 6, 2016. Dr. Scott diagnosed a right shoulder contusion and left knee sprain/strain related to the work accident. Dr. Scott took Petitioner off work and scheduled a follow-up in one week (Px. 3).

Petitioner was seen again by Dr. Scott on December 13, 2016, at which time the doctor ordered a MRI of the cervical spine and a MRI of the right shoulder. Dr. Scott continued the off-duty restriction (Px. 3).

The MRIs were both performed at Carle on February 3, 2017. The MRI of the right shoulder showed a complex tear and degeneration of the posterior labrum. The MRI of the cervical spine showed disc disruption at C3-C4, moderate stenosis at C4-C5 and C5-C6, and severe stenosis at C6-C7 (Px. 3).

Petitioner presented again to Dr. Scott on February 14, 2017, at which time the doctor referred him to the Carle Spine Center and continued the off-duty restriction (Px. 3).

Petitioner testified he was then directed by Respondent to see Dr. David Schwartz of OrthoIndy for an independent medical examination on March 8, 2017. Dr. Schwartz issued a report on March 28, 2017, which concluded that Petitioner was suffering from right cervical radiculopathy which was caused by his fall at work and suggested that surgery may be necessary. Dr. Schwartz opined that Petitioner should be restricted to no use of the right upper extremity (Px. 4).

A letter dated April 20, 2017, was sent by Dawn Holmes, Respondent's Human Resources Manager, to Petitioner advising they had light duty available per Dr. Schwartz's restrictions (Px. 15). Holmes testified that prior to sending that letter she called CCMSI to make sure Respondent could bring Petitioner back to work.

Petitioner testified that on April 22, 2017, or April 23, 2017, his TTD was terminated. Petitioner testified he did not return to work at that time because he had never received a copy of the restrictions issued by Dr. Schwartz.

On April 25, 2017, Jackie Esteves of CCMSI sent an email to Attorney Lichtenberger to which was attached the IME report of Dr. Schwartz. On April 26, 2017, Attorney Lichtenberger responded by informing her that Petitioner would return to work on April 27, 2017, pursuant to Dr. Schwartz's restriction of no use of the right upper extremity and that Petitioner had chosen to start treating with Safeworks Illinois (Px. 16).

Petitioner testified he chose to receive treatment from Safeworks Illinois and was first seen by Dr. David Fletcher on April 26, 2017. Dr. Fletcher diagnosed injury to the cervical spine and right shoulder consistent with the previous doctors' findings and diagnostic studies. The doctor prescribed physical therapy, referred Petitioner to Dr. Jesse Butler, and limited his activities to lifting ten (10) pounds or less, limited use of the right upper extremity, no ladder climbing, no above shoulder work, and no commercial driving (Px. 5).

Petitioner testified he returned to work on April 27, 2017, and counted some trailers but spent the majority of the day sitting around.

On April 27, 2017, Pam DeVault, on behalf of Respondent, sent another "Light Duty Work" letter to Petitioner advising they had work for him pursuant to the restrictions issued by Dr. Fletcher (Rx. 3).

Petitioner presented to ATI Physical Therapy for an initial evaluation on April 27, 2017. Petitioner attended seven (7) physical therapy sessions and was discharged on June 15, 2017, due to financial constraints and transportation issues. It was noted that he had made minimal progress during therapy (Px. 6).

Petitioner testified he worked again on April 28, 2017, and the work was very much the same as the previous day.

Petitioner presented to Spine Consultants on April 28, 2017, and was seen by Dr. Jesse Butler, an orthopedic surgeon. Dr. Butler diagnosed radiculopathy and stenosis in the cervical spine. Dr. Butler opined the symptoms are related to the work accident and that Petitioner would likely require surgery (Px. 7).

Petitioner testified he was off work for the weekend, returned to work on May 1, 2017, and spent the morning mostly sitting around. Petitioner testified at some point Respondent directed him to pick up trash in the parking lot, carrying a waste basket and a trash grabber. Petitioner testified Respondent also directed him to empty garbage cans in the break room. Petitioner testified he did not attempt to do either job and testified those jobs were beyond his medical restrictions. Petitioner testified Respondent also directed him to wipe down tables which he did not do.

On May 2, 2017, Jackie Esteves of CCMSI sent a letter on behalf of Respondent to Petitioner informing him that his workers' compensation claim was denied and that all bills for treatment should be submitted to his group carrier (Rx. 3). Petitioner testified his group benefits terminated in early May 2017 because he could not afford the premium.

Petitioner testified he worked for about two hours on May 2, 2017, and was sent home by Dawn Holmes and told they would further address the work accommodation issues the next day.

Respondent's agent, Dawn Holmes, testified she called Petitioner to her office on May 2, 2017, because he was upset. Holmes testified that Petitioner told her he was being asked to do things he could not do. Holmes testified she was unaware that he had been asked to empty garbage receptacles. Holmes testified she offered Petitioner work reading books in the dispatch office but that Petitioner refused to do so. She further said that she told him he did not have to empty the garbage cans, which the Petitioner said were 30 gallon cans. Petitioner testified he was told to either do the work involving trash pickup and emptying of garbage receptacles or go home.

Petitioner testified that Dawn Holmes called him on May 3, 2017, and told him Respondent was unable to accommodate the medical restrictions.

Petitioner was seen again by Dr. Fletcher on May 8, 2017, who continued to diagnose right shoulder and cervical spine problems related to the fall at work (Px. 5).

Petitioner has not had any medical treatment since that time. On July 27, 2017, Jackie Esteves of CCMSI sent an email to Attorney Lichtenberger advising that Respondent was re-directing medical care back to Carle Clinic and instructing Petitioner to contact Carle Orthopedics (Px. 18).

Petitioner testified that since he stopped working in May 2017, he has received one week of TTD.

Petitioner testified he currently experiences pain and stiffness in the neck, right shoulder, and right arm.

Conclusions of Law

In regards to the disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner's accident did arise out of and in the course of his employment by Respondent and that injuries to the cervical spine, right arm, right shoulder, and left knee are causally related to that accident.

In support of these conclusions the Arbitrator notes the following:

First of all, the parties stipulated at arbitration that the steps on which the Petitioner fell were not defective.

Petitioner testified he was required to ascend and descend various sets of steps, at various locations, in order to perform his job duties. Petitioner testified that during at average work shift he would ascend and descend these various sets of steps eight (8) to ten (10) times. Petitioner testified that on December 6, 2016, as he was ascending the steps at Respondent's Danville, IL location, heading toward the dispatch office, he missed a step and fell.

There is no question Petitioner was in the course of his employment when the accident happened. The issue is whether the injuries arose out of the employment. To satisfy that requirement, it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Falling while traversing stairs is a neutral risk and injuries resulting therefrom generally do not arise out of employment. However, an exception to noncompensability under the Act exists where the requirements of a petitioner's employment create a risk to which the general public is not exposed. The increased risk may be qualitative, such as being in a hurry to complete work, or quantitative, such as where a petitioner is exposed to a common risk more frequently than the general public.

In *Village of Villa Park v. IWCC*, 3 N.E.3d 885 (2nd Dist. 2013), the petitioner worked as a community service officer. He was walking down a stairwell to get to the employee locker room when his knee gave out and he fell to the bottom of the stairs. The evidence established he was required to traverse the stairs a minimum of six (6) times per day. The court found that the frequency with which the petitioner was required to traverse the stairs constituted an increased risk on a quantitative basis from that which the general public is exposed. The accident was found to be arising out of the employment.

In *Nee v. IWCC*, 28 N.E.3d 961(1st Dist. 2015), the petitioner worked as a plumbing inspector for the City of Chicago. His job involved inspecting five (5) to seven (7) sites per day, driving from location to location. On one of those inspection visits he tripped over a curb while walking back to his car to go to his next assignment. The court held that the risk of tripping on a curb is a risk to which the general public is exposed daily. However, the court found that because he traveled to different locations and traversed multiple curbs daily it constituted an increased risk on a quantitative basis compared to that which the general public is exposed. The accident was found to be arising out of the employment.

In this case, Petitioner was required to traverse stairs an average of eight (8) to ten (10) times per day, at various locations. This constitutes an increased risk on a quantitative basis from that which the general public is exposed.

Respondent argues that the act of climbing and descending stairs at work is not an act which establishes an increased risk of accidental injury. In support of its argument, respondent cites three Commission decisions which were all issued after the Court's opinion in Villa Park. The Arbitrator believes the cases are to some degree distinguishable from Villa Park. However, the Arbitrator also believes the Commission incorrectly interpreted that decision in their attempt to distinguish it.

In Flatt v. Caterpillar, 16 IWCC 604, a machine operator with a badly degenerated knee injured himself when stepping off a platform which he was required to climb in order to operate his machine. Initially, the Commission wrote that the reason his knee buckled when coming off the platform was because of its severe degeneration. Thus, they concluded that the risk was personal and did not arise out of the petitioner's employment. The Commission went on however, to interpret Villa Park. They said that the Court's decision finding the accident arose out of the petitioner's employment turned not only on the fact that the officer/petitioner had to climb and descend 20 stairs 6 times a day but also on the fact that the respondent knew that his knee was already injured yet they still require him to use the steps. The Arbitrator reads the opinion differently than the Commission. The Court specifically found the increased risk to have been quantitative in nature based upon the frequency step climbing required by the job.

Similarly in Haugh v. Marquette Bank, 16 IWCC 840 and Derousse v. St. Clair County. the Commission placed undue weight on the officer's degenerative knee condition in analyzing whether the was an increased risk.

The Arbitrator believes both the Villa Park and Nee decisions clearly establish that one can prove an increased risk by simply showing a quantitative difference in the exposure to said risk. Quantitative means the petitioner is exposed more frequently than the general public.

Based upon the above analysis, the Petitioner has shown that his accident arose out of his employment

The parties stipulated to causal connection regarding the cervical spine and right upper extremity. The medical records also clearly establish that Petitioner injured his left knee during the accident in question.

In regard to disputed issue (J) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that medical services provided to Petitioner are reasonable and necessary. Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's exhibits 8, 9, 10, 11, 12, 13, and 14. Respondent shall be given credit for medical bills already paid by Respondent

and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit as provided in Section 8(j) of the Act.

In regard to the disputed issue (K) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment consistent with the treatment records of Carle Physician Group, Safeworks Illinois, and/or Dr. Jesse Butler, as well as the examination records and opinions of Dr. Schwartz.

In regard to disputed issue (L) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner is entitled to TTD benefits from December 7, 2016, through April 26, 2017, but not for the periods claimed thereafter.

In support of this conclusion the Arbitrator notes the following:

While it appears from the evidence that the Petitioner was required initially to work outside of his restrictions from both Doctors Schwartz and Fletcher when required to empty 30 gallon trash cans, Ms. Holmes testified that she removed that requirement when she spoke with the Petitioner on May 1. The other work activities which were assigned to the Petitioner could have been done while observing the restrictions of Dr. Fletcher. The Arbitrator believes from the evidence that the Petitioner chose not to try and perform those activities, electing instead to go off work.

First of all, the arbitrator believes the restrictions from Dr. Fletcher, at the time the treating doctor, were more appropriate than those of Dr. Schwartz, an examiner who saw the Petitioner one time in late March. Dr. Fletcher based his restrictions on the diagnosis of a cervical spine injury which required surgery. Dr. Butler later agreed with the surgery recommendation for a multi-level fusion and did nothing to change Dr. Fletcher's restriction.

Ms. Holmes testified that the company had a policy to accommodate work restrictions and that she believed the Petitioner could have been accommodated. The Petitioner testified that he felt the jobs offered to him exceeded his restrictions. Obviously the 30 gallon trash cans did exceed the restrictions, but the Petitioner testified that he didn't even try to wipe down tables, which he probably could have done while observing his restrictions. The Arbitrator believes that if the Petitioner had given a good faith effort to perform the work requested or, in the alternative, consulted with Dr. Fletcher as to whether the work would be acceptable, then his claim for ongoing benefits would be stronger.

The Arbitrator concludes that the Petitioner refused the light duty offered after May 1 and as such his claim for TTD is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBIN FOUNTAIN,

Petitioner,

vs.

NO: 14 WC 13947

STATE OF ILLINOIS,
CHICAGO READ MENTAL HEALTH,

18IWCC0518

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 permanent partial disability (PPD) and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the award of 2% man-as-a-whole (MAW) and finds that Petitioner is entitled to 2.5% loss of use of the leg. The Arbitrator applied the factors from Section 8.1(b) of the Act in arriving at the award of 2.5% MAW. While the Commission adopts the Arbitrator's analysis of the first four factors of Section 8.1(b), the Commission modifies the analysis related to the fifth factor.

The Commission gives the fifth factor some weight noting that there is insufficient evidence establishing that Petitioner has any ongoing back pain related to her injury. The initial medical records reveal that Petitioner injured her right leg only, and the examination was negative for back pain. It was not until several appointments later that there was a mention of back pain. However, one of the medical records revealed that she had back pain in relation to her period. As the records do not support any evidence of disability between the back and the accident, the Commission modifies the award to 2.5% loss of use of the leg, as she only sustained an injury to

18IWCC0518

her right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $529.11 per week for a period of 3-1/7 weeks, (March 19, 2014 through April 4, 2014, April 30, 2014 through May 2, 2014, and June 5, 2014 through June 6, 2014) that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $476.20 per week for a period of 5.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 2.5% loss of use of the leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $48.00 for medical expenses under §8(a) of the Act.

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

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

DATED: AUG 17 2018

MJB/tdm
d: 8/7/18
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOUNTAIN, ROBIN
Employee/Petitioner

Case# **14WC013947**

STATE OF ILLINOIS MHC
Employer/Respondent

18IWCC0518

On 12/18/2017, 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 1.46% 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 AND MACIARIELLO
PATRICK SHIFLEY
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH BLEWITT
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

DEC 18 2017

GERALD A. HASKIN, Acting Secretary
Illinois Workers' Compensation Commission

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

Robin Fountain
Employee/Petitioner

v.

State of Illinois MHC
Employer/Respondent

Case # 14 WC 13947

Consolidated cases: _____

18IWCC0518

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **9/27/17**. 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 **3/14/14**, 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 **$30,952.84**; the average weekly wage was **$793.66**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $48, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $ 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 and attorney temporary total disability benefits of $529.11/week for 3 weeks, commencing 3/19/14 through 4/4/14, 4/30/14 through 5/2/14, and 6/5/14 through 6/6/14, or a total of 2 & 4/7th weeks as provided in Section 8(b) of the Act.

Based on the totality of the evidence, the Arbitrator finds that Petitioner sustained permanent partial disability to the total extent of 2% of permanent partial disability under §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.

#001 Arb. George Andros
Signature of Arbitrator

December 15, 2017
Date

DEC 18 2017

FINDINGS OF FACT 14 WC 13947

The Petitioner testified that she was an employee of the State of Illinois working at Chicago-Read Mental Health Center for 24 years as of March 7, 2014. Petitioner claimed to have suffered an injury on that date.

Petitioner testified that on March 7, 2014 she took a lunch break with a coworker, Rose Hixon. Returning from her lunch, Petitioner and Ms. Hixon parked Petitioner's car in the designated employee only parking area. Walking along a path from employee only parking to the building, Petitioner encountered a raised crack in the sidewalk and tripped. She fell onto her right side and braced herself onto her left arm. She felt immediate pain ; she was bleeding as a result of the fall. Ms. Hixon helped her up after her fall and that she returned to work.

Petitioner immediately reported her injury and filled out an incident report on the same day, Resp 1 admitted. Per the Report the Petitioner was returning from lunch and walking back from the parking lot when she fell. (Rx 1) The Petitioner claimed that the injury was witnessed by Rose Hixson, and that she had injured her right side, right side of knee, her right hip, her ankle, and her tail bone. (Rx 1)

Their after she received treatment from Physicians Immediate Care, Adventist Health Partners, and MacNeal Hospital.

On March 18, 2014 the Petitioner was seen at Physician Immediate Care. She was treated for contusion of the hip and abrasion of the leg. She was released to full duty work. (Px 2)

On March 19, 2014 the Petitioner was seen at Adventist DOC Family Practice. The Petitioner reported knee pain after falling at work while walking. She reported having been placed on light duty by the company doctor. (Px 2)

The Petitioner was given an order by Dr. Siddiqui for physical therapy at MacNeal Hospital to treat her right knee pain. (Px 2) Petitioner was placed at sedentary duty on March 19, 2014 by Dr. Siddiqui. (Px 2)

On March 31, 2014 the Petitioner was seen at MacNeal Hospital. She reported a fall at work which injured the right side of her body, swollen knee, right hip and tailbone. The Petitioner underwent physical therapy at MacNeal Hospital on April 4, 7, 11, 16, 18, 22, 25, May 6, and 9, reporting right knee pain, right hip pain, and right sided back pain.(Px 2)

On April 4, 2014 the Petitioner was seen at Adventist DOC Family Practice for headache. Petitioner's intake notes record a fall on March 14, 2014 at work and ongoing PT. (Px 2) She was returned to work as of April 4, 2014. (Px 1)

On May 1, 2014 the Petitioner was seen at Adventist DOC Family Practice by Dr.Crystal Peoples. She complained of leg cramps and had treated with ibuprofen. She was excused from work for three days, and was to return to work on May 2, 2014. (Px 2)

On May 14, 2014 the Petitioner was seen at Adventist DOC Family Practice by Dr. Siddiqui. She complained of headache. She was excused for work for two days, and was to return to work on May 16, 2014. (Px 1)

On June 9, 2014 the Petitioner was seen at Adventist DOC Family Practice by Dr. Siddiqui. At that time she complained of pain in her right back side, and for follow up on pain in her head. (Px 1) Petitioner was excused from work for June 5 and 6, 2014. (Px 1)

Petitioner testified that all of her medical bills were paid for by her group health insurance, but that she did have to pay copays. The Medical bills of Amita Health, formerly Adventist, show as paid by insurance with the exception of copays.(Px 3) The Bills of MacNeal Hospital show payment by the Chicago Health System on May 8, 2014 and June 9, 2014. A balance bill is claimed. (Px 2)

Petitioner testified that she may have fallen in the time between March 7, 2014 and June 2014. Petitioner testified however, that she had not injured herself in any falls other that the March 7, 2014 fall.

CONCLUSIONS OF LAW

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Petitioner has met her burden of proof by a preponderance of the credible evidence that an injury occurred on March 7, 2014 which arose out of and in the course of her employment with Respondent.

The Petitioner testified unrebutted she sustained an accident plus an injury while returning from her lunch break. She alleges to have tripped and fallen after returning to the employee only parking lot on her employer's property. The Petitioner's testimony is consistent with and reinforced by the report of the injury she gave on the date of her injury. (Rx 1)

Under what is commonly referred to as the "parking lot exception" courts have allowed recovery when an employee is injured in a parking lot provided by and under the control of the employer. *Vill v. Industrial Comm'n*, 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*

Once the parking lot is considered part of the employer's premises, any injury on the parking lot is compensable as 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.

In *De Hoyos* the Illinois Supreme Court concluded that "when an employer provides a parking lot for employees and an employee falls on the parking lot, this fact being uncontroverted on the record, the employee is entitled to recover as a matter of law" adding also that "an employee who falls on a parking lot provided by his employer while proceeding to work is subjected to hazards to which the general public is not exposed." *De Hoyos v. The Industrial Comm'n*, 185 NE 2d 885 (1962), at 887.

In *Chmelik v. Vana*, the court held that an injury "accidentally received on the premises of the employer by an employee going to or from his actual employment by a customary or permitted route, within a reasonable time before or after work, is received in the course of and arises out of the employment." *Chmelik v. Vana*, 31 Ill. 2d 272, 279, 201 N.E.2d 434, 439 (1964).

Here the Petitioner's testimony that she had returned to the Respondent's property and parked in an employee only parking lot is unrebutted. The Petitioner, having returned from her lunch break to an employer provided parking lot, and having tripped on a sidewalk between the parking lot and the hospital, was in the course of her duties and the hazards of the sidewalk were those to which the general public were not exposed.

Based upon the totality of the evidence, the Arbitrator thereby finds that the Petitioner's fall on the sidewalk between the employee only parking lot and the hospital was an injury which arose out of and in the course of employment.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Based upon the totality of the evidence, the Petitioner has met her burden of proof by a preponderance of the evidence that the current condition of her right knee, back, and hip are causally related to the injury.

Petitioner presented unrebutted testimony that she had fell and injured her right knee, hip, and back. Her initial report of injury was introduced by the Respondent and corroborates her testimony. (Rx 1) The medical records of from Physicians Immediate Care, Adventist Health Partners, and MacNeal Hospital document a fall at work which resulted in an injury to the right knee.

Again, based upon the totality of the evidence, the Petitioner has a current condition of ill-being which is causally related to the work accident of March 7, 2014.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?,

Based upon the totality of the evidence, Petitioner has met her burden of proof by a preponderance of said credible evidence that the medical services that were provided were reasonable and necessary under section 8a.. Petitioner introduced the unrefuted medical records of Physicians Immediate Care, Adventist Health Partners, and MacNeal Hospital. The Arbitrator adopts those records and opinions and findings therein.

The medical records introduced demonstrate that the Petitioner received conservative care for right knee, back, and hip injuries. The Arbitrator finds that all dates of treatment at Physicians Immediate Care and MacNeal Hospital relate to the Petitioner's fall on March 7, 2014.

The medical records of Adventist Health Partners show related and reasonable treatment on March 19, May 1, and June 9 related to her right hip, right knee, and right low back injuries.

The Arbitrator declines to award April 4 and May 14, 2014 dates of treatment with Adventist Health Partners as those dates of treatment relate to Petitioner's headaches, which do not appear to be related to the claimed injury.

Regarding the payment for reasonable medical services, the Arbitrator finds that the bills introduced by the Petitioner show that the Petitioner made payment of copays on March 19, May 1, and June 9 totaling $48.

The Arbitrator orders that the Respondent make payment to the Petitioner of $48.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (K) WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE IN DISPUTE;, THE ARBITRATOR CONCLUDES AS FOLLOWS:

Based upon the totality of the evidence, The Arbitrator finds by the preponderance thereof she is entitled to payment of temporary total disability benefits from March 19, 2014 through April 4, 2014 when she was released to return to work by Dr. Siddiqui. (Px 1) Additionally, medical records indicate the Petitioner was placed of work from April 30 – May 2, and June 5 and June 6 by her physicians at Adventist for reasons relating to this injury. (Px 1)

The Arbitrator therefore awards 2 & 4/7th weeks TTD for the periods from 3/19/14 – 4/4/14, 4/3014 – 5/2/14, and 6/5/14 – 6/6/14. Said TTD shall be paid to the petitioner and her attorney.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY; THE ARBITRATOR CONCLUDES AS FOLLOWS:

Because Petitioner's accident occurred after 9/1/11, the Arbitrator looks to section 8.1(b) of the Act for guidance in determining nature and extent.

The first factor, AMA Guide impairment ratings, is not relevant since neither party offered such a rating into evidence.

The second factor, occupation, is given no weight since the Petitioner returned to her pre-injury position.

The third factor, age, is given no weight as the Petitioner's age of 51 years is not shown by any evidence to be effected.

The fourth factor, future earning capacity, is given no weight as Petitioner testified that she continues to be paid at the set pay-scale for State of Illinois Employees.

The fifth factor, evidence of disability corroborated by medical records, is given weight as the Petitioner testified that she still experiences pain in her low back and knee. This is consistent with the treatment of the Petitioner's knee which required 12 PT visits to resolve/.

In light of the foregoing the Arbitrator finds that the Petitioner is permanently partially disabled to the extent of 2 % disabililty under section 8d2 for all injuries together.

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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERI MASTERS,

Petitioner,

vs. NO: 16 WC 35040

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES,

Respondent.

18IWCC0519

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability benefits (TTD), and nature and extent, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent on October 25, 2016. The Commission finds that Petitioner's left hand condition was causally related to the accident. The Commission also finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the October 25, 2016 accident. The Commission further finds that Petitioner is entitled to TTD benefits from November 1, 2016 through December 5, 2016. The Commission awards Petitioner three-percent (3%) loss of use of the left hand.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Petitioner testified that her work for Respondent involved working with the child support office, the Circuit Clerk, and the state disbursement unit. (T.13). She was required to travel to different courthouses and circuit clerks' offices for research: "I have 31 counties. I travel to ten of them. I do travel to the other 21 once a year, but I do travel at least monthly to the other 11 counties that I have." (T.14-15; T.25). Petitioner had specifically traveled to Randolph County once a month for the past five years. (T.16; T.37). Petitioner also handled phone calls from circuit clerks, clients, and the state disbursement unit, and answered questions in the local office regarding the state disbursement unit. (T.14).

2. Petitioner testified as to Petitioner's Exhibit 1, which was a photograph. "That would be the courthouse, and this would be, I think the employee parking lot, but the entrance to the courthouse is here, and I park, usually, in this parking lot, unless there is an available one here that I don't have to parallel park in." (T.16). Petitioner stated that no one from work had directed her to park in a specific area to go into the courthouse. (T.37).

3. Petitioner testified that on October 25, 2016, while walking across grass adjacent to her automobile, she had an accident after tripping on some mushrooms. She stated that she had completed her research at the courthouse, and was leaving through a public entryway around 10:00 AM. (T.21; T.23). She described how she was injured on October 25, 2016:

> I was coming out of the courthouse. I had the file folder in my arms, and I had a rental car because at the time we were doing rental cars. And I was walking towards the parking lot thinking, which car am I in today, and got – and I was on the sidewalk, and then I got ready to walk into the grass to get into the parking lot, and right before the parking lot was these mushrooms, and I guess my foot hit them, and I fell right into the parking lot on my right side. (T.18-19).

4. Petitioner indicated that the route she took to and from the courthouse was her usual and customary route, because it was the most direct and safest route. (T.23; T.44-46). She had been walking at a normal pace. (T.38). Petitioner had fallen between her vehicle and another vehicle. (T.22). She injured her left wrist and hand in the fall. (T.20). Had she not fallen, Petitioner testified that she would have been heading to the next courthouse in Murphyboro, Jackson County. (T.23).

5. Petitioner stated that on October 25, 2016, she was wearing slip-on Clark black leather shoes. (T.24). She stated that the grassy area was not uneven, and it had not been raining, so the pavement was not wet. (T.38-39). Petitioner testified that the mushroom she had tripped on was the size of a dinner plate or about one foot in diameter. (T.40).

6. Petitioner visited the Walk-In Clinic on October 25, 2016. The medical record indicated that Petitioner had left shoulder, elbow, and wrist pain after falling over large mushrooms in the parking lot. Petitioner had left shoulder tenderness and very limited range of motion in the left wrist due to pain. X-rays of the left shoulder and left wrist were taken at Marion Diagnostic Center on October 25, 2016; no fractures were identified. (PX1; T.26). Petitioner was diagnosed with a left shoulder and wrist sprain. Petitioner was given a sling and taken off work. (RX1).

7. On October 31, 2016, Petitioner returned to the Walk-In Clinic for her persistent, severe pain in her left wrist, hand, and shoulder. Findings on examination included swelling in the left wrist and hand with limited range of motion. A wrist splint was applied, and Petitioner was referred to an orthopedic specialist. (PX3; T.26).

8. Petitioner consulted with Physician Assistant Tim Jennings at Orthopaedic Institute of Southern Illinois on November 29, 2016. The mechanism of injury recorded was: "She was at the courthouse in Chester when she slipped down some mushrooms. She fell, a ground level fall, trying to catch herself on an outstretched left forearm." Petitioner was not presently working. Examination indicated left wrist pain diffusely on the carpal row; Petitioner had sharp tenderness over the scaphoid and distal ulna. X-rays of the left forearm and wrist revealed no obvious abnormality with the exception of a slight deformity in the scaphoid. Mr. Jennings ordered an MRI of the left wrist and recommended Medrol Dosepak as an anti-inflammatory. He also had Petitioner wear a thumb splint instead of a volar hand-based resting splint. (PX4).

9. On December 5, 2016, Petitioner reviewed the results of the left wrist MRI with Dr. Steven Young; the MRI had been completed on December 1, 2016. (PX4; T.26). Dr. Young noted some perched appearance of the extensor carpi ulnaris over the ulnar styloid. There was also some thinning, possible central perforation of the triangular fibrocartilage with no evidence of any obvious peripheral avulsions. At this appointment, Dr. Young administered an injection to Petitioner's left wrist. (PX4; T.26). He then recommended physical therapy and released her to work with restrictions of no use of the left upper extremity. Petitioner commenced therapy at Dr. Young's office on December 7, 2016, and was discharged on February 14, 2017. (PX4; T.26).

10. Petitioner had visited Physician Assistant Tim Jennings on January 20, 2017 with new symptoms of numbness and tingling in the left thumb; an EMG/NCV was ordered. On March 2, 2017, Dr. Young reviewed the results of the EMG/NCV which were negative. Dr. Young believed Petitioner had possible peripheral compression neuropathy based on her physical examination. Petitioner exhibited positive Tinel's at the wrist and mildly positive Tinel's at the elbow. Dr. Young believed that Petitioner may require surgery in the future, but for now he wanted to try a carpal tunnel splint and he gave her a Medrol Dosepak. Dr. Young also stated that Petitioner may also require an injection into the carpal

tunnel or a trial of a nighttime elbow extension splint. He allowed Petitioner to return to work without restriction. (PX4).

11. By April 3, 2017, Dr. Young had changed Petitioner's diagnosis to left carpal tunnel syndrome. The medical record also indicated that Petitioner had been treating for an unrelated right radial head injury. (PX4). Petitioner testified that she had fallen onto her right elbow while at a Blues games in St. Louis; she did not injure her left side in that fall. (T.28). By April 3, 2017, Petitioner wanted to give her left wrist condition more time to heal as it was improving. Petitioner reported using her left arm more and the numbness and tingling had nearly resolved; she was also not experiencing any radial and ulnar-sided wrist pain. Petitioner did indicate slight discomfort to deep palpation over the radial aspect of the wrist, as well as over the ulna aspect of the wrist over the distal ulna and fovea area. (PX4).

12. On May 30, 2017, Petitioner was released by Dr. Young on a return-as-needed basis. Petitioner reported doing quite well; she had no complaints of numbness or tingling in her extremities. Examination revealed no swelling in the left upper extremity, no pain with palpation about the wrist, either on the radial or ulnar aspects. Petitioner had negative provocative signs for carpal tunnel, and she had no pain with palpation about the elbow either medially or laterally. Petitioner was released to work full duty; she did return to work for Respondent full duty. (PX4; T.29; T.31).

13. As of the date of arbitration, Petitioner testified that her left wrist still felt weak and sometimes it went numb. "Sometimes it just doesn't work. It kind of – you know, you're holding something, and it may drop. But the pain isn't there all the time. It just comes and goes. I never know when it is going to hurt." (T.28). Petitioner was not actively treating for her left arm at the time of arbitration. (T.31-32).

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37 (1972).

The Commission disagrees with the Arbitrator's finding that Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent on October 25, 2016. The Arbitrator based her Decision on the fact that Petitioner did not fall on Respondent's premises, but instead fell in an area that was near the parking lot for the courthouse and open to the general public. The Arbitrator noted that there was no evidence of any defect in the area where Petitioner fell. The Arbitrator further stated that Petitioner had been carrying a file folder of papers when she fell. Nonetheless, "[w]hile Petitioner may have been performing a task

incidental to her employment when her fall occurred, there was no testimony offered that the file folder was large, heavy, a distraction or in any way contributed to the fall occurring." (Arbitrator's Decision, pgs. 4-5). As the Arbitrator did not find accident, she rendered the remaining issues moot.

By its Brief, Respondent does not dispute that Petitioner's fall occurred in the course of her employment. The primary issue is whether Petitioner's fall and resulting injuries arose out of said employment.

> 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 (West 2008). An injury 'arises out of' one's employment if 'its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury.' A risk is 'incidental to the employment' when it 'belongs to or is connected with what [the] employee has to do in fulfilling his duties.'
>
> 'In the course of the employment' refers to the time, place, and circumstances under which the claimant is injured. Injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment.
>
> The determination of whether an injury to a traveling employee arose out of and in the course of employment is governed by different rules than are applicable to other employees. A 'traveling employee' is one whose work requires him to travel away from his employer's office. It is not necessary for an individual to be a traveling salesman or a company representative who covers a large geographic area in order to be considered a traveling employee. Rather, a traveling employee is any employee for whom travel is an essential element of his employment. A traveling employee is deemed to be in the course of his employment from the time that he leaves home until he returns. An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable, *i.e.*, conduct that 'might normally be anticipated or foreseen by the employer.' *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P14-P17.

In this claim, the Commission finds that both the Arbitrator and Respondent failed to address the issue of whether Petitioner was a traveling employee on the date of accident; Petitioner analyzed this issue in her Brief. This inquiry is critical to the analysis for accident as traveling employees are governed by different rules than that established for other employees. *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P16. A traveling employee is any employee for whom travel is an essential element of his employment. *Id.* In the present case, Petitioner's duties qualify her as a traveling employee because travel is an essential element of Petitioner's employment; her work requires her to travel away from her employer's office to various locations throughout Illinois. *Mlynarczyk v. Ill. Workers' Comp. Comm'n*, 2013 IL App (3d) 120411WC, P16. Although Petitioner did testify that the traveling was part of her duties, neither Petitioner nor Respondent elicited any further testimony as to Petitioner's other duties, the time spent traveling versus other tasks, etc. (T.15). Petitioner testified that her job was to go out to the different courthouses and go through the records and obtain research, but she also dealt with calls from various entities and answered questions in the local office regarding the state disbursement unit. (T.14). This was the only testimony relative to other duties; the remainder of her testimony pertained to her traveling duties. Thus, the Commission finds that travel is an essential element of Petitioner's employment and Petitioner is a traveling employee.

"A finding that a claimant is a traveling employee, however, does not relieve the employee of the burden of proving that her injury arose out of and in the course of her employment." *Mlynarczyk v. Ill. Workers' Comp. Comm'n*, 2013 IL App (3d) 120411WC, P17. Our Appellate Court has instructed that a traveling employee is deemed to be in the course of his employment from the time that he leaves home until he returns. *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P16. Although Respondent does not dispute the "in the course of" element, it is worth emphasizing as Respondent's brief does not provide the correct analysis specific to traveling employees. Petitioner testified that right before her fall on October 25, 2016, she had just completed her research and was leaving the courthouse around 10:00 AM. She had a file folder in her arms and was walking towards her car that was parked in the parking lot. She further testified that had she not fallen, she would have been heading to the next courthouse in Murphyboro, Jackson County. The Commission finds that by these facts, Petitioner, as a traveling employee, was in the course of her employment, at the time of her fall.

"An injury sustained by a traveling employee arises out of his employment if he was injured while engaging in conduct that was reasonable and foreseeable, *i.e.*, conduct that 'might normally be anticipated or foreseen by the employer.'" *Kertis v. Ill. Workers' Comp. Comm'n*, 2013 IL App (2d) 120252WC, P16. Here, the Arbitrator applied the legal test applicable to non-traveling employees rather than the special rules applicable to traveling employees. Our Appellate Court has stated in similar cases that where the analysis applicable to traveling employees is utilized, "we do not need to address the claimant's alternative argument that he was exposed to a neutral risk more frequently than members of the general public by virtue of his employment." *Id.* at 20. The understanding behind this is that since Petitioner is a "traveling employee," her exposure to the hazards of the streets is, by definition, greater quantitatively than that of the general public, as long as her conduct at the time of the injury was reasonable and foreseeable to the employer. *Mlynarczyk*

v. Ill. Workers' Comp. Comm'n, 2013 IL App (3d) 120411WC, P19. Thus, in this case, the dispositive question is whether Petitioner was injured while engaging in conduct that was reasonable and that might reasonably be anticipated or foreseen by the employer. *Id.* at 19.

In the case at bar, Petitioner testified that she was on the sidewalk walking towards her vehicle that was parked in the parking lot, when she walked into a grassy area, and right before she stepped into the lot, she tripped and fell on mushrooms that were approximately one foot in diameter. Petitioner's duties required her to travel on a regular basis, which also required the use of a certain vehicle prescribed by Respondent, *i.e.*, the rental car. By her testimony and her Brief, Petitioner stated that Respondent never directed her to park in a specific area, so she parked in a public parking lot as she had done on numerous occasions. Petitioner further indicated that the route she took to and from the courthouse was her usual and customary route, because it was the most direct and safest route. It was both reasonable and foreseeable that Petitioner would regularly park in a lot or area close to the courthouse and walk to the courthouse from the lot. Thus, under the rules applicable to traveling employees, the facts establish that Petitioner's injuries arose out of her employment.

Therefore, the Commission finds that the credible evidence establishes that Petitioner sustained an accident arising out of and in the course of her employment on October 25, 2016.

The Commission further finds that Petitioner's condition is causally related to the accident. A chain-of-events analysis supports causal connection for Petitioner's injury; following her fall on October 25, 2016, Petitioner sought treatment with the Walk-In Clinic that same date. She was initially diagnosed with a left shoulder and left wrist sprain. Petitioner completed an MRI of the left wrist on December 1, 2016, and reviewed it with Dr. Young on December 5, 2016. Dr. Young noted some perched appearance of the extensor carpi ulnaris over the ulnar styloid. There was also some thinning, possible central perforation of the triangular fibrocartilage. Following Petitioner's fall and subsequent diagnosis, Petitioner necessitated treatment by way of anti-inflammatories, a sling and splint, an injection to the left wrist, and two months of physical therapy. Respondent offered no evidence to rebut Petitioner's testimony or the medical evidence offered at arbitration. Therefore, as Petitioner sustained a work-related accident, the Commission finds that Petitioner's condition is causally related to the accident.

The Commission awards all reasonable and necessary medical expenses as evidenced by the billing records contained in Petitioner's Exhibit 5, totaling $4,187.81, limited to the lesser of the fee schedule and/or the negotiated rated paid by Respondent's group health carrier. By Respondent's Brief, the only basis for disputing medical expenses was the fact that Petitioner failed to prove accident; the Arbitrator and Respondent considered this issue moot, and in fact, Respondent offered no argument or evidence disputing the reasonableness and necessity of the medical services provided. The parties did stipulate that Respondent was entitled to a credit for all amounts paid under its group health plan, if any, under Section 8(j) of the Act.

The Commission further awards TTD benefits to Petitioner based upon the stipulation of the parties; Respondent had stipulated to Petitioner's entitlement to five (5) weeks of TTD from November 1, 2016 to December 5, 2016. The parties further stipulated that Respondent was entitled to a credit of $4,851.61 for TTD previously paid.

As to the nature and extent of Petitioner's injury, the Arbitrator did not consider the five factors under Section 8.1(b) of the Act as she considered the issue of nature and extent moot. Respondent also considered the issue moot and disputed any liability toward permanent partial disability (PPD) benefits on the basis that Petitioner failed to prove accident.

Having found accident and causal connection in this claim, the Commission awards Petitioner three-percent (3%) loss of use of the left hand, taking into consideration the following five factors listed under Section 8.1(b) of the Act:

(i) Impairment Rating: No weight should be given to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: The Commission gives this factor some weight, noting that Petitioner was released to work full duty, and she returned to work for Respondent.

(iii) Petitioner's Age: Petitioner was 52 years old on the accident date; the Commission gives this factor no weight as there is no evidence in the record that Petitioner's age had any effect on the level of permanent partial disability.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Commission gives this factor great weight. Petitioner had complaints to her left shoulder and left elbow. She was initially diagnosed with a left shoulder and left wrist strain. However, about one week later, after October 31, 2016, there is no further mention of left shoulder complaints and Petitioner received no formal treatment for her left shoulder other than a sling. The record is also silent as to the left elbow until March 2, 2017, when Petitioner began reporting new symptoms of numbness, as well as tingling in her left thumb. Dr. Young noted positive Tinel's at the wrist and mildly positive Tinel's at the elbow; he diagnosed Petitioner with left carpal tunnel syndrome. However, the results of an EMG/NCV were negative. As noted above, the December 1, 2016 MRI of the left wrist revealed some perched appearance of the extensor carpi ulnaris over the ulnar styloid, and there was also some thinning, possible central perforation of the triangular fibrocartilage.

Petitioner was discharged from treatment on May 30, 2017. She reported doing quite well; she had no complaints of numbness or tingling in her extremities. Examination

revealed no swelling in the left upper extremity, no pain with palpation about the wrist, either on the radial or ulnar aspects. Petitioner had negative provocative signs for carpal tunnel, and she had no pain with palpation about the elbow either medially or laterally.

As of the date of arbitration, Petitioner testified that her left wrist still felt weak and sometimes it went numb. "Sometimes it just doesn't work. It kind of – you know, you're holding something, and it may drop. But the pain isn't there all the time. It just comes and goes. I never know when it is going to hurt." Petitioner was not actively treating for her left arm at the time of arbitration.

Based on the totality of the evidence, the Commission awards Petitioner three-percent (3%) loss of use of the left hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 7, 2017, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $970.27 per week for a period of five (5) weeks, from November 1, 2016 to December 5, 2016, 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 shall be given a credit of $4,851.61 for TTD previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses as detailed in Petitioner's Exhibit 5 totaling $4,187.81 pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit for all amounts paid under its group health plan, if any, under Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 6.15 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused three-percent (3%) loss of use of the left hand.

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

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

DATED: AUG 17 2018
MJB/pm
O: 08-07-18
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MASTERS, TERI
Employee/Petitioner

Case# **16WC035040**

IL DEPT OF HEALTHCARE & FAMILY SERVICES
Employer/Respondent

18IWCC0519

On 12/7/2017, 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 1.45% 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:

4075 FISHER KERHOVER COFFEY ET AL
JASON E COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

DEC 7 - 2017

GERALD ANASCIA, Acting Secretary
Illinois Workers' Compensation Commission

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

Teri Masters
Employee/Petitioner

v.

Illinois Department of Healthcare & Family Services
Employer/Respondent

Case # **16** WC **35040**

Consolidated cases: **n/a**

18IWCC0519

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 **November 15, 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 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.

In the year preceding the injury, Petitioner earned **$75,681.32**; the average weekly wage was **$1,455.41**.

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

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

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

Respondent shall be given a credit of **$4,851.61** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,851.61**.

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

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit for **all amounts paid under group health plan** 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.

Millinda M. Rowe-Gillibrand

Signature of Arbitrator

12/4/17

Date

DEC 7 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Teri Masters
Employee/Petitioner

Case # 16 WC 35040

v.

Consolidated cases: N/A

Illinois Department of Healthcare & Family Services
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she works in the child support office for the Respondent, Illinois Department of Healthcare and Family Services. Petitioner testified that part of her job duties was to travel to area courthouses to gather information on court cases. She testified that she visited the Randolph County courthouse monthly to gather court case information.

Petitioner testified that on October 25, 2016, she was walking back to her vehicle after exiting the Randolph County courthouse when she fell after tripping on a mushroom in a grassy area near the parking lot. Petitioner testified that the accident occurred about 10:00 a.m. At the time of arbitration, Petitioner described her path from the courthouse entrance to her car in the courthouse parking lot. She testified that she went across the crosswalk across the street, turned left down a sidewalk and then crossed over a small grassy area towards the parking lot. She described the grassy area near where her car was parked as about 5-feet wide. She testified that this was the typical path that she took to the parking lot from the courthouse. She testified that she did not see any mushrooms in the grassy area before she fell. She testified that she believed it was the mushroom that caused her fall because she felt something hit her foot right before she fell.

After having described the treatment she underwent for her injuries, Petitioner testified that her wrist and hand are weaker now, that she has complaints of numbness, that she occasionally drops things and that her pain comes and goes. She testified that she was released to work without restrictions.

On cross examination, Petitioner testified that no supervisor or any other person at work instructed her where to park at the Randolph County courthouse. Petitioner testified that she did not know who maintained the area in which she fell. She testified that she was walking at a normal pace and was not in a hurry. She testified that she did not recall the grassy area where she fell to be uneven. She testified that the reason she believed that it was a mushroom she tripped on was because she felt her toe hit something before she fell. She described the mushroom as being 1-foot in diameter. She testified that after she fell, she did not have any mushroom residue on herself and that she did not see any smashed mushroom. She testified that the mushroom was solid enough that she described her fall as a trip as opposed to a slip and that the mushroom stubbed her toe.

On cross examination, Petitioner testified that it was possible that after crossing the crosswalk to continue straight on the sidewalk and into the parking lot without having to cross the grassy area where she

fell. She testified that she crossed the grassy area because it was the most direct route to her car. She testified that walking on the sidewalk to the parking lot as opposed to crossing the grassy area would have been about an additional 10 feet of walking. She testified that she believed crossing the grassy area was the safest path to travel as she might get hit by a car while walking in the parking lot. She further testified that it is always a possibility to get hit by a car while walking in a parking lot.

On cross examination, Petitioner testified she had returned to work full duty without restrictions. She testified that she had recently had a performance evaluation, that she had satisfactory results and that she had no complaints from her supervisors. She testified that she will be retiring in February of 2018.

The Picture of the Randolph County Courthouse was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The Incident Report was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The report noted that Petitioner indicated that she was walking across the grass to get to her car in the parking lot and that she tripped over large mushrooms and felt onto the concrete, hitting her left hand on the concrete. It was noted that Petitioner also went down on her knees. It was noted that Petitioner fell in the parking lot across from the Randolph County Courthouse in Chester. (PX2).

The medical records of Marion Diagnostic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent x-rays of the left shoulder on October 25, 2016, which were interpreted as revealing no acute fracture. X-rays of the left wrist also performed on October 25, 2016 were interpreted as revealing no acute fracture. The Walk-In Clinic noted that Petitioner was seen on October 31, 2016, at which time it was noted that she was seen for a re-check of her left shoulder and arm. It was noted that Petitioner stated that it was worse and that she was still having pain and swelling. It was noted that Petitioner continued to have severe pain in the left wrist and hand and that her left shoulder was improving. The diagnosis was noted to b that of left shoulder, wrist and hand pain. A wrist splint was applied. Petitioner was referred to Orthopedics for further evaluation and a possible MRI. (PX3).

The medical records of The Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on November 29, 2016, at which time it was noted that on October 25, 2016 she was at the courthouse in Chester when she slipped down some mushrooms. It was noted that Petitioner fell, a ground-level fall, trying to catch herself on an outstretched left forearm. It was noted that Petitioner had had continuous pain since the date of accident which she described as pierce, stabbing and sharp. It was noted that Petitioner had tried heat and ice on her own but had had no formal treatment. Petitioner was recommended to proceed with an MRI of the left wrist and to take an anti-inflammatory. At the time of the December 5, 2016 visit, it was noted that Petitioner had had no substantial improvement and had tried a Medrol Dosepak. It was noted that Petitioner denied any popping or clicking in the left wrist. It was noted that it appeared on the MRI to be some perched appearance of the extensor carpi ulnaris over the ulnar styloid but otherwise a fairly benign evaluation. It was noted that there was some thinning, possible central perforation of the triangular fibrocartilage with no evidence of any obvious peripheral avulsions. The assessment was noted to be that of left wrist pain. Petitioner was given an injection which she tolerated well. Petitioner was placed back in a splint and instructed to start therapy. (PX4).

The records of The Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on January 20, 2017, at which time it was noted that she had limited benefit from the injection. It was noted that Petitioner was now complaining of numbness and tingling in the right [*sic*] thumb which was a new onset of symptoms. The assessment was noted to be that of new onset of numbness and tingling involving the thumb of the left hand. Petitioner was instructed to proceed with a nerve conduction study of the left

hand. At the time of the March 2, 2017 visit, it was noted that Petitioner had been in a thumb spica splint and stated that she had very minimal discomfort in the hand and occasionally had some tingling in the long and the ring finger. It was noted that the small finger sometimes was involved but to a lesser extent. It was noted that the nerve conduction study was found to be negative. The assessment was noted to be that of possible peripheral compression neuropathy. Petitioner was instructed to try a carpal tunnel splint and was given a Medrol Dosepak. It was noted that Dr. Young was reluctant to perform surgery based on the negative nerve conduction study but that it was certainly not outside the realm of possibility if she continued to have problems and had evaluation consistent with peripheral compression neuropathy. At the time of the April 3, 2017 visit, it was noted that Petitioner had previously been treating for a right radial head injury and had no real complaints and as far as the right upper extremity was concerned she felt that she had been making good progress. It was noted that as for the left side, Petitioner stated that it was getting better, that she had been utilizing the left side quite a bit and had become more functional and that the numbness and tingling was nearly resolved. It was noted that Petitioner initially had radial and ulnar-sided wrist pain, but stated that there were no real problems at that point in time. The assessment was noted to be that of left wrist pain, which appeared to be resolving. (PX4).

The records of The Orthopaedic Institute of Southern Illinois reflect that Petitioner was seen on May 30, 2017, at which time it was noted that she had some left upper extremity discomfort, which was essentially healed at that point. It was noted that Petitioner had been effectively performing work activities with no restrictions and that she would be retiring in the very near future. It was noted that Petitioner had no complaints of numbness or tingling in the extremities and felt that she was doing quite well. The assessment was noted to be that of previous left wrist pain. It was noted that Petitioner could return to work full duty and was to return as needed. (PX4).

Included within the records of The Orthopaedic Institute of Southern Illinois was a Physical Therapy Initial Evaluation dated December 7, 2016, which noted that Petitioner reported that while at the courthouse retrieving items for a case file she fell over mushrooms in the parking lot on October 25th resulting in a fall on the left wrist. It was noted that Petitioner reported that her pain was primarily in the TFCC area and the ulnar side of the left arm, that she reported that there was pain that would shoot along the radial side of the wrist and proximally into the elbow and that she stated that the entire arm just hurt and that it was hard to pinpoint a specific area. The Discharge Summary dated February 14, 2017 noted that Petitioner's therapy modality cycle was completed and that she was released by her physician at the last visit. (PX4).

Also included within the records of The Orthopaedic Institute of Southern Illinois was an MRI report dated December 1, 2016, which noted that the films were interpreted as revealing (1) examination limited by motion artifact; (2) the bones are intact, no fracture is identified; (3) fluid collection on the volar aspect of the radiocarpal joint radially measuring 4x7x9 mm most compatible with a ganglion cyst; (4) intrasubstance tear of the triangular fibrocartilage along its ulnar aspect, no full-thickness tear identified; (5) extensor carpi ulnaris tendon is perched on the ulnar styloid suggesting injury to the synovial sheath; the tendon otherwise is intact with normal signal; (6) mild degenerative changes of the first carpometacarpal joint. (PX4).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The Workers' Compensation Documentation Packet was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has failed to prove that the accident of October 25, 2016 arose out of and in the course her employment with Respondent.

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. Industrial 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. Industrial 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.

As the Fourth District Appellate Court has explained, "[e]mployment related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling." *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799, 304 Ill. Dec. 722 (2006), as cited in *Decatur Memorial Hospital v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100733WC-U.

The evidence presented at the time of arbitration revealed that Petitioner tripped on a mushroom in a grassy area near where her car was parked. There was no evidence presented at trial that the fall occurred on Respondent's premises and, in fact, the evidence reveals that the fall occurred near the parking lot for the Randolph County Illinois courthouse in an area open to the general public. There was no evidence presented at trial of any structural defects on the sidewalk, the grassy area or the parking lot. Petitioner testified that grassy area was not uneven and she admitted that she was walking at a normal pace and was not in a hurry. Petitioner did, however, testify that she was carrying a file folder with copies of court documents. While Petitioner may have been performing a task incidental to her employment when her fall

occurred, there was no testimony offered that the file folder was large, heavy, a distraction or in any way contributed to the fall occurring. Petitioner did not testify that the area in which she walked was wet or slippery, but rather testified that she simply stubbed her toe on a mushroom growing in a 5-foot wide grassy area near the parking lot. Petitioner characterized her fall as a trip and not a slip. The Arbitrator finds that a wild-growing mushroom in a grassy area is not a defect or hazard just as the grass itself is not a defect or hazard, or is any other type of naturally occurring growth in grassy areas. Furthermore, Petitioner admitted she did not have to cross the grassy area and that she only crossed the grassy area as it was the most direct route to where her car was parked and taking that route saved her about 10 feet of walking. Petitioner admitted she could have simply walked on the crosswalk to the sidewalk to the parking lot and would not have had to traverse the grassy area. Petitioner admitted she was familiar with the parking lot at issue as she traveled to the Randolph County courthouse monthly.

Having considered the entirety of the testimony and documentary evidence in this case, the Arbitrator finds the Petitioner's fall was not caused by any defect or hazard in the area where the fall occurred. Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on October 25, 2016. As a result thereof, all benefits are denied. The remaining issues of causation, medical bills and nature and extent of the injury are moot, and the Arbitrator makes no conclusions as to those issues.

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

LISA KEPPNER,

Petitioner,

vs. NO: 12 WC 17113

CHOATE MENTAL HEALTH CENTER,

18IWCC0520

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 reinstatement and being advised of the facts and applicable law, hereby reverses and vacates the Arbitrator's denial of Petitioner's Petition to Reinstate; the Commission reinstates and remands this claim back to the Arbitrator for further proceedings. A separate Decision has been issued for case number 12 WC 17114.

On a Petition to Reinstate, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Indus. Comm'n*, 345 Ill. App. 3d 1138, 1140 (5th Dist. 2004). The decision to grant or deny a timely Petition to Reinstate is a matter which rests within the sound discretion of the Commission. *Id.*; *See also Conley v. Indus. Comm'n*, 229 Ill. App. 3d 925, 930 (4th Dist. 1992). Here, Petitioner had the burden of justifying reinstatement of her claims after the Arbitrator had dismissed them on July 10, 2017, on the basis that Petitioner's Petition was not timely.

The Rules Governing Practice Before the Illinois Workers' Compensation Commission provide that a Petition to Reinstate must be filed within 60 days from receipt of a dismissal order. Notices of dismissal shall be sent to the parties. §9020.90(a). Petitioner's attorney, Gary Matheny, stated that he never received notice of the July 10, 2017 dismissals from the Commission. (T.9-10). A review of the record indeed demonstrates that the dismissal notices were sent on July 11, 2017 to Respondent, but not to Mr. Matheny's correct and current address of 303 N. Jackson, Farmington, Missouri. (T.10-11). Instead, the notices were sent to Mr. Matheny at two different

addresses – 400 N. Washington, Ste. 113, Farmington, MO 63640 and 1015 Locust St., Ste. 500, St. Louis, MO 63101. The notices were also sent to Robert Devoto at 9322 Manchester Road, St. Louis, MO 63119. (RX1; RX2). Mr. Devoto was a prior attorney in the claim and had since passed away in March 2015. (T.10). Mr. Matheny advised the Arbitrator that he had vacated the 400 N. Washington address in 2013, and vacated the 1015 Locust St. address in 1993. (RX1; RX2).

By Petitioner's Brief, Petitioner's attorney first received the dismissal notices from the Commission at the November 28, 2017 hearing. The notices were made part of the record as Respondent's Group Exhibit 1 and 2.

In light of the foregoing, a patent error exists on the Commission's file system as in some instances, by the record, Petitioner's attorney received certain communications from the Commission and in some instances he did not. Based on the requirements of our Rules, the Commission finds that Petitioner received defective notice relative to the dismissal of Petitioner's claims.

The Commission further finds that Petitioner's claims merit reinstatement as Petitioner's counsel has pursued Petitioner's rights with due diligence. This case had previously come before an Arbitrator pursuant to a Section 19(b) hearing on May 21, 2015; an Arbitration Decision was rendered finding both claims compensable; this was later affirmed and adopted by the Commission; and, Petitioner was in fact receiving benefits up to and until October 11, 2017 when Respondent terminated said benefits after receiving notice of the dismissals. This is not an issue where Petitioner's claims sat stale at the Commission for a number of years, or wherein Petitioner's attorney did not exercise due diligence in progressing Petitioner's claims; there is no pattern of non-movement or delay by Petitioner's attorney. Accordingly, this matter is reinstated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator is hereby reversed and vacated; and, the above-referenced claim is reinstated and remanded back to the Arbitrator for further proceedings.

DATED: AUG 17 2018

MJB/pm
O: 08-07-18
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

LISA KEPPNER,

Petitioner,

vs. NO: 12 WC 17114

CHOATE MENTAL HEALTH CENTER,

18IWCC0521

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 reinstatement and being advised of the facts and applicable law, hereby reverses and vacates the Arbitrator's denial of Petitioner's Petition to Reinstate; the Commission reinstates and remands this claim back to the Arbitrator for further proceedings. A separate Decision has been issued for case number 12 WC 17113.

On a Petition to Reinstate, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Indus. Comm'n*, 345 Ill. App. 3d 1138, 1140 (5th Dist. 2004). The decision to grant or deny a timely Petition to Reinstate is a matter which rests within the sound discretion of the Commission. *Id.*; *See also Conley v. Indus. Comm'n*, 229 Ill. App. 3d 925, 930 (4th Dist. 1992). Here, Petitioner had the burden of justifying reinstatement of her claims after the Arbitrator had dismissed them on July 10, 2017, on the basis that Petitioner's Petition was not timely.

The Rules Governing Practice Before the Illinois Workers' Compensation Commission provide that a Petition to Reinstate must be filed within 60 days from receipt of a dismissal order. Notices of dismissal shall be sent to the parties. §9020.90(a). Petitioner's attorney, Gary Matheny, stated that he never received notice of the July 10, 2017 dismissals from the Commission. (T.9-10). A review of the record indeed demonstrates that the dismissal notices were sent on July 11, 2017 to Respondent, but not to Mr. Matheny's correct and current address of 303 N. Jackson, Farmington, Missouri. (T.10-11). Instead, the notices were sent to Mr. Matheny at two different

addresses – 400 N. Washington, Ste. 113, Farmington, MO 63640 and 1015 Locust St., Ste. 500, St. Louis, MO 63101. The notices were also sent to Robert Devoto at 9322 Manchester Road, St. Louis, MO 63119. (RX1; RX2). Mr. Devoto was a prior attorney in the claim and had since passed away in March 2015. (T.10). Mr. Matheny advised the Arbitrator that he had vacated the 400 N. Washington address in 2013, and vacated the 1015 Locust St. address in 1993. (RX1; RX2).

By Petitioner's Brief, Petitioner's attorney first received the dismissal notices from the Commission at the November 28, 2017 hearing. The notices were made part of the record as Respondent's Group Exhibit 1 and 2.

In light of the foregoing, a patent error exists on the Commission's file system as in some instances, by the record, Petitioner's attorney received certain communications from the Commission and in some instances he did not. Based on the requirements of our Rules, the Commission finds that Petitioner received defective notice relative to the dismissal of Petitioner's claims.

The Commission further finds that Petitioner's claims merit reinstatement as Petitioner's counsel has pursued Petitioner's rights with due diligence. This case had previously come before an Arbitrator pursuant to a Section 19(b) hearing on May 21, 2015; an Arbitration Decision was rendered finding both claims compensable; this was later affirmed and adopted by the Commission; and, Petitioner was in fact receiving benefits up to and until October 11, 2017 when Respondent terminated said benefits after receiving notice of the dismissals. This is not an issue where Petitioner's claims sat stale at the Commission for a number of years, or wherein Petitioner's attorney did not exercise due diligence in progressing Petitioner's claims; there is no pattern of non-movement or delay by Petitioner's attorney. Accordingly, this matter is reinstated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator is hereby reversed and vacated; and, the above-referenced claim is reinstated and remanded back to the Arbitrator for further proceedings.

DATED: AUG 17 2018

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB/pm
O: 08-07-18
052

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

Gregory Malone,
Petitioner,
vs.

NO: 14WC 24529

Chicago Transit Authority,
Respondent.

18IWCC0522

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2017, 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 17 2018
o080718
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MALONE, GREGORY
Employee/Petitioner

Case# 14WC024529

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

18IWCC0522

18IWCC0522

On 12/22/2017, 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 1.48% 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:

0307 ELFENBAUM EVERS & AMARILIO PC
JOSEPH D ARMARILIO
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
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
NATURE AND EXTENT ONLY

Gregory Malone
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 14 WC 024529

18IWCC0522

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **October 12, 2017**. By stipulation, the parties agree:

On the date of accident, **07/18/2014**, 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 **$66,144.00**, and the average weekly wage was **$1,272.00**.

At the time of injury, Petitioner was **33** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been or will be provided by Respondent, per the agreement of the Parties. (ArbX 1)

Respondent shall be given a credit of **$105,204.08** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$105,204.08**.

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 $735.37/week for a further period of 75 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the 15% loss of use of a person as a whole.

Respondent shall pay Petitioner compensation that has accrued from 07/19/2014 through 10/12/2017, 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

December 22, 2017
Date

DEC 22 2017

ICArbDecN&E p.2

FINDINGS OF FACT

Petitioner is a right handed switchman employed by the CTA ("Respondent") since 2003.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on July 18, 2014. He injured his right shoulder while pulling on a stuck door in the train yard.

Petitioner initially treated with Dr. Thomas Bilko, who is an Orthopedic Surgeon. An MRI of the right shoulder was performed. Dr. Bilko recommended a right shoulder arthroscopy and labral repair. Petitioner was seen by Dr. Craig Westin, also an Orthopedic Surgeon, for an Independent Medical Examination at Respondent's request, on September 26, 2014. Dr. Westin believed that Petitioner had a right shoulder anterior labral tear and recommended surgery. The right shoulder arthroscopy was performed on January 17, 2015 by Dr. Bilko. The postoperative diagnosis was a torn rotator cuff and labral repair. (PX 2, 8)

Petitioner presented for another Independent Medical Examination by Dr. Westin on September 25, 2015. Further physical therapy was recommended. (RX 2)

Dr. Bilko opined that Petitioner had permanent restrictions which would keep him from returning to his job at CTA. (PX 2)

Petitioner sought a second opinion from Dr. Brian Cole, an Orthopedic Surgeon at Midwest Orthopedics at Rush. Dr. Cole recommended an MRI of the right shoulder. Dr. Cole reviewed the MRI and opined that Petitioner had ongoing right shoulder pain due to anterior inferior labrum insufficiency or capsular redundancy. He recommended an arthroscopic right shoulder stabilization. Petitioner underwent the right shoulder arthroscopic stabilization on March 16, 2016. He began a postoperative regimen of physical therapy and was released to full duty work, without restrictions and at maximum medical improvement, on September 29, 2016. At that visit Dr. Cole noted that Petitioner was doing well with no complaints. He was released from treatment. (PX 1, 9)

Petitioner was unable to return to CTA until November 22, 2016 due to CTA administrative procedures and scheduling. TTD

Petitioner testified that, since returning to work, he ices his shoulder and takes hot showers. He testified that he performs home exercises 2 to 3 times per week. He testified that he does not take any prescribed medications for his shoulder. He takes ibuprofen in the morning and afternoon. He was asked if there was a specific activity that increases his right shoulder pain and testified that lifting his body weight onto a train "was about it". He has not visited a doctor for his right shoulder since returning to work in November of 2016.

Petitioner testified that after a full day his right shoulder is sore and tight. He relieves his symptoms with ice, hot showers and ibuprofen. He testified that at work he needs to climb a train and pull himself up steps and a ladder with both arms. He testified that he tries to favor the left arm over the right. He testified that he notices the pain just at the end of the day.

Petitioner testified that he used to play basketball and table tennis, but does not play anymore due to issues with his range of motion. He testified that it can be difficult to open a tight jar, or take an object off a shelf due to issues with his range of motion. He testified that he can make a bed or lift a bag or suitcase and he uses both hands. He testified that he pulls a sweater on using his right arm first, and then his left arm.

Petitioner testified that he has no problems with cutting food. He testified that he has issues with lifting his younger relatives such as his niece. He testified that he sleeps on his back.

Petitioner testified that he performs all required activities at his job as a CTA Switchman. He has not received any reprimand or suffered any wage loss. He testified that there was a change made by CTA in terms of how a train is decoupled and coupled, which is easier for him to do. He testified that this change by CTA was not made specifically for him, but was made for all employees.

CONCLUSIONS OF LAW

The Arbitrator adopts the Findings of Fact set forth above 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)

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)

Nature and Extent:

Regarding the nature and extent of Petitioner's injuries, Section 8.1b of the Illinois Workers' Compensation Act states that permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. The five factors are relevant because of the prescribed method of determining PPD.

There was no AMA rating offered by either party in this matter. Of course, impairment is not the same as disability. Therefore, this factor is given no weight in determining PPD.

The Arbitrator notes that with regard to (ii), Petitioner continues to be employed as a CTA Switchman. Petitioner testified that he is capable of performing the duties associated with his position. He testified that after work he experiences some soreness and tightness and will take over the counter medication, a hot shower, or ice his shoulder. The Arbitrator places some weight on this factor in determining PPD.

With respect to (iii), Petitioner was 33 years old at the time of the injury and is 36 years old at the present time. While he may be expected to spend another few decades in the workforce, the Arbitrator notes that his residual symptoms are of a mild to moderate nature, consisting of mostly soreness and tightness. Petitioner relieves these symptoms with home remedies such as ice and hot showers, along with over the counter medications such as ibuprofen. The Arbitrator also notes that post-workday soreness and tightness is a symptom that could reasonably be expected with any physically demanding job. The Arbitrator further notes that Petitioner is able to perform all duties of his position and has not returned for treatment to either Dr. Bilko or Dr. Cole since returning to work in November of 2016. The Arbitrator places some weight on this factor in determining PPD.

With respect to (iv), the Arbitrator notes that following his work injury, the Petitioner returned to work at his pre-accident employment with CTA and there is no evidence demonstrating that his future earning capacity has been impaired. The Arbitrator places no weight on this factor in determining PPD.

With respect to (v), the Arbitrator notes that at his final visit with Dr. Brian Cole on September 26, 2016, it was noted that he was doing well with no complaints. He was deemed at maximum medical improvement and was released from treatment on an as-needed basis. He was released to work as a switchman with no restrictions. The Arbitrator notes that Petitioner has not returned to Dr. Cole or Dr. Bilko since returning to work. Although Petitioner made several references to deficiencies with his right shoulder range of motion, the last medical note from Dr. Cole does not mention any issues with range of motion. Dr. Cole's notes specifically mention that Petitioner had "no complaints". Petitioner was then released on an "as-needed" basis, but nearly a year later he has not returned to Dr. Cole or any other physician. The injury is to Petitioner's dominant upper extremity.The Arbitrator places great weight on this factor in determining PPD.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant.

Based on the above factors and the record in its entirety, the Arbitrator concludes that the injuries sustained caused Petitioner to suffer permanent partial disability to the person as a whole to the extent of 15% thereof, as provided in §8(d)2 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 DUPAGE)	☒ Reverse accident	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN CWIRLA.

Petitioner,

vs.

NO: 10 WC 28398

CITY OF ELMHURST,

18IWCC0523

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on Remand from an Order of the Circuit Court of DuPage County entered December 19, 2013 for the subject case, assigned number 13 MR 252. The Circuit Court directed the Commission to issue a decision with more complete findings with respect to the Commission's analysis "in relation to the date of injury and how the evidence of any notice was inadequate and whether the decision at all involved application of Section 6(f) of the Act. In addition, the Court requires further findings of fact regarding the finding of (sic) that Petitioner failed to prove he sustained an accidental injury and there was a causal connection in light of Section 6(f) of the Act, if Section 6(f) applied to the findings."

On November 7, 2011, Arbitrator Andros issued a Decision finding that Petitioner failed to prove accidental injuries arising out of and in the course of his employment on June 14, 2010, failed to prove he provided notice to the Respondent and failed to establish a causal connection between his condition of ill-being and his work environment and compensation was denied.

On November 16, 2011, Respondent timely filed a Petition for Review with respect to the November 7, 2011 Decision of Arbitrator Andros. On August 13, 2012, the Commission, after considering the issues of accident, notice, temporary total disability benefits, permanent partial disability, medical expenses, and application of benefits pursuant to Section 6(f) of the Act, and being advised of the facts and law, affirmed and adopted the Decision of the Arbitrator denying

accident and causal connection.

Based upon the December 19, 2013 Remand Order from the Circuit Court, and upon a review of the entire record, the Commission makes the following additional findings:

Findings of Fact and Conclusions of Law

Section 6(f) Rebuttable Presumption

Section 6(f) of the Act provides in pertinent part, as follows:

> "Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), or paramedic which results directly or indirectly from any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT, or paramedic. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission." 820 ILCS 305/6(f) (West 2014).

Since the Commission issued its prior Decision on August 13, 2012, the Appellate Court addressed the issue of the Section 6(f) rebuttable presumption burden of proof in the case of *Johnston v. Ill. Workers' Comp. Comm'n*, 2017 IL App (2d) 160010WC, 80 N.E.3d 573, 414 Ill. Dec. 430.

In *Johnston*, the issue before the Court was whether or not the firefighter suffered a heart attack arising out of and in the course of his employment and further, application of Section 6(f)'s rebuttable presumption when the evidence was not sufficient to establish firefighter Johnston was shoveling, or doing any physical exertion, when he had a heart attack during the course of his employment. The Court noted the presumed fact was that claimant's coronary artery disease—not just the cardiac event—arose out of his employment as a firefighter. "Thus, the issue before us was whether the evidence introduced by the employer was sufficient to rebut the presumed fact as we have stated it." *Johnston v. Ill. Workers' Comp. Comm'n*, 2017 IL App (2d) 160010WC, P47

The *Johnston* Court first reviewed the legal precedent relevant to the application of a presumption such as 6(f) and quoted in pertinent part:

> "With regard to the procedural effect of presumptions, most jurisdictions in this country follow the rule that a rebuttable presumption may create a *prima facie* case as to the particular issue in question and thus has the practical effect of requiring

> the party against whom it operates to come forward with evidence to meet the presumption. However, once evidence opposing the presumption comes into the case, the presumption ceases to operate, and the issue is determined on the basis of the evidence adduced at trial as if no presumption had ever existed. (See 1 Jones, Evidence sec. 3:8 (6th ed. 1972).) The burden of proof thus does not shift but remains with the party who initially had the benefit of the presumption. *Diederich v. Walters*, 65 Ill. 2d 95, 100-01, 357 N.E.2d 1128, 1130-31, 2 Ill. Dec. 685 (1976),
>
> The supreme court provided further guidance with regard to rebuttable presumptions in *Franciscan Sisters Health Care Corp. v. Dean*, 95 Ill. 2d 452, 448 N.E.2d 872, 69 Ill. Dec. 960 (1983). In that case, the court expanded upon its discussion in *Diederich*, noting "[t]he prevailing theory regarding presumptions that Illinois follows and *Diederich* speaks about is Thayer's bursting-bubble hypothesis: "once evidence is introduced contrary to the presumption, the bubble bursts and the presumption vanishes." *Id.* at 462, 448 N.E.2d at 877. In other words, once evidence has been presented to rebut the presumption, the metaphorical bubble bursts and the trier of fact must then consider the evidence presented in the case as if the presumption had never existed. *Id. Johnston v. Ill. Workers' Comp. Comm'n*, 2017 IL App (2d) 160010WC, P36-P37.

After examining the legislative history, the *Johnston* Court found that section 6(f) does not involve a strong rebuttable presumption, meaning the (need for) clear and convincing evidence. "Rather, we conclude that the legislature intended an ordinary rebuttable presumption to apply, simply requiring the employer to offer *some e*vidence sufficient to support a finding that something other than claimant's occupation as a firefighter caused his condition." *Johnston* at 44.

The *Johnston* Court further noted that if the employer is successful in rebutting the section 6(f) presumption, at that point the claimant may, if the evidence supports it, assert that his occupational exposure was a cause of his condition of ill-being, thus entitling him to an award of benefits. *Id.* at 51. In *Johnston*, the Court held that the Claimant presented no evidence that his occupational exposure contributed to cause his coronary artery disease. Respondent's expert opined "his underlying disease was a direct consequence of his multiple risk factors, the smoking, the family history, his male sex, et cetera, *and that work as a fireman was not the cause of his underlying coronary artery disease, that had he been doing another job he would still have experienced progressive and life-threatening coronary disease*." *Id.* at 49.

In the subject case, Petitioner was first diagnosed with a hernia on November 3, 2008 by his primary care physician (PCP), Dr. Cichon. Petitioner never indicated to the doctor on that date his condition was related to work for Respondent. (T, p. 28) Petitioner amended his Application for Adjustment of Claim at the arbitration hearing and alleged a new date of accident on June 14, 2010. When Petitioner saw his PCP on June 14, 2010, it was noted that his pre-existing hernia had grown. Petitioner again never indicated in any way his condition was related to his work for Respondent nor did he report any specific incident or pain complaints to Respondent at the time. (T, p. 29) The Petitioner's PCP referred Petitioner to a surgeon, Dr. Woodland.

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Hernia Precedent

Historically, a hernia has been treated as a specific trauma injury. See *Joyce Bros. Storage & Van Co. v. Industrial Comm'n.*, 399 Ill. 456, 78 N.E.2d 262; *Olney Seed Co. v. Industrial Comm'n.*, 403 Ill. 587, 88 N.E.2d 24; *Calendar Packing Co. v. Industrial Comm'n.*, 38 Ill. 2d 506, 507, 232 N.E.2d 698, 699.

The Court in *Olney Seed* delineated the requirements of the Statute at that time to prove a hernia case:

> Section 8(d-1) of the Workmen's Compensation Act, (Ill. Rev. Stat. 1943, chap. 48, par. 145 d-1,) provides: "An injured employee, to be entitled to compensation for hernia, must prove: 1. The hernia was of recent origin; 2. Its appearance was accompanied by pain; 3. That it was immediately preceded by trauma arising out of and in the course of the employment; 4. That the hernia did not exist prior to the injury." The burden of proof in a hernia case, as in other compensation cases, is on the claimant. (*Mirific Products Co. v. Industrial Comm'n 356 Ill. 645.*) We have held that all the attending circumstances and conditions prescribed by the statute must be proved by the preponderance of the evidence. (*Joyce Bros. Storage and Van Co. v. Industrial Comm'n. 399 Ill. 456*; *Wagner Malleable Iron Co. v. Industrial Comm'n 358 Ill. 93.*) *Olney Seed Co. v. Industrial Comm'n.*, 403 Ill. 587, 588-590.

Although the Statute's Section 8(d-1) provision has since been eliminated, the same requirements are precedent under the principle of *stare decisis*. In *Joyce Bros. Storage and Van Co.*, the employer contended that the claimant had not satisfied the above referenced statutory requirements relating to eligibility for compensation in hernia cases. *Joyce Bros. Storage and Van Co. v. Industrial Comm'n.*, 399 Ill. 456 at 460. The Court noted that the (then-existing) statute ignores the causal relationship between the employment and the aggravation of an old hernia and establishes the prerequisite that the employee's work must result in a new hernia. *Joyce Bros. Storage and Van Co.*, 399 Ill. 456, 461-462. The Court held the Petitioner failed to prove that his hernia did not exist prior to his alleged accident date. *Id.* at 462.

It would thus appear that the subject Petitioner's hernia, pre-existing since November 2008, would not be a new hernia since Petitioner amended his Application for Adjustment of Claim at trial to reflect an accident date on June 14, 2010, only after his hernia worsened. Under the *Joyce Bros. Storage et.al.* line of cases, Petitioner would not have satisfied the test for an injured employee to be entitled to compensation for hernia.

Analysis

It is also clear that by the enactment of Section 6(f), the legislature intended to provide firefighters with the rebuttable presumption for certain types of diseases if they worked as a firefighter for five years. However, if the Respondent provides *some* evidence that the condition is not related to work, the burden shifts back to Petitioner to prove every element of his case pursuant to Section 1(d) of the Act.

Without the presumption, the subject Petitioner would fail to prove he sustained a hernia in the course and scope of his employment with Respondent. The burden of proof in a hernia case has not changed; a Petitioner must prove a specific trauma *i.e.* 1. The hernia was of recent origin; 2. Its appearance was accompanied by pain; 3. That it was immediately preceded by trauma arising out of and in the course of the employment; 4. That the hernia did not exist prior to the injury. (citations omitted).

Thus, the issue presented in the subject case is whether or not the Respondent presented some evidence to rebut the presumption that the Petitioner's hernia condition is related to his work for Respondent.

Petitioner worked as a firefighter for Respondent for more than fifteen years. (T, p. 9) It is unequivocal the Petitioner's hernia was initially diagnosed on November 3, 2008 and the Petitioner never reported a lifting incident or trauma of any sort to his doctor at the time that would link the hernia to his employment with Respondent. (T, p. 28) Petitioner testified that he never noticed the lump prior to November 3, 2008. (T, p. 17) Petitioner did not seek any other medical treatment for the hernia at that time. (T, p. 18) Petitioner testified he did not give his PCP any history of the hernia being related to his employment with Respondent at that time. (T, p. 28) Petitioner testified he did not need medical treatment for the hernia at that time. (T, p. 23) Petitioner never testified an accident occurred in 2008 in the course and scope of his employment while working for Respondent and he never testified to a specific incident that caused the condition of ill-being at that time. Furthermore, Petitioner presented no evidence of a causation opinion.

Petitioner testified he continued to work as a firefighter/EMT between November 4, 2008 through May 2009, a period of eight months following the appointment with his primary care physician (PCP), Dr. Cichon on November 3, 2008. (T, pp. 18-19, 28). In May 2009, Petitioner went for a department physical, performed by Dr. Ebert and he mentioned a small lump in his belly, and Dr. Ebert determined he was fit for duty. (T, p. 19) The hernia did not impede his duties as a firefighter and Petitioner denied the lump was bothering him at that time. He continued to work from May 2009 until June 2010 performing the same duties. He did not notice any pain during that time. (T, pp. 20-21)

Petitioner testified, and his medical records confirm, that his hernia grew. On June 14, 2010, the hernia was starting to cause him some discomfort and he felt it should be taken care of. (T, p. 21) Dr. Cichon, Petitioner's PCP, advised him he still had the umbilical hernia, and referred Petitioner to a surgeon, Dr. Woodland. T (T, pp. 28-29) On June 14, 2010, Petitioner did not indicate to Dr. Cichon that his hernia was in any way related to his work environment at the City of Elmhurst. (T. p. 29)

The OSF intake sheet at Dr. Woodland's office indicated his injury was from November 2008 and indicated in March 2009, Petitioner advised the City of Elmhurst. At the Arbitration hearing, Petitioner testified he advised Dr. Ebert of the hernia in March 2009. Dr. Ebert provided physicals for the fire department. Petitioner conceded, however, Dr. Ebert is not an employee of the City of Elmhurst. (T, p. 30) Dr. Ebert reported Petitioner was fit for duty and there is no evidence in the record that he would have otherwise notified Respondent that Petitioner had a hernia. Petitioner testified he never told anyone at the City of Elmhurst about the hernia in 2009. (T, p. 30)

When Petitioner saw Dr. Woodland on August 25, 2010, he gave a history of being diagnosed by Dr. Cichon with a hernia in 2008. (T, p. 31) Petitioner never told his PCP, Dr. Cichon, or his surgeon, Dr. Woodland, the hernia occurred because of a specific work incident.

Additionally, Petitioner testified he did not know if he had a single heavy-lifting accident on or about June 14, 2010 in the course and scope of his employment while working for Respondent. (T, p. 23) The Commission finds the Petitioner's testimony that he put an accident date of November 2008 on Dr. Woodland's intake form was also persuasive evidence that Petitioner knew he had a hernia since November 2008 and that it was the same hernia he had on June 14, 2010.

The Commission finds that Petitioner would fail to sustain his burden of proving accident under the strictures of Section 1(d), however, the Commission finds that in light of the Court's holdings in *Johnston v. Ill. Workers' Comp. Comm'n,* Section 6(f) requires Respondent to present evidence that something other than firefighting was the cause of Petitioner's hernia condition in order to shift the burden to Petitioner to prove every element of his case. The Commission finds Respondent presented no evidence that shifted the burden of proof back to Petitioner as required by the rebuttable presumption of Section 6(f), however, Respondent instead relied solely on Petitioner's failure to prove he had an accident, failure to provide notice to Respondent, and failure to prove causal connection, elements that would be required only if the burden was shifted back to Petitioner, and in all other cases that do not fall under the mandates of Section 6(f).

Therefore, the Commission finds that under the rebuttable presumption of Section 6(f), the Petitioner sustained his burden of proving his hernia injury arose out of and in the course of his employment with Respondent and that his job duties were, at minimum, a contributory cause to his condition of ill-being.

The Commission, based upon the December 19, 2013 Circuit Court Remand Order, and after reviewing the entire record, reverses its August 13, 2012 Decision and Opinion on Review on the issues of accident, temporary total disability, permanent partial disability, medical expenses, and application of benefits pursuant to Section 6(f) of the Act, reverses the November 7, 2011 Arbitrator's Decision and modifies as herein, finding that Petitioner sustained his burden of proving that he sustained accidental injuries arising out of and in the course of his employment on June 14, 2010, that Petitioner provided timely notice of accident to Respondent, and that a causal relationship exists between those injuries and his current condition of ill-being as it relates to his hernia.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission's prior Decision on Review is vacated and that the November 7, 2011 Decision of the Arbitrator, is hereby reversed on the issues of accident, temporary total disability, permanent partial disability, medical expenses, and application of benefits pursuant to Section (6) of the Act and is modified as herein, finding that Petitioner sustained his burden of proving that he sustained accidental injuries arising out of and in the course of his employment on June 14, 2010, that Petitioner provided timely notice of accident to Respondent, and that a causal relationship exists between those injuries and his current condition of ill-being as it relates to his ventral and umbilical hernia repair.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,020.00 per week for a period of 4-3/7 weeks, for the period between September 17,

18IWCC0523

2010 through October 17, 2010, 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 reimburse Petitioner $815.00 for his out-of-pocket medical payments, pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 15 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 3% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit in the amount of $17,731.61 under Section 8(j) of the Act; provided Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
KWL/bsd
R: 6/26/18
42

AUG 17 2018

Kevin W. Lamborn

Stephen Mathis

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

☐ 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

Connie Arco,

Petitioner,

vs.

NO: 10 WC 28260

Casey's General Store, et al.,

18IWCC0524

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, TTD, medical expenses, penalties, credit due Respondent, and compliance with IWCC Administrative Rule 9110.10, and being advised of the facts and law, modifies the Decision of the Arbitrator on the issue of nature and extent as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the interest of efficiency, the Commission will not recite the facts of this matter as they are detailed in the Decision of the Arbitrator. After carefully considering the totality of the evidence, the Commission finds Petitioner sustained a significant permanent disability as a result of the June 12, 2010, work accident. Petitioner sustained a minor injury to her left knee and a significant injury to her lumbar spine after she slipped and fell on ice cubes at work. The Commission finds Petitioner sustained a left knee contusion that resolved prior to a subsequent intervening left knee injury unrelated to this work accident.

Petitioner sustained a significant injury to her lumbar spine due to the work accident. Dr. Szachnowski, Petitioner's treating physician, diagnosed Petitioner with spinal stenosis at L3 – L4 and L4 – L5 with radiculopathy. Dr. Szachnowski credibly testified that the work accident worsened Petitioner's preexisting degenerative disc disease. Petitioner received chiropractic care as well as physical therapy and medication following the accident. She also underwent a series of three lumbar epidural injections from October 2010 through February 17, 2011. Despite extensive conservative treatment from the date of accident through February 17, 2011 (the date of MMI), Petitioner never regained the prior level of function that she enjoyed before the work accident. Furthermore, Dr. Szachnowski credibly testified that Petitioner was totally disabled from working her usual job as a cashier during the entire period Petitioner was under his care.

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The Commission finds that Petitioner failed to meet her burden of proving that the work accident rendered her permanently and totally disabled. However, she did meet her burden of proving a severe permanent disability due to the low back injury she sustained as a result of the work accident. Petitioner never returned to work and Dr. Szachnowski credibly testified that Petitioner was unable to return to her job as a cashier because the position requires constant standing. Petitioner testified that she experiences back spasms if she is on her feet longer than 15 or 20 minutes. It is difficult for her to perform household chores because she must constantly sit down and rest. Petitioner testified that her husband now performs most of the housework. Petitioner testified that she is only able to walk comfortably for approximately 15 minutes. She still takes the dog for very short walks; however, Petitioner never walks alone. Petitioner now has difficulty dressing herself and showers when her husband is home due to a history of falling. Petitioner testified that she uses a cane and has a handicap placard for her car. She testified that her back aches whether she's sitting or standing and if she lifts anything.

Petitioner's injury has affected her independence as well as her marriage. Petitioner testified that she no longer sleeps in the same bed as her husband because she constantly must get up due to her back pain. Petitioner and her husband also are unable to engage in activities they once frequently enjoyed. For example, they no longer shop frequently due to her back pain. Petitioner testified that she and her husband used to frequently go out to dinner. However, she is so uncomfortable sitting for a prolonged time that the couple rarely dines in restaurants. Petitioner now uses a wheelchair while in an airport. Finally, Petitioner testified that her back hurt during the arbitration hearing due to prolonged sitting in the waiting area and during the hearing.

The Commission finds Petitioner testified credibly regarding her treatment and numerous ongoing complaints. After considering the totality of the evidence, including Petitioner's testimony, the severity of Petitioner's lumbar injury, Petitioner's inability to return to her job as a cashier, and her ongoing difficulties affecting her ability to complete daily activities, the Commission finds the Arbitrator's award of 15% loss of use of the whole person does not properly account for the clear evidence of Petitioner's permanent disability as a result her low back injury. Instead, the Commission finds Petitioner suffered a 50% loss of use of the whole person.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 2016, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner permanent partial disability benefits of $222.47 for 250 weeks, because Petitioner's injuries caused 50% loss of use of the whole person as provided for in §8(d)2 of the Act.

IT IS FURTHER ORDERED that Respondent is liable only for medical treatment that is reasonable, necessary, and related to the work accident through February 17, 2011. Thus, Respondent shall pay the following outstanding bills pursuant to §§8 and 8.2 of the Act: $365.00 to Dr. Javaid Iqbal/Odessa Neurology Clinic; $2,045.00 to Dr. Keith Potetti/Back in Shape Chiropractic; $1,595.00 to Monroe Clinic; $1,379.05 to Monroe Hospital; and $2,414.00 to OSF St. Anthony Hospital.

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IT IS FURTHER ORDERED 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 that Respondent pay to Petitioner interest pursuant to §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 $65,000.00. 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 1 2018

o: 6/26/18
TJT/jds
51

Thomas J. Tyrrell

Stephen J. Mathis

DISSENT

I respectfully dissent from the Majority's opinion modifying the Arbitrator's decision. I find Arbitrator Ory's decision to be persuasive. I concur with the Arbitrator's findings that petitioner sustained a lumbar strain that aggravated her pre-existing degenerative disc disease. I would affirm and adopt.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARCO, CONNIE
Employee/Petitioner

Case# **10WC028260**

CASEY'S GENERAL STORE & STATE TREASURER EX OFFICIO OF THE RATE ADJUSTMENT FUND
Employer/Respondent

18IWCC0524

On 2/19/2016, 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 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
PHILLIP A BARECK
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

18IWCC0524

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

- [ ] 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

Case # 10 WC 28260

Connie Arco
Employee/Petitioner

v.

Casey's General Store & State Treasurer, Ex Officio of Rate Adjustment Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine M. Ory**, Arbitrator of the Commission, in the city of **Rockford**, on **November 17, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 12, 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 **$11,568.44**; the average weekly wage was **$222.47**.

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

To date, Respondent has paid **$ 0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of **$4,163.47**for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,163.47**.

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

ORDER

Medical Benefits

Respondent shall pay the bills totaling **$7,798.05**, subject to the fee schedule and pursuant to §8 and §8.2.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$222.47**/week for **35-5/7 weeks**, commencing **06/13/2010 through 02/17/2011**, as provided in §8(b) of the Act.

Credit

Respondent shall be given credit of **$1,275.03** for payment to Dr. Keith Potetti and **$4,163.47** for TTD paid.

Permanent Disability

Respondent shall pay the sum of **$222.47**/week for a period of **75** weeks, as provided in **§8 (d) 2**of the Act, because the injuries sustained caused **15% loss of use of person as a whole.**

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 Moy

02/19/2016

Signature of Arbitrator — Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Connie Arco	)	
Petitioner,	)	
vs.	)	**No. 10 WC 28260**
Casey's General Store & State Treasurer,	)	
Ex-Officio of Rate Adjustment Fund	)	
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Rockford on November 17, 2015. The parties agree that on June 12, 2010, the Petitioner and the 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. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $11,568.44, and that her average weekly wage was $222.47.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether respondent is liable for the unpaid medical bills.
3. What temporary benefits are in dispute?
4. What is the Nature and Extent of Injury?
5. Should penalties or fees be imposed upon Respondent?
6. What credit is due respondent.

STATEMENT OF FACTS

Testimony

Petitioner testified she was hired by respondent in 2002 as a cashier. Originally she worked 32 to 35 hours a week. In 2005 she took on kitchen duties. In 2009 she reduced her hours to 20 to 25 hours a week as she became allergic to flour used to make pizza dough. She continued working at the reduced hours of 20 to 25 hours a week until her work accident on June 12, 2010.

Her duties as cashier included doing anything to help customers, which might include carrying purchases to the customer's car, emptying trash inside and outside, as well as mopping the floors. The trash weighed anywhere from a few pounds to 20 to 25 pounds. Sometimes the trash outside was so heavy petitioner would have to lay the bin on its side and yank the bag out of the bin as it was too heavy for her to lift the trash up out of the trash bin. Depending upon the weather, she might have to mop the floor every 15 minutes. She also did laundry.

Once a week a semi full of supplies arrived and four employees would line up and unload it. The supplies included cases of Gatorade which were stacked two deep and weighed 40 pounds.

Additionally, if it was petitioners turn behind the counter, she would have to run back behind the register and wait on customers. Petitioner also filled ice machines and stocked all the coolers with milk and soda. Petitioner testified that the most physical aspect of the job was mopping the floors, filling ice machines and unloading trucks.

Petitioner testified that prior to June 12, 2010, her back, right leg and left leg were fine. On June 12, 2010, petitioner was filling an ice machine with a bucket when she slipped and fell on a piece of ice that had fallen to the floor. She fell on her fanny. She screamed, got back up and then slipped and fell again landing on her left knee.

She testified her back hurt and she had problems standing up right. She walked the length of the store bent over. Brandy, who was working in the kitchen, called Alicia Smith, petitioner's supervisor to tell her to get to the store as petitioner had hurt herself. Petitioner had excruciating pain in her back over her right hip and then started having back spasms. Her left knee and leg began to swell.

Petitioner's husband took her to the hospital (Monroe Clinic) that day. She called her doctor, Dr. Donovan, who referred her to a chiropractor, Dr. Keith Potetti. She first saw Dr. Potetti on June 14, 2010.

Petitioner testified she had received treatment at FHN Health Care in 2002, 2003, 2005, 2006, 2007 and 2008, as this is where her personal physician was located. She admitted she had seen Dr. Potetti for neck, middle and lower back problems starting in February, 2008. She received treatment ten to twelve times in 2008; ending on August 13, 2008. She never missed any work due to back problems. Her back ached from August, 2008 until her fall on June 12, 2010.

Petitioner testified that on June 30, 2010, Dr. Potetti referred petitioner to neurologist, Dr. Iqbal.

On July 29, 2010 respondent sent petitioner for an exam by Dr. Stephen Weiss.

Petitioner continued to treat with Dr. Donovan, who was with Monroe Clinic. Dr. Donovan referred petitioner to Dr. Szachnowski, whom she first saw on September 10, 2010. She testified she was having back spasms and pain down her right leg at that time. Dr. Szachnowski referred her for injections. She received the first injection on October 7, 2010.

She was sent for a second exam by Dr. Stephen Weiss on October 21, 2010.

Petitioner's first TTD check was issued on July 20, 2010, which was for the period from June 2, 2010 (sic) through July 17, 2010. She received a second check dated September 22, 2010 for the period from July 19, 2010 through September 18, 2010. During the period petitioner was paid TTD, she was not paid on a weekly basis.

Petitioner testified she received a letter from respondent dated October 29, 2010 directing her to return to work within Dr. Weiss' restrictions (RX.9). Petitioner understood Dr. Weiss' restrictions were no lifting over ten pounds and to periodically sit and stand throughout the day.

Petitioner returned to work, however there were no modifications to her work duties to conform to Dr. Weiss' restrictions. Within 30 minutes of waiting on customers, petitioner's back went into spasms. Petitioner told supervisor, Alicia Smith that she need modified work. Alicia told her to just pace herself. After an hour, her back hurt so badly she had to leave. She had been prescribed Skelaxin and Vicodin, but was not able to take it before her shift.

Petitioner obtained her second epidural injection by Dr. Szachnowski on November 2, 2010. Dr. Szachnowski kept her off work and ordered physical therapy. She had her third epidural steroid injection on February 17, 2011. Shortly after her third injection she suffered a heart attack and had a stent put in.

Petitioner continued treatment with Dr. Szachnowski through 2011.

After the exam by Dr. Weiss on October 21, 2010 petitioner no longer received TTD or medical payment.

Petitioner obtained another steroid injection in February, 2012.

Petitioner twisted her left knee while on a treadmill doing cardiac rehab. Before that incident, her left knee was doing fine. She had surgery to her left knee at Monroe Clinic in May, 2012.

She last saw Dr. Szachnowski on June 12, 2012, at which time she received her last steroid injection from him. She stopped seeing Dr. Szachnowski when she moved to North Carolina. She moved to North Carolina for family reasons as her husband was retiring.

After her move to North Carolina, petitioner saw Dr. Nicole Stanzione at Pinehurst Medical Center. Dr. Stanzione referred her to Dr. Andrea Burns for pain management. Dr. Burns referred petitioner to Dr. Place for steroid injections. In 2013 and 2014 petitioner had injections to her back and her knee.

At no time had petitioner's treating physicians released her to return to work.

Petitioner was examined by Dr. Jeffrey Coe on April 24, 2014 at her attorney's request. She continues to receive treatment, including injections, by the doctors in North Carolina. She contemplated surgery, but could not have back surgery due to her cardiac situation.

The only income petitioner has been receiving was social security disability, and then social security retirement benefits after she reached age 65.

The highest education petitioner had achieved was high school diploma. Petitioner had previously worked for Rockford Memorial in guest relations. She took college courses while working for Rockford Memorial, which helped her deal with guest relations. She worked for 13 years for Rockford Memorial. It required her to walk a lot and to push people in wheel chairs.

Petitioner testified she continues to have back spasms. Her husband does the majority of the housework and helps her with the shopping. She does not like to socialize or go out for dinner as by the time she goes out, get served and eats, she is in pain.

She walks with a cane that was prescribed by Dr. Potetti and recommended by Dr. Andrea Burns. She needs it for her back in order to keep her balance as she has fallen a few times. She does not like to shower without having her husband present for fear of falling and not being able to get up. She uses TENS unit at home five out of seven days a week. She has a difficult time dressing; especially putting on socks. Traveling through airports is difficult. She requires wheelchair assistance. She has a handicap parking sticker.

After October 21, 2010, all medical bills were paid through petitioner's husband's health insurance or Medicare.

On cross examination petitioner admitted she was encouraged to use a cane after she injured her knee on a treadmill during cardiac rehab. Petitioner underwent surgery to her left knee in May, 2012 and had injections in both her right and left knee in February, 2013. She indicated she may need a left knee replacement.

Petitioner admitted that when she was treated at Freeport Health Systems from 2002 to 2008 she checked the box indicating she had pain weakness, numbness in her back.

Petitioner admitted she began treatment with Dr. Potetti in February, 2008 for lower back pain. She continued treatment in March, 2008. She admitted that in April, 2008, the pain in her back and down the right leg intensified. She admitted Dr. Potetti had given her work restrictions in 2008. Before June 12, 2010, petitioner admitted her back would hurt when she did not wear croc shoes.

Petitioner did not receive any back treatment from February, 2011 until May, 2011. She also did not receive any treatment from June, 2012 until October 2012 (76)

Even though petitioner admitted she had relief for about six months after she received the injections, she did not try to return to work after October 2010. The last treatment she received for her back was by Dr. Burns in August 2015.

Although she did not look for work, she tried to volunteer at a library in North Carolina, but could not stand long enough to help. Petitioner had some sort of testing done in Rockford, but it was not physical testing; nor was it a functional capacity evaluation.

Prior to her employment with Rockford Memorial, petitioner worked for Morgan Building Maintenance as a regional manager/supervisor. She traveled and did building inspections. She worked there for five years. She had received training in building inspections.

Prior to her employment with Morgan, she was employed by ASI, a movie company. She did consumer research for commercials. She could sit at that job and was able to use a computer. She has a valid driver's license. She was never offered a job back at respondent's or vocational rehabilitation. She denied having any CAT scans or MRIs from 2002 through 2008.

John Arco, petitioner's husband, testified in her behalf. John Arco testified that before the accident, petitioner did everything around the house. He said after accident, she couldn't do most anything, such as walks or going out to dinner.

Laura Bremmer was called to testify by petitioner. Bremmer had been the acting manager from 2005 to 2008, at the store location where petitioner worked. Bremmer was petitioner's supervisor. Bremmer was not aware of petitioner having any back difficulties while she supervised the petitioner. Bremmer testified petitioner was capable of doing her job as a cashier which required her to lift up to 40 pounds from 2005 to 2008. Petitioner never missed any work do to back problems and worked 30 to 35 hours a week during that period of time. Bremmer confirmed petitioner's duties included unloading trucks. Petitioner and Bremmer became friends after Bremmer left her employment with respondent.

Petitioner's Exhibits

PX. 1 Dr. Keith Potetti DC Records

Petitioner introduced the records of Dr. Potetti. These records began on June 14, 2010. On that date, Dr. Potetti reported that [petitioner] presented with a noticeable limp. She has difficulty walking without assistance; she is using a cane. She was having difficulty changing positions getting in and out of care, up from seated position. She could not bend at the waist. Going up and down stairs is very difficult.

On June 14, 2010, Dr. Potetti noted decreased right S1 dermatome sensation as compared with the left. Right knee there was no swelling; left knee swollen. Dr. Potetti noted severe right buttock muscle spasms and moderate thoracic muscle spasm. Dr. Potetti noted decrease in S1 right reflex. Petitioner reported radiating pain down right leg. She received treatment by Dr. Potetti through July 17, 2010. During that time petitioner reportedly continued to use a cane. On June 28, 2010 petitioner was referred to Dr. Iqbal, a neurologist.

Dr. Javaid Iqbal reported on June 30, 2010, that petitioner had radiating numbness and tingling down the right leg and radiating pain in the right buttock since the accident. Dr. Iqbal also reported petitioner fell from favoring her right leg and injured her left knee. Dr. Iqbal indicated the strength was normal except there was giveaway weakness involving the right leg do to back

pain. Dr. Iqbal diagnosed falling down accident at work leading to low back pain and pain and numbness going down the right leg since June 12, 2010. Dr. Iqbal ordered and MRI and an EMG.

The findings on the MRI from July 2, 2010 were reported as multilevel degenerative changes; most predominantly at the L3-L4 level.

PX.2 Monroe Clinic and Hospital Records

The records of Monroe Clinic were introduced by petitioner. These records begin with petitioner's emergency room records from June 12, 2010. The history recorded was consistent with the work accident. Petitioner complained of low back pain that radiates into her right side as well as left knee pain. Her main complaints were in the back. She denied having chronic back problems. X-rays reported showed degenerative changes of the lumbar spine with decreased disc space at L3-L4. She was diagnosed with acute lumbar strain and knee contusion. Vicodin was prescribed. She was taken off work.

On June 14, 2010 petitioner contacted/visited Dr. Donovan on June 14, 2010 requesting a referral to a chiropractor, which was granted. On July 21, 2010, petitioner was seen by Dr. Donovan due to back pain. Dr. Donovan assessment was of radicular pain. Petitioner was prescribed Skelaxin and Vicodin and was referred to Dr. Szachnowski. Dr. Donovan excused the petitioner from work from July 29, 2010 to August 31, 2010. On August 27, 2010 petitioner was authorized off work until September 11, 2010. On August 31, 2010, Dr. Donovan authorized petitioner off work from June 12, 2010 to October 11, 2010.

Petitioner was first seen by Dr. Szachnowski on September 10, 2010. History was consistent relative to the work accident. Dr. Szachnowski reviewed the MRI and examined the petitioner. Dr. Szachnowski diagnosed spinal stenosis at L3-4 and L4-5 with central foraminal with radiculopathy more on the right than left with neurogenic claudication. Dr. Szachnowski recommended physical therapy and an epidural steroid injection.

On September 15, 2010 petitioner was evaluated by the physical therapist. She was observed walking in distress with a cane. Petitioner reported painful lumbar range of motion in flexion and extension and right. Physical therapy has compromised function due to pain. Original radicular symptoms were not present as they had been. Petitioner's gait was abnormal; using a cane since the accident due to fear of falling at home after work injury; legs gave way. She was instructed to use the cane on the left instead of the right. Physical Therapy was discontinued as of February 11, 2011.

On October 12, 2010, petitioner followed up with Dr. Szachnowski post epidural injection. Petitioner noted modest improvement. She was scheduled for another epidural injection on November 2, 2010.

Epidural steroid injections were carried out on October 7, 2010, November 2, 2010 and November 9, 2010. February 17, 2011 and June 12, 2012.

She returned to Dr. Szachnowski on November 16, 2010. Petitioner reported she had tried to work, but was unable to stand. Based upon Dr. Szachnowski review of the objective evidence, he did not believe petitioner was capable of returning to work. He recommended petitioner continue with physical therapy; hold off on injections and return to see him in three months. Surgery was not ruled out.

Petitioner was seen again on February 11, 2011 by Dr. Szachnowski. He recommended another injection. He also recommended petitioner settle her case to see how she is doing psychologically. He ordered her off work from February 11, 2011 until May 5, 2011.

On April 1, 2011 patient was admitted to the hospital due to myocardial infarction.

On May 12, 2011, Dr. Szachnowski ordered petitioner off work for nine months. Injections were being set up.

Petitioner underwent a Venous Doppler of the right leg on July 11, 2011 for a suspicion of a deep vein thrombosis which was ruled out.

On September 2, 2011 petitioner arrived at the emergency department due to increase left knee pain after twisting it several hours before arrival.

On December 12, 2011 petitioner returned to Dr. Szachnowski for treatment of the spinal stenosis. Dr. Szachnowski reported petitioner had done extremely well after her last injection [February, 2011], but due to the heart attack two months later, additional injections were put on hold. Dr. Szachnowski injected her left knee, which was doing fine until the new injury in September, 2011 [while on a treadmill during cardiac rehab]. She returned to Dr. Szachnowski due to knee pain on January 19, 2012, February 3, 2012, April 9, 2012 and arthroscopic surgery on May 3, 2012.

On June 4, 2012 petitioner returned to Dr. Szachnowski due to her back pain and injections were discussed.

PX.3 Dr. Peter Szachnowski July 21, 2015 Deposition

Dr. Szachnowski was called upon to testify by petitioner via deposition. Dr. Szachnowski originally saw petitioner on September 10, 2010 (P.10). Dr. Szachnowski's findings at that time were that petitioner had limited motion but petitioner's strength and reflexes were normal (P.9). He provided treatment from September 10, 2010 until June 12, 2012 (P.12). Dr. Szachnowski believed petitioner had pre-existing and bulging discs superimposed on degenerative disc disease which was silent, or asymptomatic, until the fall at work on June 12, 2010 (P.14). Petitioner remained symptomatic the entire time he treated petitioner (P.14) Dr. Szachnowski believed petitioner's condition was caused by the work accident and that petitioner was totally disabled during the period he provided treatment to her due to her work injury (P.18). Dr. Szachnowski agreed that his opinion regarding petitioner's ability to work was based upon her return to her full-time work where she had to stand (P.39). He indicated she could potentially work at another position (P.39). Petitioner told Dr. Szachnowski that her condition never improved to the point where she could return to full-time work (P.42-43).

PX.4 Dr. Jeffrey Coe March 2, 2015 Deposition

Dr. Coe, who examined the petitioner at her attorney's request on April 24, 2014, testified in petitioner's behalf via deposition.

Dr. Coe's diagnosis was that the fall at work aggravated preexistent lumbar degenerative disc disease and degenerative arthritis causing both acute and chronic pain (P.43). Dr. Coe believed petitioner's condition at the time of his examined on April 14, 2014 was caused by the work accident which caused petitioner's inability to return to work for respondent (P.44). Dr. Coe found petitioners' movement was restricted moderately (P.42). He found her straight leg raising was normal (P.40). Her deep tendon reflexes were normal except for in the left leg which was the result of the unrelated injury to her left knee (P.42). Based upon his examination, Dr. Coe did not believe petitioner was capable of working in a competitive market (P.46). Dr. Coe relied upon the work history petitioner had with respondent in rendering his opinion as to petitioner's ability to work (P.44-45). Dr. Coe did not find radiculopathy at the time of his exam (P.54). No herniated discs were found on the MRIs (P.58-59). Dr. Coe believed petitioner could work at a sedentary

level which means lifting 10 pounds or less or anything that required bending or twisting (P.70). He agreed petitioner could try and do something within her restrictions (P.70-71).

PX.5 First Health Moore Regional Hospital Records

These records indicate petitioner received her first pain management in seven months, since moving to North Carolina, was on January 30, 2013, (P.49-50). Petitioner had been referred by Dr. Stanzione to Dr. Andrea Burns for pain management. At the time of her initial evaluation by Dr. Burns, petitioner had complaints of low back pain with pain down legs, mostly on right (P.49-50). Petitioner underwent a lumbar steroid injection on March 28, 2013 by Dr. Place (P.54). Petitioner also received diabetes management, bilateral knee injections and treatment for e coli.

PX.6 Pinehurst Medical Clinic/Dr. Michol Stanzione Records

Petitioner was first seen at Pinehurst Medical Clinic by Dr. Stanzione on October 15, 2012. At that time, petitioner had multiple complaints, including ddd (degenerative disc disease). On January 17, 2013 Dr. Stanzione reported petitioner needed more treatment on back as pain up; petitioner could not walk and her weight was increasing. She was treated for her heart condition by Dr. Anderson on April 4, 2013. She was treated by Dr. Stanzione for her back on April 18, 2013. On July 18, 2013 petitioner reported to Dr. Stanzione that she was doing well under Dr. Burns' care.

PX. 7 Petition for Penalties and Attorneys Fees

PX. 8 TTD check issued on July 20, 2010

PX. 9 TTD check issued on September 22, 2010

PX. 10 Medical Bills

PX. 11 Social Security Disability Award of September 4, 2014.

Respondent's Exhibits

RX.1 Dr. Stephen F. Weiss March 24, 2011 Deposition

Dr. Weiss, who examined petitioner at respondent's request on July 29, 2010 and October 21, 2010, testified in behalf respondent via deposition.

Dr. Weiss testified that at the time of his initial evaluation of petitioner on July 29, 2010, petitioner denied having prior problems, chiropractic treatment, medication or any work restrictions prior to the work accident (P.6-7). Petitioner advised that her right leg gave out a second time shortly after the work accident which required her to use a cane and she has used a cane ever since (P.8). Dr. Weiss examined the petitioner and noted petitioner had an antalgic gait on the right, but had paravertebral muscle spasms on the left side (P.9-10). Dr. Weiss agreed that petitioner should have complaints as the exam was only six weeks after the accident (P.10). The only objective findings by Dr. Weiss was muscle spasms on the asymptomatic side and an abnormal MRI (P.11). He recommended six to twelve weeks of PT (P.11).

On October 21, 2010 petitioner reported to Dr. Weiss that her pain was worse (P.14). There was depressed knee jerk on the right side and quadriceps weakness (P.15). Dr. Weiss also noted

a new finding of radiculopathy for which he suggested an EMG in order to definitively state whether the radiculopathy was due to the pre-existing condition or the work accident (P.18).

Dr. Weiss stated that probably the current complaints and ongoing treatment as of October 21, 2010 were related to the normal progression of the pre-existing condition (P.25). Dr. Weiss agreed that petitioner's complaint of pain down her right leg into her calf on August 3, 2010 could be a sign of radiculopathy (P.40). The antalgic gait noted on the August 3, 2010 report was from the work accident (P.43). Dr. Weiss would not say that the radiating numbness down petitioner's right leg as reported to Dr. Iqbal on June 30, 2010 was related to the work accident (P.47). Dr. Weiss did not see the need to address symptom magnification in petitioner's case (P.48-49). Dr. Weiss believed petitioner had developed right radiculopathy as she had a depressed knee jerk and quadriceps weakness at the time of his October 21, 2010 exam (P.51). Dr. Weiss believed petitioner's condition had stabilized as of October 21, 2010 (P.67-68) Dr. Weiss believed petitioner treatment between June 12, 2010 and October 21, 2010 was necessitated by the work injury (P.70) Dr. Weiss did not believe petitioner's present complaints were related to the work accident (73). The only thing that would change Dr. Weiss' opinion regarding the ongoing complaints after October 27, 2010 would be if the petitioner had undergone an EMG (P.74-75). Dr. Weiss agreed surgery would be warranted if petitioner continued to have radiculopathy but he did not believe it is related to the work accident (P.76).

RX. 2 Dr. Stephen Weiss August 6, 2015 Deposition

Dr. Weiss authored a supplemental letter on July 15, 2015 after receiving additional information. Dr. Weiss noted the MRI showed an abnormality on the opposite size of petitioner's symptomology (P.18). Dr. Weiss concluded that due to the abnormality on the opposite side of her symptomology, then the condition dated back to her prior problems (P.20). Dr. Weiss believed petitioner would have restrictions due to her radiculopathy, which Dr. Weiss did not believe was caused by the work accident (P.22). As a result of the injury from the work accident, Dr. Weiss believe petitioner sustained a lumbar strain; for that, petitioner had no restrictions (P.23). Dr. Weiss agreed petitioner should have permanent restrictions of no lifting greater than 20 to 25 pounds and occasionally 30 to 35 pounds (P.23)

After reviewing the medical records of Dr. Potetti, Dr. Weiss agreed there was sign of radiculopathy as earlier as June, 2010 (P.42-43). Dr. Weiss agreed he would recommend steroid injections for radicular symptoms (P.48).

Petitioner's symptomology had not abated by the time Dr. Weiss saw petitioner the last time (P.56). Dr. Weiss agreed petitioner had never been symptom free relative to her back since the accident of June 12, 2010 (P.58). Dr. Weiss agreed the records from February 16, 2008 through August 13, 2008 indicate petitioner had radicular complaints at that time (P.60-61). Dr. Weiss found no symptom magnification (P.66).

RX.3 Dr. Stephen Weiss July 29, 2010 exam report

Most notable on the report was that Dr. Weiss found L3-4 DDD an abnormal MRI, and mild to moderate muscle spasm on the left side. Petitioner had also denied prior back treatment.

RX.4 Dr. Stephen Weiss October 27, 2010 report

Petitioner had depressed onset of L4 radiculopathy with depressed right knee jerk and quadriceps weakness. Dr. Weiss released petitioner to return to work with a10-pound weight lifting restriction.

RX.5 Dr. Stephen Weiss February 1, 2011 supplemental report

Dr. Weiss determined petitioner did not need further treatment or any work restrictions for her back injury.

RX.6 Dr. Stephen Weiss July 15, 2015 supplemental report

Dr. Weiss reported petitioner had radiculopathy that began between July 1, and July 15, 2010. Also, Dr. Weiss' review of the February, 2013 MRI showed compression at the L4-5 level on the left.

RX.7 Dr. Potetti Medical records from February 6, 2007 through August 13, 2008

The February 6, 2007 reported petitioner had low back pain on right. She received treatment from February 6, 2007 through August 13, 2008.

RX.8 FHN Family Medical Center records

The records were for treatment from 2002 through 2008 for various conditions. Although petitioner did check the box indicating she had pain, weakness, numbness in her back, leg and hip, she did not receive any treatment for these complaints.

RX.9 Respondent's letter offering petitioner to return to work within Dr. Weiss' restrictions.

RX.10 Utilization review

A utilization review was completed by Rising Medical Solutions on September 1, 2010 modifying the request for medical treatment by Dr. Poretti, DC.

RX 12 Payment schedule

This shows respondent issued four checks; the first one on June 29, 2010. Petitioner was paid TTD from June 17, 2010 through October 26, 2010.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following finding:

There is no dispute petitioner had pre-existing degenerative disc disease. The evidence supports a finding that petitioner's pre-existing degenerative disc disease had been aggravated by the fall at work on June 12, 2010 which resulted in radiculopathy that subsequently subsided by the time of petitioner's exam by Dr. Coe on April 24, 2014. Although the radiculopathy had resolved, petitioner had ongoing back pain.

In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

Based upon all the medical evidence, the Arbitrator awards medical bills through February 11, 2011, which is the time petitioner's medical had reached maximum medical improvement. The following bills are awarded and to be paid pursuant to §8 and §8.2:

$365.00-Dr. Javaid Iqbal/Odessa Neurology Clinic
$2,045.00 Dr. Keith Potetti/Back in Shape Chiropractic
$1,595.00 Monroe Clinic (Treatment 02/11/2011-02/17/2011)
$1,379.05 Monroe Hospital (Treatment on 02/17/2011)
$2,414.00 OSF St. Anthony Hospital (MRI 07/02/2010)

In support of the Arbitrator's decision with regard to temporary benefits, the Arbitrator finds the following:

Respondent stopped temporary total disability based upon Dr. Weiss exam of October 21, 2010 at which time Dr. Weiss agreed petitioner had work restrictions of no lifting greater than 20 to 25 pound and occasionally 30 to 35 pounds. There is no evidence respondent accommodated these restrictions. To the contrary, petitioner testified, without rebuttal, that respondent took her back to work without making any modifications. Petitioner's job with respondent required her to lift up to 40 pounds. Within 30 minutes of petitioner returning to work, she developed back spasms. The only modification to her work load, based upon the unrebutted testimony of petitioner, was that she was instructed by her supervisor to take it slow. Based upon this evidence, the Arbitrator finds petitioner was not provided work within her restrictions. Temporary total disability should have been continued beyond October 21, 2010.

Dr. Szachnowski, who examined petitioner on November 16, 2010, determined petitioner was disabled. He had performed Steroid injections on October 7, 2010, November 2, 2010 and November 9, 2010. On November 16, 2010, he held off on further injections, but ordered petitioner to continue PT. Another injection was performed on February 17, 2011. Petitioner reported she had felt relief for six months after the injections. On February 22, 2011, Dr. Szachnowski order petitioner off work until May 5, 2011. Dr. Szachnowski also recommended petitioner settle her case. He did not rule out surgery.

On April 1, 2011, petitioner suffered a heart attack. Petitioner also suffered an injury to her left knee during cardiac rehab on September 2, 2011. Her left knee was doing well until that re-injury. Petitioner did not receive any treatment to her back from February 17, 2011 until she returned to Dr. Szachnowski on December 12, 2011. Petitioner reported to Dr. Szachnowski that she had done extremely well [with her back] after the last injection, but due to her heart attack she had to put her injections on hold. On December 12, 2011, Dr. Szachnowski diagnoses was spinal stenosis. She saw Dr. Szachnowski in January, February and April, 2012 for treatment of her left knee injury caused by the cardiac treadmill accident. She did not see Dr. Szachnowski for her back until June 4, 2012.

Dr. Szachnowski testified petitioner could not return to her regular employment with respondent during the period he provided treatment to her back. He agreed petitioner could potentially work at another position.

The Arbitrator finds petitioner is entitled to TTD from June 12, 2010 through February 11, 2011, which is when petitioner's condition had stabilized. Although she returned to Dr. Szachnowski on December 12, 2011, she did not receive any additional treatment. She had to put her treatment on hold due to the heart attack.

Furthermore, Dr. Weiss, after reviewing additional medical records regarding petitioner's previous medical treatment, opined as of February 1, 2011 that petitioner did not require any further medical treatment or work restrictions.

Petitioner did not seek work within her restrictions. Nor did she demand vocational rehabilitation. Petitioner did not offer the opinion of a vocational counselor as to her employment

capabilities. Although Dr. Szachnowski and Dr. Coe testified petitioner was totally disabled from her employment with respondent, both doctors agreed petitioner may be capable of some type of employment.

Based upon the foregoing, the Arbitrator finds petitioner is entitled to TTD from June 13, 2010 through February 17, 2011.

In support of the Arbitrator's decision with regard to the nature and extent of injury, the Arbitrator finds the following:

Petitioner claims to be permanently and totally disabled, relying upon the testimony of both Dr. Szachnowski and Dr. Coe. However, both treating doctors agreed petitioner may be capable of performing some sort of employment with restrictions. Dr. Szachnowski testified he based his opinion that petitioner was totally disabled on her inability to work full time standing. He conceded petitioner may be capable of some sort of employment. Dr. Coe agreed he based his opinion that petitioner was capable of competitive employment in a stable labor market in petitioner's occupation with respondent. Dr. Coe agreed petitioner would be capable of working at the sedentary level.

Petitioner admitted she looked into volunteering at a library in Carolina. There is no evidence petitioner could not have sought out actual work within her restrictions, and not just volunteer work, in light of her education, employment history and limitations.

Therefore, the Arbitrator finds petitioner sustained a lumbar strain that an aggravated petitioner's pre-existing degenerative disc disease from the work accident and awards 15% person as a whole under §8 (d) 2.

In support of the Arbitrator's decision with regard to penalties and attorneys' fees, the Arbitrator finds the following:

Respondent paid the petitioner sporadically. There is no evidence, however, as to when petitioner made a demand for TTD. The petition for penalties only made a general statement petitioner repeatedly asked for TTD, without confirming when the request was made.

Furthermore, respondent relied upon the opinion of Dr. Weiss. Although it may not be sufficient to defeat TTD, it is sufficient to uphold denial of penalties.

In support of the Arbitrator's decision with regard to the credit due respondent, the Arbitrator finds the following:

Respondent is to be given credit for $1,275.30 paid to Dr. Keith Potetti.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alfredo Jimenez,

Petitioner,

vs.

NO: 16 WC 21795

18IWCC0525

Homer Tree Care/R.P. Reposh, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact

The Commission notes that Petitioner filed two (2) Applications for Adjustment of Claim – namely, 16 WC 21794 (D/A=1/12/15) and 16 WC 21795 (D/A=2/15/16) -- and that the parties agreed to proceed to trial solely on 16 WC 21795 on 2/24/17. Unfortunately, the Arbitrator's decision referenced 16 WC 21794 in the caption while addressing the claim relative to the alleged date of accident on 2/15/16. In an Order dated 5/24/18 the Commission corrected this clerical error to show 16 WC 21795 as the claim currently in dispute, and the subject of both the Arbitrator's decision filed on 6/20/17 and the present review.

Petitioner, a 43-year old foreman, testified that he began working for Respondent "[t]hree, four years ago." (T.14). Petitioner agreed that he had a prior neck or cervical issue about 15 to 20 years ago and that he saw several doctors for that condition, including Drs. Jacker

and Adamson. (T.14-15).

With respect to this previous cervical issue, the record contains a report by Dr. Michael Jacker dated 4/21/95 wherein it was recorded that Petitioner "... is a tree worker... [who] states that he had no problems with his back until March 16, 1995 while at work. On that date, he states that he was lifting a big log and felt a 'crack or sharp pain' on the left side of his back... He currently complains of pain up and down the left side of his back (and he points to the area extending from the upper lumbar spine to the mid-thoracic level)." (RX5). Dr. Jacker's impression was "... thoracolumbar myofascial strain in a lifting injury while at work." (RX5).

In a letter dated 1/14/98, Dr. Jacker recorded that he saw the patient "... concerning back pain related to an injury sustained in a motor vehicle accident while working." (RX5). Dr. Jacker noted that Petitioner works as a "tree climber" and "... has had some lower back and mid-back pains in the past, but has had no symptoms over the past two years and was free of any problems when he was involved in an accident on December 6, 1997. At that time he was driving a truck. The truck was struck on the passenger's side by another vehicle. He was wearing a belt and shoulder harness. There was no loss of consciousness. He developed pain in his neck and back right away... Currently he complains of pain primarily in his mid-back (he points to the thoracic levels) extending into his lower back. Occasionally he has some pain moving up into his neck and occasionally some pain traveling around to the front of his chest. He also has had occasional symptoms of weakness about the left shoulder, but this is not currently present. He denies any radiation of pain distally in the upper or lower extremities. He denies any numbness, tingling or other symptoms of weakness." (RX5). Following his examination and review of x-rays, Dr. Jacker's impression was "... a myofascial strain involving his cervical, thoracic and lumbar levels. Of note there is some reversal of cervical lordosis at the C3-C4 level on radiographs. I would expect that all these conditions will be self-limited and improve with conservative management including physical therapy and exercises over the next several weeks." (RX5). Dr. Jacker recommended physical therapy three times a week for the next two weeks and imposed a 30 lbs. lifting restriction as well as a restriction from tree climbing for the next two weeks. (RX5).

In a letter dated 1/28/98, Dr. Jacker continued the above restrictions and ordered MRI scans of the cervical and lumbar spines. (RX5).

An MRI of the cervical spine performed on 2/2/98 revealed "mild disk degeneration from C3 to C6. Mild broad[-]based left paramedian disk bulge at C4-5 partially effaces the ventral cerebrospinal fluid and with mild flattening of the underlying ventral aspect of the cervical spinal cord." (RX5). An MRI of the lumbar spine also performed on 2/2/98 revealed "minor disk degeneration L3-4 otherwise unremarkable Lumbar Spine MRI." (RX5).

In a letter dated 2/4/98, Dr. Jacker noted that MRI scans dated 2/2/98 were reviewed and revealed the following: "Lumbar MRI scan reveals no evidence for any significant abnormalities. Cervical MRI scan reveals evidence of a central to left perimedian disk bulge with some effacement of the ventral CSF and flattening of the ventral aspect of the cervical spinal cord at the C4-C5 level." (RX5). Dr. Jacker's impression was that "... this man has symptoms related to a lumbar myofascial strain and that his cervical spine symptoms are probably in part secondary to the disk protrusion centrally and slightly to the left at C4-C5." (RX5). Dr. Jacker continued to

impose lifting restrictions of 30 lbs. as well as no tree climbing; he also renewed physical therapy with an added modality of cervical traction and a home cervical halter traction program. (RX5).

In a letter dated 2/25/98, Dr. Jacker noted that Petitioner continued to have pain in his neck, that often travels into his left arm, as well as some soreness in his lower back. (RX5). Dr. Jacker's impression was "... persistent symptoms related to a lumbar myofascial strain, but more notably he has persistent symptoms, most likely secondary to the disk protrusion centrally and to the left at C4-5." (RX5). Dr. Jacker continued to impose a 30 lbs. lifting restriction in addition to no tree climbing, and referred Petitioner to Dr. Adamson for neurosurgical evaluation. (RX5).

In a letter dated 3/12/98, Dr. James Adamson recorded a history of motor vehicle accident in the course of work on 12/6/97 with initial symptoms of neck and low back pain. (RX5). Dr. Adamson noted that "[s]ince then he has also noted periods of diffuse paresthesias in the entire left upper extremity as well as intermittent paralysis of the left arm." (RX3). Following his examination and review of the MRIs, Dr. Adamson noted that "[t]here is a mild broad[-]based disc bulge at C4-C5 which is slightly larger on the left side. There appears to be adequate cerebrospinal fluid all around the cord and I do not believe that there is any cord compression. He certainly has no signs of a cervical myelopathy. I cannot explain his symptoms on a clinical basis at the present time. The mild bulging at C4-C5 would not cause diffuse paresthesias and intermittent paralysis of the left upper extremity. I recommend that he undergo an electromyogram to objectively test the nerves of the upper extremity... If this EMG is normal he may eventually need an evaluation by a physiatrist since physical therapy for his neck has not improved him so far." (RX5).

An EMG performed on 3/20/98 revealed "[n]o electrophysiologic evidence of cervical radiculopathy, focal or diffuse peripheral neuropathy." (RX5).

In a letter dated 3/30/98, Dr. Adamson noted that the EMG was interpreted as normal and that "... there is no evidence for cervical radiculopathy or a more peripheral neuropathy. I do not believe that further neurosurgical workup is warranted at this time and I reassured him that I do not believe that he will need cervical spine surgery. I would recommend further physical therapy and/or evaluation by a physiatrist if he does not continue to make satisfactory progress. I will be glad to see him at any[ ]time in the future on a p.r.n. basis." (RX5).

In a letter dated 4/6/98, Dr. Jacker recorded that Petitioner presented with "... complaints primarily involving his neck. Since he was last seen, he states that he does not have the pains in his left upper extremity as previously, though he does feel weakness in his left upper extremity. His primary complaint is of pain in his neck region which is worsened with any types of motion. He also does have some soreness in his lower back." (RX5). Dr. Jacker noted that "[s]ince this man was last seen, he has been evaluated neurosurgically by Dr. James Adamson and with EMG testing by Dr. Karen Levin. The EMG testing of the upper extremities did not reveal evidence for cervical radiculopathy, focal or diffuse peripheral neuropathy. Dr. Adamson reviewed his studies and did not see any indication for neurosurgical intervention at this time. He recommended follow up by a physiatrist." (RX5). Dr. Jacker's impression was that "... this man has persistent symptoms as previously noted related to disk protrusion at C4-5 with associated degenerative changes." (RX5). Dr. Jacker concurred with Dr. Adamson as to a follow up

evaluation by a physiatrist and recommended that "... he continue at his current restriction with 30 lbs. maximum lifting and no tree climbing." (RX5). Petitioner was to follow up on an as-needed-basis. (RX5).

In a report dated 4/17/98, Dr. Martin Lanoff recorded that Petitioner had been referred by Dr. Jacker for initial evaluation. (RX5). It was also noted that Petitioner had been in a motor vehicle accident on 12/6/97 and that "[h]e has had suboccipital headaches as well as cervical, thoracic, and lumbar discomfort ever since the accident. They all hurt equally." (RX5). It was also noted that he denies any prior injuries to his back, neck, or thoracic spine region." (RX5). In addition, it was recorded that "[c]ervical lumbar spine MRI's were obtained, and the cervical spine MRI did show left pyramidian disc bulge at C4-5; the lumbar spine showed minor desiccation of the disc at L3-4. Neither of these studies has any clinical relevance. The patient did see a neurosurgeon, Dr. Adamson, who stated that this man was not a neurosurgical candidate. A recent electomyographic evaluation was negative." (RX5). Dr. Lanoff concluded that "I explained to this gentleman that I have nothing to offer him at this point. I think that his therapy has been appropriate. I do not think that medications are the answer for him. He is apparently seeing an 'insurance company physician' next week. I explained to him that at this point, I would recommend that he be seen at the Lake Forest Pain Clinic because his subjective complaints are out of proportion to objective findings. Short of that, I have nothing else to offer him. I have no problem with his being on light-duty, with no lifting of over 30 lbs ... Until he can be seen at the pain clinic, I gave him restrictions for 3 weeks, but I think that he can get into the clinic to be seen much earlier than that. If anyone has anything to offer this gentleman, it is most likely the pain clinic, as I see no pathology in this gentleman at this time." (RX5).

Petitioner agreed that the aforementioned MRI and EMG were previously performed in 1998, and it was fair to say that he was told he was not a surgical candidate at that time. (T.15-16). He also indicated that he was released by the above physicians, and he denied experiencing any problems or visiting any doctors with respect to his neck or cervical spine from that time until the date of the alleged accident in February of 2016. (T.16-17). In addition, Petitioner noted that he continued to work doing tree work during this roughly 20-year interval. (T.17). He indicated that tree work is his chosen profession, and that he has been in that profession for 30 years. (T.17). He also noted that the job is "[v]ery physical", and that he had no further problems with his neck until 2/15/16. (T.17-18).

With respect to the present claim, Petitioner testified that he worked for Respondent as a foreman, which he noted involved "... cutting down trees. Climbing trees. Grabbing big logs. Branches. Heavy chainsaws. Ropes." (T.18). He indicated that he would do this every single day and that he worked steadily for Respondent during the three or four years leading up to the accident. (T.18-19). He noted that the chainsaws varied in weight from about 25 to 45 pounds. (T.19). He also indicated that he would have to lift logs weighing from 10 to 500 pounds, and that he would have to do this "[e]very day. Day in and day out." (T.19-20). In addition, as a foreman, he agreed that he had some management responsibilities during the entire time he worked for Respondent. (T.20).

Petitioner testified that on 2/15/16 he was "... taking [down] big, a big tree in the backyard. And starting chainsaw, I pulled it, and I grabbed – I felt a pinch right in my neck

going all the way down" the left arm. (T.20-21). He agreed that it was also painful, and that he had not had any pain in his neck for the past 15 years. (T.21). He indicated that the pain did not subside or get any better. (T.21).

Petitioner agreed that he visited Dr. Thomas Baier at Greenleaf Orthopedics pretty close to the date of the accident. (T.21-22). He indicated that Dr. Baier sent him to physical therapy as well as an MRI of his neck. (T.22). He noted that the pain in his neck and left arm did not get any better during the approximately six (6) weeks of physical therapy he attended. (T.22-23).

In a progress note dated 3/1/16, Dr. Baier recorded that the patient presented with left shoulder and elbow complaints, noting that "[h]e states on February 15 he was trying to start a chain saw and he was doing this with his left arm. In doing so it took several times to pull the cord. The last time he pulled it the cord came out and he instantly felt a pain from his left shoulder blade all the way down to his hand. He did report this to work and on the following day went to see the work physician. They placed him on Norco and ibuprofen. He has been on modified duty since then. He says that the arm is feeling a little bette[r], but he still has pain particularly in the shoulder blade and on top of the shoulder. He has not been to formal physical therapy. He says that there are days where the arm becomes swollen and he'll have tingling into the fingers. He also notices stiffness with his neck." (PX3). Dr. Baier's assessment was 1) strain of muscle, fascia and tendon at neck level, 2) strain of muscles and tendons of the rotator cuff of left shoulder, and 3) transient synovitis, left elbow. (PX3). Dr. Baier switched the patient to a different anti-inflammatory, recommended getting off the Norco and sent him to formal physical therapy. (PX3).

In a Physical Therapy Initial Evaluation dated 3/3/16, it was recorded that on 2/15/16 the patient was "... starting a chain saw with the cord and his hand lost grip of the cord and he started to get extreme pain in his left arm, shoulder, and neck. He states that he was also doing a lot of carrying of large logs on his shoulder that day. Patient states that the pain starts at the base of his neck, goes down his shoulder, and splits in 2, going down the front of his shoulder and the pectoralis major and into the armpit, and also down the back of his arm along the lateral aspect to the elbow and into the palmar surface of his forearm and hand." (PX3).

In a progress note dated 3/8/16, Dr. Baier noted that the patient was doing better and was off the pain medication completely. (PX3). He recorded that Petitioner had recently started physical therapy and "... still gets pain into the base of the neck on the left side, the shoulder and the left elbow. He states the tingling that he had in his arm is gone. He is back to work doing office work. He denies numbness in his arm. He denies weakness in his arm." (PX3). Dr. Baier recommended Petitioner continue with light duty work and noted that "[r]ight now I don't see a need for an MRI of his shoulder or neck unless things do not improve." (PX3).

In a progress note dated 3/15/16, Dr. Baier noted that "Alfredo continues to have symptoms. He hurt himself about 2 or 3 weeks ago while at work. He works for a tree removal service and he hurt himself pulling on a chain saw. Therapy did tend to aggravate things. He will get tingling into his fingers and not really numbness. He gets pain on the left side of his neck, as well as by the shoulder blade and the shoulder itself. He is doing light duty, just office work." (PX3). Dr. Baier prescribed a muscle relaxant (Flexeril) and ordered an MRI of the cervical spine as well as continued physical therapy. (PX3). He indicated that "[p]ending on the

results of the MRI scan we may need to consider an epidural injection." (PX3).

An MRI of the cervical spine performed on 3/23/16 was interpreted as revealing 1) inflammatory and/or degenerative changes at the anterior atiantoaxial articulation, flexion and extension plain films are suggested to rule out instability; 2) cervical spondylosis with moderate C3-4 and C5-6 central and foraminal stenosis; and 3) prominent central disc herniation superimposed on degenerative changes at C4-5 with moderate to severe central and moderate bilateral foraminal stenosis, there is spinal cord edema versus myelomalacia at this level. (PX2 [Citow Dep.] Ex.5).

In a progress note dated 3/29/16, Dr. Baier noted that Petitioner's "... shoulder pain is getting better. He still has some stiffness in his neck. Most of the pain now is in the upper chest and front of the left shoulder. Occasionally he gets some pain going down the left arm. Occasionally he will get tingling, but no true numbness." (PX3). Dr. Baier's review of the cervical MRI revealed "... very significant spinal stenosis. He also has a herniated disc on top of this spinal stenosis causing significant nerve irritation, particularly C5-C6 region." (PX3). Dr. Baier recommended continued light duty work and "... gave him the name of the neurosurgeons. I am afraid that if he goes back to his regular manual labor that he will continue to irritate the nerve, which could lead to permanent nerve damage." (PX3).

In a separate Work Status report dated 3/29/16, Dr. Baier imposed a lifting restriction of 10 pounds maximum and "[n]o regular work duties until evaluated and released by the neurosurgeon." (PX3). Petitioner indicated that Dr. Baier referred him to neurosurgeon Dr. Jonathan Citow. (T.23).

In a progress report dated 4/6/16, Dr. Citow recorded a history of injury on 2/15/16 "... when he was starting a chainsaw at work for Homer Tree Company, where he developed significant neck pain extending through the left upper extremity towards the fingers with numbness, weakness, and paresthesias. He was evaluated by orthopedic surgery the next day and subsequently he has been at work with a ten[-]pound lifting restriction. He has had 11 sessions of physical therapy without significant benefit." (PX2 [Citow Dep.] Ex.2). Following his examination and review of the cervical spine MRI from March of 2016, Dr. Citow's assessment was 1) cervical spondylosis with myelopathy; 2) spondylolisthesis of cervical region; 3) cervical stenosis, and 4) work related injury. (PX2 [Citow Dep.] Ex.2). Dr. Citow concluded that "[d]ue to his significant pathology, injections likely would not help his spinal cord compression and impending myelopathy. Therefore, we will proceed with a C3-6 anterior decompression and stabilization." (PX2 [Citow Dep.] Ex.2).

In a "Work Status Report" dated 4/6/16, Dr. Citow indicated Petitioner was able to return to work as of 4/6/16 with restrictions of no lifting more than 10 pounds. (PX2 [Citow Dep.] Ex.4).

Dr. Citow last saw Petitioner on 11/9/16 at which time he recorded that Petitioner "... returns with persistent neck pain extending through the left upper extremity towards the fingers with numbness, weakness, and paresthesias ranging from a 5-7/10 in severity. He does not have back pain or radicular leg pain. He has no problem bending at the hips. He had an IME by Dr. Butler, who opined that his neck and radicular symptoms are related to his work injury and

agreed he required a C3-6 anterior decompression and stabilization. Video surveillance, however, documented that he can bend over without much problems and lift things. This seems reasonable since he does not have a lumbar issue and strictly a cervical issue. He still has significant problems in his neck that requires surgical intervention and requires the surgery the IME agreed about." (PX2 [Citow Dep.] Ex.2).

At the request of Respondent, Petitioner visited Dr. Jesse Butler for purposes of a §12 examination on 5/16/16. On that date, Dr. Butler recorded that "[t]he patient was attempting to start a chainsaw on February 15, 2016 when he developed significant neck and left upper extremity radiating pain. He has tingling of the fingers and numbness of the forearm. He has pain in the left chest and scapular region with radiation down the arm. The patient notes weakness with the left arm. There are no right sided symptoms. He denies prior injury to the neck." (RX2). As part of his evaluation, and pursuant to the OSWESTRY Disability Index, Dr. Butler recorded that his pain intensity was rated "1 – Pain is bad but I manage without taking pain medication" and that his ability to lift was a "5 – I cannot lift or carry anything at all." (RX2). He also noted that on a scale of 0 to 10 his pain level at its worst was a "6". (RX2).

Following his examination and review of the medical record, Dr. Butler opined that "[t]he patient's current condition is significant cervical myeloradiculopathy affecting the left upper extremity. This condition is work related to the work accident of February 15, 2016. The medical basis for this opinion is as follows. The patient has cervical kyphosis with stenosis from C3 through C6. The physical act of starting a chain saw with the jerking motion of the upper extremity either aggravated a preexisting degenerative condition or caused additional tearing and herniation of the disc in the cervical spine to create this symptomatic condition. The patient's current medical care and treatment relative to this injury has been reasonable, necessary, and causally connected to the accident of February 15, 2016. The performance of medical management and physical therapy along with diagnostic imaging was reasonable. Referral to a neurosurgeon for surgical consultation was also reasonable. The patient does require further medical care relative to this injury. This treatment is causally related to the work accident of February 15, 2016. The patient requires an anterior cervical discectomy and fusion from C3 through C6 as recommended by his treating neurosurgeon. The medical basis for this surgery is significant deformity and spinal cord compression with myelomalacia affecting the cord at two of the three levels. The patient is not currently capable of engaging in employment activities relative to his conditions. The patient is unable to perform the activities required in the job description provided. The patient has work limitations relative to his condition... The patient has not reached maximum medical improvement." (RX2).

In a subsequent §12 report dated 7/12/16, Dr. Butler recorded that "[o]n May 31, 2016 the patient was noted to lift garbage bags and place in a dumpster. He was bending without issue. He lifted a dolly out of a truck. He then lifted a garage door by the handle and crouched down to climb under the door. He was seen lifting multiple items out of a pickup truck to place in the garage. He carried a tool box out of the truck to the garage. He was then seen carrying multiple items including a weed trimmer and full bins/tubs. On June 6, 2016 he was seen carrying two full bags from the car to the home. He was able to reach into the trunk of a car. On June 16, 2016 he was seen moving a garbage can. During all of the above activity there was no pain behavior noted. There was no limitation of upper extremity function consistent with active radicular pain or neurologic impairment." (RX3). Dr. Butler concluded that "[t]he patient's

clinical picture is markedly inconsistent with the examination and diagnostic imagining for which he presented on May 16, 2016. The need for surgery is based on radiographic issues that identify significant spinal cord compression and damage that poses significant risk for him without surgery. Clearly based on the video he is able to function without limitation or restriction at work. His subjective complaints are not consistent with the activity demonstrated in the video. I still believe he needs to consider surgery but whatever exacerbation he may have had from work is clearly resolved. The need for surgery relates to the underlying degenerative issues." (RX3).

At the request of Respondent, Dr. Butler testified by way of evidence deposition on 2/15/17. (RX4). Dr. Butler noted that he is a certified independent medical examiner and that he examined Petitioner on 5/16/16. (RX4, p.7). Dr. Butler noted a history of injury on 2/15/16 while trying to start a chainsaw. (RX4, p.11). He stated that Petitioner described significant neck and left upper extremity radiating pain with tingling of the fingers and numbness of the forearm, and that he denied any prior injury to his neck. (RX4, p.10). Dr. Butler also noted that Petitioner completed a couple of questionnaires prior to his physical exam, including an Oswestry Disability Index wherein he indicated that his pain intensity "... was a 1, where he said pain was bad, but he could manage without taking pain medication" and that "[u]nder lifting he said he could not lift or carry anything at all..." (RX4, p.14). Dr. Butler noted that his diagnosis, after reviewing the actual MRI scan from 5/5/16, was "... cervical myelopathy, disc herniation, and stenosis. One could also throw in there cervical kyphosis." (RX4, p.15). He testified that his opinion at that time was that "... the symptoms he currently described were causally related to the work activity of starting the chainsaw of February 15, 2016." (RX4, p.15). He also indicated that "[a]ll of this was degenerative and pre-existing", the level of which he described as "[s]evere." (RX4, p.16).

Dr. Butler testified that "[i]t's very possible that [Petitioner] could have had symptoms of myelopathy without any specific injury, just with basic activities of daily living." (RX4, p.16). He also felt the care Petitioner had received as well as the recommended surgery was reasonable and necessary. (RX4, pp.16-17). In addition, Dr. Butler indicated that as of the date of his examination Petitioner had not reached maximum medical improvement and was to remain off work, at least on a temporary basis. (RX4, pp.17-18).

Dr. Butler agreed that he subsequently issued a second report on 7/12/16 following his review of surveillance videos. (RX4, pp.19-20). Dr. Butler noted that Petitioner exhibited no pain behavior in the surveillance footage, and that "[t]he patient's own disability index from his evaluation on May 16th stated that he can't lift or carry anything at all and that was clearly contradicted by what was observed on these three separate dates." (RX4, p.23). Dr. Butler testified that "[o]bviously one can't change the fact that he has a terrible neck with very advanced degenerative issues. [But] [b]ased on these three separate dates of video, it appears that whatever aggravation he sustained from starting the chainsaw had since subsided." (RX4, pp.23-24).

Dr. Butler testified that "... it is still my opinion that based on what he has in his cervical spine, it is not in his best interest to be doing this type of lift activity. But the video clearly shows that whatever pain or neurologic function he has is not enough to prevent him from doing essentially normal activities of daily living and then some." (RX4, p.24).

Dr. Butler testified that he was not aware of any treatment or diagnostic tests prior to 2/15/16. (RX4, p.24). He was then shown records from Adult & Pediatric Orthopedics. (RX4, p.25). Dr. Butler noted that the first time he saw the aforementioned APOrtho records was the day of his deposition. (RX4, p.40). After reviewing these prior records, Dr. Butler noted that Petitioner had an MRI of the cervical spine on 2/2/98 that "... essentially showed mild degeneration from C-3 through 6 with left-sided disc bulge at C4-5." (RX4, p.26). When asked whether these records changed his opinion regarding the level of degeneration, Dr. Butler responded: "[n]o, he had severe degeneration at the time I had seen him, and the most recent MRI [shows] his degenerative findings were significant. At th[e] time [of the prior MRI] he was only, I believe, 25 years of age, and he did not have severe degeneration, at least at this stage. He was already starting to develop some loss of lordosis and abnormal pathology in the neck, but this is very early on." (RX4, pp.26-27). He indicated that "... it just shows that he's had rather significant progression of that degeneration over the past 20 years... It is hard to know, given the records that we have, if there had been other issues or incidents in between that may have accelerated that. Nonetheless, what we are faced with now as a 43-year-old or a 44-year-old male, the degeneration is severe." (RX4, p.27).

On cross, Dr. Butler indicated that he does about 500 IMEs a year, the vast majority of which are related to workman comp cases, and of which 90 percent are for the Respondent. (RX4, pp.28-29).

Dr. Butler agreed that at the time of his evaluation he believed the mechanism of injury described by Petitioner – pulling on a chainsaw – was consistent with causing injury to the cervical spine. (RX4, p.36). In fact, he noted that "I grew up on a farm, and I've had many cold-blooded chainsaws, so I can understand the mechanism of injury very well." (RX4, p.37).

Dr. Butler also noted that he was able to discern a diagnosis of cervical myelopathy from the MRI, or what he described as "... signal changes within the spinal cord" which he agreed was a significant condition. (RX4, p.38). He also agreed that he was able to identify on the MRI a disc herniation at C4-5 and C5-6 as well as stenosis at C3-4 and C5-6. (RX4, pp.38-39). However, he noted that "... these were not acute herniated discs. These all appeared to be somewhat chronic in nature. There was prominence in the disc at those two levels primarily." (RX4, p.39).

When asked whether it was still his opinion that the mechanism of injury could have caused additional tearing and a herniation of the disc, as noted in his initial report, Dr. Butler responded: "Sure, absolutely." (RX4, p.39). He indicated that he would not be able to quantify any additional tearing without "... a preinjury MRI scan to determine what, if any, structural change may have occurred." (RX4, pp.39-40). When asked to compare the current MRI to the one from 20 years ago, Dr. Butler testified that "... the appearance of the MRI is entirely different. The C3-4, 4-5, and C5-6 levels have undergone tremendous degenerative change in that interval period. C4-5 you would have characterized as just a small protrusion or bulge of the disc at the time with some contact with the ventral spinal cord. Still there was plenty of room there, and no spinal cord damage whatsoever. So that progression has been extreme over the last 20 years." (RX4, p.41). He also agreed that it was fair to say that there was no myelopathy condition in the MRI from 20 years ago, and that the disc herniation at C4-5 was worse or more pronounced. (RX4, p.41). Dr. Butler conceded that the worsening of the herniation could have

been caused by the work injury or accident on 2/15/16. (RX4, pp.41-42). As to the significance of these prior records, Dr. Butler stated that "... it just contradicts his history that he had no prior injury to the neck. Other than that, it doesn't add much radiographically." (RX4, p.42). He also agreed that it was possible that a patient could forget an injury that occurred 20 years ago, and that could have applied here to Petitioner. (RX4, p.42).

Dr. Butler indicated that he was in agreement with Dr. Citow's recommendation, made prior to video surveillance, for cervical fusion. (RX4, p.43). He also agreed that he was of the opinion that the cervical fusion and its necessity was a result of the work accident. (RX4, p.43). When asked why he believed Petitioner needed a three-level fusion, Dr. Butler stated that "[i]t was a combination of the subjective complaints, the interference with activities of daily living, the physical exam findings, and the imaging studies that led me to conclude that surgery was reasonable and necessary." (RX4, pp.43-44). Dr. Butler also noted that it was his understanding Petitioner was not treating for his neck prior to the work accident, and that it was fair to say he was not aware of any complaints of neck problems during the 15 years leading up to the accident. (RX4, pp.44-45).

Dr. Butler agreed that the myelopathy is a significant problem. (RX4, p.45). He also indicated that "... it is objective and irreversible." (RX4, p.45). He indicated as well that Petitioner needs surgery to stabilize his condition and "... prevent it from getting worse. You can't correct or improve that condition." (RX4, p.45). In addition, Dr. Butler noted that based on the job description provided by Respondent, Petitioner's job as a crew leader "... seems to be at least at the higher end up to a medium demand level." (RX4, pp.46-47).

Dr. Butler agreed that in his initial report he felt the need for fusion surgery was a direct result of the work accident, and that he changed his opinion after he was provided the video surveillance. (RX4, p.48). When asked if the sole basis for his opinion change was the videos, Dr. Butler stated that it was "... a combination of the surveillance videos and the discrepancy from the disability index and subjective complaints he reported at the time of the IME." (RX4, p.48). He denied that there was any other basis for his change in opinion. (RX4, p.48).

Dr. Butler indicated that he viewed all three videos in their entirety, and that he identified Petitioner lifting items in those videos. (RX4, p.49). However, in terms of how much those items weighed, Dr. Butler noted that "I don't know that I could give you specifics for each item." (RX4, p.49). When asked whether it mattered how much these items weighed, Dr. Butler stated that "... it was just a general sense that the force he was applying, the objects he was lifting, directly contradicted what he said, which is he can't lift anything." (RX4, p.49). However, he noted that "... it's different if he was just carrying a couple of grocery bags as opposed to fully loaded bins and tubs, weed trimmers, toolboxes, a dolly. Individually they may not all weigh at the most maybe 35, 40 pounds, the manner in which he was doing this activity showed that he really didn't have any pain behavior or obvious limitation from a neurologic standpoint." (RX4, pp.49-50).

When asked if it would surprise him to learn that most of the items in the videotape weighed less than ten pounds, Dr. Butler responded: "I wouldn't be surprised." (RX4, p.50). However, he indicated that he did not know how heavy the toolboxes and bins/tubs were, and that it would matter "[b]ecause of the force required to carry these things. When you are

carrying things on a repetitive basis, as was noted in the video, it takes strength. It requires dexterity. If he was just carrying one heavy item, that may be easier to do and tolerable with his underlying condition. The volume that he was carrying, again, seemed to be inconsistent with what his clinical presentation was." (RX4, pp.50-51). However, he agreed that he truly did not know the weight of these items. (RX4, p.51).

Dr. Butler agreed that he had the same assessment or diagnosis in his second report, and that he likewise found that Petitioner still needs the surgery. (RX4, p.53). He agreed that his change of opinion relates to why he needs it – namely, from a work accident necessitating surgery to a pre-existing degenerative condition necessitating the surgery. (RX4, p.53). He likewise agreed that at the time of his initial visit he was aware that Petitioner had degenerative changes in his cervical spine and yet he still was of the opinion that the work accident necessitated the surgery. (RX4, p.54). Similarly, he agreed that these degenerative changes did not change between the time of his first report and his second. (RX4, p.54). He noted that if Petitioner had grimaced in pain while lifting these items "[i]t would have had an impact on my opinion. Whether it would have changed it, I can't say for sure." (RX4, p.55).

On redirect, Dr. Butler testified that none of the questions on cross changed any of his opinions with respect to the level of degeneration or whether normal daily activities could have contributed to the symptoms at the time of his examination. (RX4, pp.56-57).

At the request of Petitioner, Dr. Citow testified by way of evidence deposition on 11/23/16. (PX2). Dr. Citow noted that he is a board-certified neurological surgeon and that he saw Petitioner on two occasions. (PX2, pp.6-7). He indicated that following his initial visit on 4/6/16 he allowed Petitioner to return to work with a 10-pound lifting restriction, a restriction that remains in place to this day. (PX2, pp.7-8). Dr. Citow noted that he reviewed the MRI performed in March of 2016 which "... demonstrated C3 to 6 reversal of the normal lordotic curvature and spondylolisthesis with very severe bilateral foraminal narrowing and significant central stenosis with compression of the spinal cord and signal changes within the spinal cord itself at C4/5." (PX2, p.9). Dr. Citow stated that he felt that "... due to the significant cervical MRI findings and his symptoms, that injections would not help his spinal cord compression, which was now symptomatic, and, therefore, [he] felt [Petitioner] required a C3 to 6 anterior decompression and stabilization." (PX2, p.9).

Dr. Citow indicated that the hope with surgery was to "... get rid of the pain that [Petitioner's] complaining about now, hope to get rid of any numbness, weakness, pins and needles, and also to prevent deterioration, because in his case he's pretty far gone. And if we didn't do anything, he's going to slowly worsen and he can become myelopathic where he loses control of his legs and bowel and bladder function as well as spine, coordination of his hands, and we're hoping to prevent that as well." (PX2, p.11).

When asked whether the work accident of 2/15/16, as described by Petitioner, resulted in any injury or harm to his cervical spine, Dr. Citow responded: "[l]ikely he had preexisting cervical spondylosis since multiple levels were involved, and this is exacerbated by his work injury causing it to become symptomatic for the first time, and, therefore, required him to ultimately have surgery." (PX2, p.11). He also indicated that the three-level fusion he is recommending is a result of the work accident based on "[t]he timing of the onset of symptoms

to the work environment." (PX2, p.12).

Dr. Citow testified that he saw Petitioner a second time on 11/9/16. (PX2, p.12). He agreed that between the two visits Petitioner's condition had not gotten better, and that he presented with the same complaints and physical findings upon exam. (PX2, pp.13-14). Likewise, he agreed that his diagnosis and recommendation for a three-level fusion had not changed. (PX2, p.14).

Dr. Citow noted that he had reviewed the video surveillance and that it did not change the opinions he had expressed. (PX2, p.15). He also agreed that the restriction of no lifting greater than 10 pounds remains in place, and that it is the result of the accident. (PX2, p.15). He indicated that this restriction will not change absent surgery, and that without surgery Petitioner's condition is "[l]ikely to get worse, but not likely to get better." (PX2, p.15). He noted that "[i]f we actually fix the problem, down the road hopefully he can return to full duty without restrictions and have no significant limitations." (PX2, pp.15-16). He also indicated that the treatment to date, including the treatment he prescribed, was related to the work accident in question. (PX2, p.16). In addition, he agreed that Petitioner's condition with respect to his cervical spine was permanent in nature. (PX2, p.16).

On cross, Dr. Citow agreed that the accuracy of his opinion on causation is dependent on the accuracy of the history as reported by the patient. (PX2, p.17). He also agreed that the video surveillance wasn't available to either him or Dr. Butler prior to his initial opinion. (PX2, p.19). Dr. Citow indicated he was aware that Dr. Butler had changed his opinion with respect to causation following his review of the surveillance footage. (PX2, p.20). However, he noted that he would disagree that the patient was able to function without limitation or restriction, or that his subjective complaints were inconsistent with the activity shown in the video. (PX2, pp.20-21). Likewise, he would disagree with the opinion that any exacerbation he may have suffered from work had clearly resolved. (PX2, p.21).

When asked whether neglecting the 10-pound lifting restriction would cause an exacerbation of Petitioner's condition, Dr. Citow stated: "[i]t could. That with pressure on the spinal cord and changes on the MRI showing that the pressure on the cord is already causing swelling in there, I'm concerned that if he does lift too much and has too much excessive flexion, rotation, twisting, things of that nature of the cervical spine, he can develop more damage to his spinal cord." (PX2, p.21). Dr. Citow also agreed that these things could occur in his every-day activities. (PX2, pp.21-22).

For his part, Petitioner testified that "... I definitely want to have the surgery because I really want to go back to work; and the way that I am right now, I can't do my physical work." (T.24-25). He noted that over the last six months he has "... been suffering a lot of pain... [o]n my left shoulder, neck, my shoulder blade." (T.25). He indicated that Dr. Citow placed restrictions on him that do not allow him to return to the kind of work he used to perform for Respondent. (T.25). Petitioner agreed that as a result he has not returned to work for Respondent. (T.26).

Petitioner acknowledged that he was fired by Respondent and that he believed his last date of employment was 5/15/16. (T.26). He agreed that he was alleged to have stolen some

money by virtue of using a company credit card. (T.26). By way of explanation, Petitioner noted that he was "... putting gas in [his] car to go to medical appointments and [his] physical therapy." (T.27). He indicated that "I told them I was willing to pay them back. I told them – they gave me the list, which it was $231. I talked to the owner. I was willing to pay them back." (T.27). Petitioner indicated that it was his understanding that he was let go because of this issue. (T.28). However, he agreed that he continued to receive workers' compensation TTD checks until about the last week of August, or around 9/1/16. (T.28-29).

Petitioner indicated that he has not returned to any sort of employment since 9/1/16. (T.29). He also noted that he is still under the care of Dr. Citow, and that he still has work restrictions that prevent him from returning to his job with Respondent. (T.29). He testified that he "... really would love to go to surgery so I could go back to work and have my life regular working procedures 'cause I'm – bills are really hard to pay." (T.29-30).

Petitioner noted that he viewed the video surveillance tapes and provided a description of his own (PX1) that includes the approximate weights of the items he was seen carrying. (T.30-31). He agreed that these were every day, household items and that the weights listed were his best estimation. (T.34). Petitioner testified that he was moving these items on the dates in question "[b]ecause my landlord told me to move, and her sister had to move in her house so I had to move all the stuff into a storage." (T.34). He indicated that his brother and some friends moved the heavier items – including the stove, refrigerator, dishwasher, dryer, couches, beds, tables, televisions – and that he did not participate in moving those items. (T.34-35). He indicated that there were three (3) people in his family that he had to move, and that he didn't have a choice in moving at that time. (T.35).

Petitioner agreed that he had already been told by Dr. Citow that he needed fusion surgery prior to the first date of surveillance on 5/31/16. (T.37-38). He also agreed that prior to the surveillance dates he had already decided that he wanted the surgery in question. (T.38). In addition, he agreed that he had already seen Dr. Butler, Respondent's §12 examining physician, who had likewise indicated that he needed surgery prior to that date. (T.38). He agreed as well that his neck was hurting leading up to the first day of surveillance and that it has not gotten any better. (T.38). Furthermore, he denied that the lifting of any of these items seen on surveillance increased the problems or pain in his neck. (T.38-39). He noted that when he told Dr. Butler that he couldn't lift anything he was "... referring to physical work, my type of work that I do, carrying a chainsaw or a log." (T.39). He also agreed that after he was told he needed surgery he was still lifting things at home -- such as a chair, a gallon of milk or bags of groceries on occasion. (T.39-40). He likewise agreed that the majority of the things shown in the video were pretty much similar to the weights of things he would lift on a daily basis. (T.40). However, he agreed that there were some heavier items that weighed 20 pounds or so. (T.40).

On cross, Petitioner conceded that he did not actually weigh the items he noted in PX1, nor did he list any specific name brands or model numbers. (T.42). He agreed that the weights listed were essentially his speculation. (T.42).

When asked whether he informed the therapist on 3/3/16 that he could not lift more than 5 pounds, Petitioner responded "[y]es, if I recall." (T.44). He also agreed that he told the therapist he could carry things when they were close to his body, but not away from his body.

(T.44). He agreed as well that he told the therapist that reaching and putting on a seat belt bothers him, and that at times he has pain with overhead work like washing his hair or putting items on a shelf. (T.44).

When asked whether he filled out a questionnaire for Dr. Butler at the time of his IME on 5/16/16 wherein he indicated that he could not lift or carry anything, Petitioner responded: "I believe so, yes." (T.46). However, he later noted that he thought this was with respect to his job, although he acknowledged that the question did not specify as much. (T.55). Petitioner also agreed that he informed Dr. Butler that his pain prevents him from both standing for more than 30 minutes and from sleeping. (T.46-47). In addition, Petitioner agreed that he did not inform Dr. Butler, at the time of his exam, about any prior injury to his neck. (T.52). Petitioner stated that "... I never thought about that. That was 20 years ago." (T.52). He agreed that he filed a workers' compensation claim for that injury. (T.52). However, he indicated that he did not have any neck pain and did not see any doctor for same during the period leading up to 2/15/16. (T.53). He also stated that he "hardly" took any Advil or other-the-counter medication for any pain that he may have had between 1997 and 2016. (T.53-54).

Petitioner indicated that he is not currently working for anyone, and that he has not looked for a new job since he was released by Respondent. (T.52).

On re-direct, Petitioner indicated that he also injured himself in a separate incident involving his elbow on 1/12/15, which is the subject of claim 16 WC 21794. (T.55). He agreed that he was seeing a doctor and taking pain medication for that condition, and that he subsequently injured his neck on 2/15/16. (T.56).

Conclusions of Law

A claimant must prove his or her condition of ill-being is causally related to an at-work accident. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244, 249 (1976). It is axiomatic that employment need only be *a* cause, and not the sole or primary cause, of an injury for a claimant to recover under the Act. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Commission*, 386 Ill. App. 3d 779, 784 (2008). Causation presents a question of fact. *Caterpillar, Inc. v. Industrial Commission*, 228 Ill. 2d 288, 293 (1992).

In the present case, the Arbitrator found that Petitioner failed to prove that his current condition of ill-being is causally related to the accident on February 15, 2016 based principally on his determination that Petitioner was not a credible witness. In support of this credibility determination, the Arbitrator referenced surveillance footage which he believed showed Petitioner "... engaged in activities which involved a wide range of motion of his neck and use of his left arm without any indication of pain or limitation" as well as "compelling" evidence that "... demonstrated that Petitioner was not a reliable medical historian", particularly with respect to the reporting of a prior injury involving his cervical spine almost twenty (20) years earlier and his apparent inability to recall undergoing an MRI at that time. Along these lines, the Arbitrator posited that "... undergoing an MRI is a memorable event not easily forgotten." (Arb.Dec., pp.16-18).

The Commission disagrees with the Arbitrator's credibility assessment and finds that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being with respect to his cervical spine is causally related to the accident on 2/15/16. The Commission notes that credibility speaks to the plausibility or believability of that which is being offered as the truth. It is not a test of one's ability to recall distant events that may or may not have any bearing on the issue at hand. Nor is it meant as a litmus test requiring a lifetime of unwavering fidelity to the truth. Instead, it is simply an examination of what one professes as fact compared to the evidence presented, and a determination by the trier of fact as to whether that particular claim is more likely than not true based upon a preponderance of the evidence.

In this case, Petitioner credibly testified that he had worked in the physically demanding job of a tree trimmer for 30 years, and that 15 to 20 years earlier he had suffered a prior injury to his cervical spine and left shoulder. Along these lines, the evidence shows that in 1995 he injured his upper lumbar and mid-thoracic spine after picking up a log, and that on 12/6/97 he was involved in a motor vehicle accident after which he received conservative treatment for cervical, mid-back and left shoulder complaints. Diagnostic studies at that time, including cervical and lumbar MRIs performed on 2/2/98, revealed little more than mild degenerative changes at L3-4 and minimal bulging at C4-5. An EMG performed on 3/20/98 revealed no electrophysiologic evidence of cervical radiculopathy, focal or diffuse peripheral neuropathy. No surgery was recommended by any physician at that time, and in April of 1998 he was released with instructions to return on an as-needed basis.

Petitioner credibly testified that on 2/15/16, or almost eighteen (18) years later, he was cutting down a big tree while working for Respondent when he felt a pull or pinch along with pain in his neck and left arm while trying to start what Dr. Butler colorfully referred to as a "cold-blooded chain saw." Petitioner indicated that prior to this incident he had not had any pain in his neck for 15 years, and there is no evidence that Petitioner sought any treatment for his neck and/or left shoulder at any time leading up to the accident on 2/15/16. The records show that Petitioner provided consistent histories of the accident to his various providers, not to mention Respondent's IME, Dr. Butler. And while he may not have mentioned his prior cervical complaints from 15-20 years earlier to Dr. Butler, it is not all that surprising given the passage of almost two decades.

In addition, the Commission notes that the diagnostic studies taken before and after the accident clearly show that Petitioner's condition had significantly worsened since his previous injury in 1997. Indeed, even Dr. Butler noted that "... the appearance of the [current] MRI is entirely different [from the one 20 years ago]. The C3-4, 4-5, and C5-6 levels have undergone tremendous degenerative change in that interval period. C4-5 you would have characterized as just a small protrusion or bulge of the disc at the time with some contact with the ventral spinal cord. Still there was plenty of room there, and no spinal cord damage whatsoever. So that progression has been extreme over the last 20 years." (RX4, p.41). He likewise agreed that it was fair to say that there was no myelopathy condition in the MRI from 20 years ago, and that the disc herniation at C4-5 was worse or more pronounced. (RX4, p.41). Dr. Butler also conceded that the worsening of the herniation could have been caused by the work injury or accident on 2/15/16. (RX4, pp.41-42).

Furthermore, the Commission is not persuaded that the activities shown on the surveillance tapes provided a sufficient basis to find no causation. The Commission, having viewed the footage in question, notes that most of the items Petitioner is seen lifting and carrying as part of his forced move were below the 10-pound lifting restriction imposed by Dr. Citow – as evidenced by the estimated weights provided by Mr. Jimenez (PX1), an assertion that went unrebutted by Respondent. In addition, Petitioner is not seen lifting or moving any large pieces of furniture and the like, but instead is seen lifting and carrying various sundry items using both hands below shoulder level, a position that would not appear to place a great deal of strain on Mr. Jemenez's neck. Indeed, as Dr. Citow points out, it is not inherently unreasonable that Petitioner was able to bend over and lift these items given that "… he does not have a lumbar issue [but] strictly a cervical issue."

Most telling, however, is the fact that Dr. Butler continues to restrict Petitioner from work and to recommend surgery in the form of a three-level cervical fusion, even after viewing the surveillance footage. This speaks to the seriousness of Petitioner's cervical problem, and what little if any effect those activities had on his underlying condition. Indeed, one would think evidence of Petitioner's ability to perform beyond his claimed limitations would be more relevant in assessing his entitlement to ongoing TTD, medical expenses and/or prospective medical treatment, *not* whether a causal relationship exists. As such, the Commission is unwilling to find the surveillance video to be a sufficient basis on which to deny compensation.

Therefore, the Commission reverses the Arbitrator and finds that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being with respect to his cervical spine and left shoulder is causally related to the accident on 2/15/16. Along these lines, the Commission finds the opinion of Dr. Citow on the question of causation to be more persuasive than the revised opinion offered by Dr. Butler.

Furthermore, based on the above finding as to causation, the Commission finds that Petitioner is entitled to temporary total disability benefits from 2/16/16, the day after the date of accident, through 2/24/17, the date of arbitration, for a period of 53-4/7 weeks (including the extra leap year day in February of 2016). The Commission notes that while Petitioner was given light duty restrictions at various points during his treatment, there is no evidence to suggest that any such position was offered or made available by Respondent, or even existed, given the heavy physical nature of Petitioner's occupation. The Commission also corrects a clerical error in the Arbitrator's decision to show a TTD rate of $758.88 (2/3 x $1,138.32).

Finally, based on the above, the Commission finds that Petitioner is entitled to prospective medical treatment in the form of the three-level cervical fusion recommended not only by Dr. Citow but Dr. Butler as well. The expenses associated with this treatment shall be paid by the Respondent pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

All other aspects of the Arbitrator's decision are otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated June 20, 2017 is hereby reversed as stated herein.

18IWCC0525

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $758.88 per week for a period of 53-4/7 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 reasonable and necessary medical expenses of $5,538.08 to Greenleaf Orthopedics and $700.00 to Dr. Jonathon Citow, pursuant to §8(a) and the medical fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the current treatment recommendations of Dr. Citow in the form of three-level cervical fusion surgery, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act 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 pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers for which Respondent is receiving credit under this order.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $32,000.00. 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 1 2018
o:6/26/18
TJT/pmo
51

Thomas J. Tyrrell

Stephen J. Mathis

18IWCC0525

DISSENT

I respectfully dissent from the Majority's opinion reversing the Arbitrator's decision. I find Arbitrator Fruth's decision to be thorough and well reasoned. Particularly persuasive are the arbitrator's numerous and detailed findings regarding Petitioner's credibility. I give great weight to the Arbitrator's contemporaneous observations of Petitioner at trial and his analysis based on the surveillance video of the Petitioner and numerous conflicting medical records and histories. I would affirm and adopt this decision.

Kevin W. Lamborn

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 Choose reason	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HUGH DOYLE,

Petitioner,

vs.

NO: 14 WC 10089

TRIBCO CONSTRUCTION SERVICES, INC.,

Respondent.

18IWCC0526

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

The Commission finds that the Arbitrator's Decision overlooks Dr. Robertson's March 3, 2016 addendum report. When Dr. Robertson authored his first Section 12 opinion report, he had reviewed solely the 2014 MRI report. After authoring his opinion report and testifying at his evidence deposition, Dr. Robertson reviewed the Petitioner's 2007 and 2014 MRIs and authored the March 3, 2016 addendum report. Therein, Dr. Robertson compared the L4-L5 disc herniations and opined: "the one of 2007 was large, producing a large indentation on the nerve roots. The last study shows a much larger disc herniation that occupied almost the entire canal. This means that between both studies there had been a larger extrusion of the L4/L5 disc." (Px8)

Dr. Bernstein also authored an addendum report dated April 13,2016 and opined that he also reviewed both the March 4, 2014 and August 13, 2007 MRIs side-by-side and he found there was no material change:

> "Both demonstrate some degenerative change especially at L4-L5 but also at L5-S1. Both studies show signal changes and some disc space narrowing. Both studies also show a shallow left-sided disc protrusion or herniation at the L4-5 level. There is no material change from one study to the next. They show similar pathology. There is no evidence of a new or an acute disc abnormality. The pt's MRI scan form (sic) 2007 until 2014 (remains) unchanged. There is a similar small left shallow disc herniation demonstrated at the L4-5 level. The disc herniation for which this pt underwent surgery is a chronic condition on the lumbar spine for this patient. It is not causally related to his work incident." (Rx5)

Both Dr. Robertson and Dr. Bernstein agree the Petitioner had a pre-existing disc herniation at L4-L5. The Commission finds Dr. Bernstein's opinion regarding causation is more credible than Dr. Sampat's and Dr. Robertson's opinions because a) Dr. Bernstein's opinion comports with Petitioner's ongoing treatment prior to the alleged work accident and b) neither Dr. Sampat nor Dr. Robertson reviewed the Petitioner's treating records prior to the alleged date of accident that evidence Petitioner's many years of active treatment at his PCP's office managing his preexisting lumbar condition with increasing use of narcotics. (Px9, p. 12, Px10, pp. 17-20)

Furthermore, neither Dr. Sampat nor Dr. Robertson reviewed the medical records that evidence Petitioner went to his PCP the day before the alleged work accident with similar complaints. *Id.* In fact, Dr. Robertson's initial report documents Petitioner reported "similar episodes in the past which resolved on their own with no radicular pain." This is also contrary to Petitioner's PCP's records which evidence radiculopathy complaints on multiple occasions including July 2, 2007, January 5, 2009, November 13, 2012, January 16, 2013, March 20, 2013, May 8, 2013, November 11, 2013, December 9, 2013, January 4, 2014 and January 29, 2014.

Dr. Robertson also admitted the PCP's records from February 20, 2014 and March 4, 2014 do not elaborate on any trauma specifically and the first record of work injury while Petitioner was shoveling snow is not until Dr. Sampat's April 1, 2014 history. (Px9, p. 37)

Neither Dr. Sampat nor Dr. Robertson reviewed the Homer Chiropractic treating medical records that are also silent regarding a work-related accident. (Px9, p. 12, Px10, pp 17-20) Petitioner testified it was his own handwriting on the Homer Chiropractic Clinic form. (T, p. 71) The preprinted form required "the date symptoms started" and Petitioner wrote "Saturday, February 1, 2014." (Px2) Thus the chiropractor, Dr. Burkhart, charted low back pain from shoveling on February 1, 2014, a Saturday. *Id.* Petitioner testified he was not working on Saturday February 1, 2014 but that was the day he "could not get out of bed." (T, pp. 22-23, 72) The Commission finds the initial treating medical records are more reliable than Petitioner's history and testimony.

The Commission therefore finds Dr. Robertson's causation opinion is entitled to little weight. *See, e.g.*, Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n, 2014 IL App (3d) 130028WC, 14 N.E.3d 16, 383 Ill. Dec. 184 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

When Petitioner consulted Dr. Sampat for the first time on April 1, 2014, he reported he

was asymptomatic prior to the work-related injury and was doing well until shoveling snow. The Petitioner's representation about his pre-work-related injury condition is contradicted by the AMG records including a visit on January 29, 2014, the day before the alleged work accident, with consistent complaints of lumbar back pain and lumbar radiculopathy and a narcotic prescription refill. (Rx1) Therefore, the Commission also finds Dr. Sampat's causation opinion is entitled to little weight. *See, e.g.*, Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n, 2014 IL App (3d) 130028WC, 14 N.E.3d 16, 383 Ill. Dec. 184 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

The Associated Radiologists of Joliet's intake form dated May 12, 2004 is critical to the history of Petitioner's pre-existing condition. The intake form, included with the Advocate Medical Group (AMG) records, documents the Petitioner's chief complaint at the time: "I fell off a wall about 9 feet at work on Monday May 10, 2004." Petitioner complained of both neck and lumbar back pain and lumbar spine x-rays were ordered. (Rx1) The AMG primary care physician's (PCP) office note dated July 2, 2007 documents Petitioner's findings were positive for back pain and tingling in his left lower extremity at that time. (Rx1) Petitioner underwent a lumbar spine MRI on August 13, 2007. (Rx5, Px8)

When Petitioner was asked the reason that his PCP ordered an MRI in 2007, Petitioner replied "I honestly don't remember I used to frame houses back then. It could've been anything." (T, p. 56) The Petitioner's former co-worker Joel Curiel testified he no longer works for Respondent. Consistent with the statement he wrote and signed in 2014, Curiel testified Petitioner told him: "...years back his brother or someone dropped a wall on him and it landed on him, and since then that he had been going to a chiropractor, you know, because he had been having back problems." (T, p. 162, Rx9). The Commission finds Curiel's statement regarding the precipitation of Petitioner's lumbar back condition comports with the Petitioner's PCP's records at AMG. The Commission is not persuaded by Petitioner's testimony that he forgot the reason he had an MRI in 2007.

The Petitioner also went on to deny that he previously hurt his back despite the order for the 2007 lumbar spine MRI. Petitioner testified: "I might have fell one time, but that was my neck. It had nothing to do with my back." (T, p. 57) He further testified "...about once a year I'd have just a little tingling down my left butt cheek, sometimes just a little bit down the thigh, but that was it. It would go away after a week or two." (T, pp. 57-58) This testimony does not comport with Petitioner's PCP's records evidencing multiple visits following the July 2, 2007 AMG entry, culminating in monthly visits in 2013 and two office visits on January 4, and January 29, 2014 preceding the subject date of accident. The AMG office notes document various lumbar back and lumbar radiculopathy complaints, a history of lumbar herniated disc for approximately 10-11 years, and constant narcotic prescriptions. (Rx1)

Jorge Moreno testified that on January 31, 2014 the Petitioner told him: "there was too much snow at his house. He was shoveling the snow and he got hurt, and he was already going to the doctor." (T, p. 144) The Commission is persuaded by Moreno's testimony based upon the totality of the evidence. Petitioner marked "no" he did not have a work injury on his attendance logs on January 30th and he continued to deny a work injury on these logs thereafter daily until he stopped working. (T, p. 68) In addition, the Petitioner did not seek any emergency or any other

medical care until the appointment he had with his chiropractor on February 4, 2014, and he was "already going" to his PCP on a regular basis.

The Petitioner testified he also saw his chiropractor regularly prior to the alleged date of accident. The Petitioner testified he last saw the chiropractor: "possibly the year before.... maybe once every two years." (T, pp. 51-52, 54-55) The Petitioner testified that he told his chiropractor about a work accident, however, the chiropractor's office notes are silent regarding a work accident. Petitioner subsequently saw his PCP on February 20, 2014 and March 4, 2014 and those records are also silent regarding a work accident although the Petitioner testified he told his PCP what had happened to him. The February 20, 2014 office note documents that Petitioner relayed a history of low back pain for three weeks (which comports with his last office visit on January 29, 2014) and both PCP notes refer to a history of a lumbar herniated disc for 10-11 years. The treatment plan and prescriptions remained consistent with the visits on January 4, 2014 and January 29, 2014 (T, p. 25)

The Petitioner denied a work accident to his supervisor, denied a work accident in his attendance logs, provided a conflicting history to his chiropractor, and his testimony regarding the alleged accident is inconsistent with multiple providers' records and is thus not credible. In addition, based upon the totality of the contradictions between the medical records and the Petitioner's testimony, the Commission finds the Petitioner is not credible. The Commission further finds Dr. Robertson's opinion report is not outcome determinative regarding the issues of accident or causation and the Arbitrator's omission of the addendum report was harmless error.

The Commission therefore finds Petitioner has not established by a preponderance of the evidence a work-related accident occurred on January 30, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 7, 2017, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for compensation is denied. Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of employment by Respondent on January 30, 2014 and Petitioner failed to prove a causal connection between any suck work injury and his current condition of ill-being regarding his low back.

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.

18IWCC0526

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 2 1 2018
KWL:bsd
O: 6/26/18
42

Kevin W. Lamborn

Stephen Mathis

DISSENT

I believe Petitioner, and the witnesses he presented in support of his claim, credibly testified as to the circumstances surrounding the alleged accident on January 30, 2014, and that he suffered an aggravation of his pre-existing lower back condition on the date in question. I also believe that a preponderance of the evidence shows his current condition of ill-being is causally related to said incident, based on the opinions of board certified orthopedic surgeons Dr. Sampat and Dr. Robertson. More to the point, I believe that the incident was *a* causative or contributing factor in Mr. Doyle's resulting condition of ill-being and subsequent need for treatment, per the dictates of *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), and as such was compensable under the Act. As a result, I believe that the Arbitrator erred in denying compensability, and would reverse and award appropriate temporary total disability, medical expenses and permanent partial disability benefits in this case.

Therefore, I respectfully dissent.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOYLE, HUGH
Employee/Petitioner

Case# **14WC010089**

TRIBCO CONSTRUCTION SERVICES INC
Employer/Respondent

18IWCC0526

On 2/7/2017, 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:

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

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

H. Doyle V. Tribco. etc. , 14 WC 010089

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

HUGH DOYLE
Employee/Petitioner

v.

TRIBCO CONSTRUCTION SERVICES, INC.
Employer/Respondent

Case # 14 WC 010089

18IWCC0526

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 **8/9/16 and 10/14/16**. 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 _____

18IWCC0526

FINDINGS

On 1/30/2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $59,145.32; the average weekly wage was $1,137.41.

On the date of accident, Petitioner was 34 years of age, ***married*** with 1 dependent children.

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

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

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

Claim for compensation denied. Petitioner failed to prove that he sustained accidental injuries, arising out of and in the course of his employment by Respondent on January 30, 2014 and Petitioner failed to prove a causal connection between any such work injury and his current condition of ill-being regarding his low back.

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

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

Signature of Arbitrator

February 7, 2017
Date

ICArbDec p. 2

FEB 7 - 2017

INTRODUCTION

This is a disputed accident case, with Respondent disputing accident/arising out of and in the course of; notice; causation and the related issues of medical expenses, TTD and nature and extent.

Petitioner presented his own testimony and that of four witnesses at trial, along with the evidence deposition testimony of two physicians. Respondent presented the testimony of six witnesses and submitted 3 reports from its §12 physician.

Petitioner claims that he sustained accidental injuries, arising out of and in the course of his employment by Respondent on January 30, 2014, shoveling snow at a construction site. He claims that the injuries led to a back surgery performed by Dr. Sampat.

STATEMENT OF FACTS

Petitioner was employed by Respondent as a union carpenter. Respondent is a commercial concrete construction company. Petitioner testified that he began working for Respondent in January of 2014. He signed a copy of Respondent's "Work Rules" on December 27, 2013 and his first day of work appears to have been December 30, 2013. (RX 10; RX 17) Petitioner's job duties included framing and shoring so that concrete floors could get poured. In the winter, he would shovel snow to get to the job surface.

Petitioner testified that, on January 30, 2014, he was engaged in snow removal on the job. This was at the WERC job site. Respondent flew a dumpster by crane up to the floor that Petitioner was working on. Petitioner and other employees shoveled snow onto a tarp; the tarp was hooked to the crane and the snow was dumped in the dumpster; the dumpster and snow where then taken to the ground by crane. Petitioner testified that he shoveled for a few hours on January 30th. Petitioner was shoveling with his foreman, Jorge and two other workers, Joe Gura, a carpenter and Amber Owens, a laborer. Petitioner said that he was shoveling from a drift of snow about chest high (Petitioner is 6'3" tall). He cracked off a big piece of snow and, as he turned to throw the snow, he felt a pop in his low back. This event occurred before coffee break (9:30) and Petitioner was able to complete his work day. Petitioner did not report any injury and did not seek medical treatment on January 30, 2014. He signed out on Respondent's "Attendance Log" at 3:30. Petitioner marked "N" (no) in the column headed "Injury/Lesion?". (RX 14)

Petitioner worked the next day, a Friday. He shoveled more snow and framed crash walls. When he bent over to nail a sill plate to the ground, he felt a shock up and down his back. Petitioner said that he made an "ahh" sound. This happened in the morning, before break. Petitioner's foreman, Jorge, was nearby. Petitioner testified that he had a conversation with Jorge and told Jorge that he had injured his back the day before, shoveling snow. Jorge asked Petitioner if he wanted to go to the clinic and Petitioner declined. Petitioner told Jorge that he had back problems before and he thought that he had just tweaked his back. Petitioner thought that he would go to a chiropractor and take care of it. Petitioner worked until the end of the day and again signed out at 3:30, marking "N" in the column regarding injuries. (RX 17)

The next day, Saturday February 1, 2014, Petitioner felt pain in his back and he was unable to straighten up in bed. Petitioner's wife had to help him up. Petitioner did not work for Respondent on February 1, 2014.

Petitioner returned to work on Monday, February 3, 2014 and performed his regular duties. Petitioner testified that he saw Dr. Burkhart at Homer Chiropractic on February 3, 2014. The records of Homer Chiropractic show

that Petitioner was seen on February 4, 2014. Petitioner testified that he told Dr. Burkhart what happened to him. There is no mention of an injury at work. Petitioner filled out a document stating that his lower back pain was due to shoveling snow. The onset was Saturday 2/1/2014. Dr. Bruce Burkhart charted low back pain, 5, sharp, from shoveling on 2/1/14. Petitioner underwent chiropractic care at Homer Chiropractic for about 10 visits through February 27, 2014. He stopped this treatment because there was no improvement. (PX 2, 2(a))

Petitioner sought treatment with his PCP, Dr. Mikaitis at Advocate Medical Group, on February 20, 2014. There was a history of low back pain for 3 weeks. No history of an injury at work is noted, although Petitioner said that he told Dr. Mikaitis of the work injury. Norco, Cyclobenzaprine and other medications were ordered, along with MRI's of the lumbar spine, brain and right knee. On March 4, 2014, Dr. Mikaitis ordered an MRI of the lumbar spine, heat and ice therapy, prescribed pain medication and gave Petitioner a cortisone shot in his left gluteal region. Petitioner testified that he was in excruciating pain at this time. The history was of left calf and foot pain for one week. Left low back pain was said to be present for months. There was a "history of trauma" noted in the EMR. There was a history of lumbar herniated disc for 10-11 years. There was no history of an injury at work, shoveling snow. (PX 1)

The MRI was performed on March 4, 2014 at Homer Glen MRI and was said to show a herniated disc at L4-L5. (PX 3)

Petitioner next sought treatment with Dr. Anthony Rinella at Spine & Scoliosis Center. He had seen Dr. Rinella previously. On March 6, 2014, Petitioner was seen by Douglas Stevens, MMS, PA-C, Dr. Rinella's PA. Petitioner filled out a patient information sheet, stating that he had back pain for 10 years. Petitioner marked that this was not a workers' compensation matter on the information sheet. PA-C Stevens charted a history of low back pain and left lower extremity pain after an injury shoveling snow at work. The pain was in the low back at first and then was more in the left lower extremity for the last two weeks. While there were prior back strains noted, these resolved with conservative treatment. There was no history of prior similar symptoms. The impression was: 1.) Multi-level lumbar stenosis with left sided disc herniation at L4-L5; 2.) Left lower extremity radiculopathy secondary to number 1; 3.) Lumbar strain/pain. A referral to Dr. Abusharif for pain treatment was made. (PX 4)

Petitioner continued to work as a carpenter for Respondent until March of 2014. He transferred from the WERC job to a parking garage job in mid-February. The foreman at the parking garage site was Abel Segura. Petitioner testified that he told Segura about his injury at work. Petitioner testified that a fellow employee, Joseph Gura, was present for this conversation. Neither Party presented the testimony of Segura.

Petitioner's last day of work for Respondent was March 17, 2014. He was installing decking and his back pain worsened, causing Petitioner to take frequent breaks to rest and cry in the port-a-potty. Petitioner called Segura the next day and a meeting with Jason Ramirez, the Site Safety Coordinator, was arranged. Petitioner met with Ramirez on March 18 and told him about his injury and the treatment to that date. Petitioner said that Ramirez told him that he had "screwed himself", apparently by not properly reporting the injury and by seeking treatment with a chiropractor. Petitioner was scheduled for an ESI later that week and thought that he might get better. Ramirez asked Petitioner to keep him advised.

Petitioner had an Epidural Steroid Injection by Dr. Bajaj at Silver Cross Hospital on March 20, 2014. The history was of prior pain complaints that became worse about 6 weeks before, after an injury at work, shoveling snow. This was on a referral by Dr. Rinella's office. (PX 7) The ESI had no effect.

Petitioner had further injections by Dr. Abusharif, beginning on March 26, 2014. They did not provide relief. Dr. Abusharif's records document a history of the onset of low back pain on January 30, 2014, working at Tribco and shoveling snow. (PX 5)

Petitioner followed up with Ramirez on March 24, 2014. Ramirez advised Petitioner that he had checked with the foreman, Jorge and Jorge said that Petitioner told him that he injured his back shoveling his driveway at home. Petitioner inquired if Respondent could do anything further regarding the matter and Ramirez said that he would not aid in a fraudulent claim. Petitioner did not believe that he was asking to file a fake injury claim.

Petitioner followed up with Dr. Kedainis at his PCP's office on March 18, 2014. Dr. Kedainis recommended medication, PT and an orthopedic consult. No history of an injury shoveling snow at work in January was documented. Activity was to be as tolerated. (PX 1)

It should be noted that the records of the PCP, Advocate Medical Group, reveal that Petitioner was receiving monthly scripts for the Opiod, Norco, for several years before January of 2014. Petitioner testified that Dr. Mikaitis had been giving him scripts for Norco since 2006. Indeed, Petitioner was seen by Dr. Mikaitis on January 4, 2014 (LBP, right knee pain, muscle spasm and occasional sciatica; Norco prescribed) and January 29, 2014 (refills, headaches, recent head concussion, back pain-works in construction with heavy lifting, low back pain and muscle spasm, occasional sciatica pain radiating down the left leg; refill Norco). (RX 1)

Petitioner was referred to Dr. Sampat, an orthopedic surgeon, by Dr. Kedainis. (PX 1) Petitioner was seen by Dr. Sampat on April 1, 2014 and Dr. Sampat recommended surgery. Petitioner underwent back surgery on April 5, 2014 at Silver Cross Hospital. Petitioner had post surgery therapy and was released to full duty work, effective June 2, 2014. The last visit with Dr. Sampat was on May 27, 2014 and Petitioner was released, PRN. (PX 6; 7)

Petitioner was able to find employment as a carpenter about 3 weeks after June 2, 2014. He had follow up at AMG in June of 2014. He regularly took Norco through December of 2015. Petitioner cannot lift as much as he used to. He has a pinching feeling in his back on a daily basis. He has back pain frequently and feels a weird tingling in his left leg. He takes Aleve once in a while. Petitioner tried to put his bills through Group, but was unsuccessful. He has had no subsequent back injuries and had prior back injuries, for which he had chiropractic treatment.

Petitioner has been working again as a carpenter since June of 2014. He does framing and he makes $46.00 per hour.

Petitioner testified that he never shovels his driveway. His neighbor, Richard, clears his driveway with a snow blower.

Petitioner was seen by Dr. David Robertson, for an IME and AMA impairment rating, at the request of his attorney, on March 31, 2015. (PX 8 & 9) Petitioner was seen by Dr. Avi Bernstein, at the request of Respondent, for a §12 exam and an AMA impairment rating on June 22, 2015. (RX 3 & 4) Dr. Bernstein authored an Addendum Report, dated April 13, 2016, after his review of the MRI studies of March 4, 2014 and August 13, 2007. Dr. Bernstein thought that there was no material change in the scans and the herniated disc at L4-L5 was chronic and not related to the January 2014 accident. (RX 5)

On cross examination, Petitioner said that the only prior treatment for his low back was with a chiropractor and his PCP. The prior chiropractic treatment records were not submitted into evidence. Homer Chiropractic Clinic

claimed that they had no record of prior treatment for Petitioner, although Petitioner testified that he had received prior treatment from Dr. Burkhart. (PX 2(a)) He did not receive prior treatment from an orthopedic doctor for his back. Dr. Mikaitis did order a lumbar MRI in 2007. The Record contains several references to a back injury that Petitioner sustained while working with his brother on a residential project. A wall fell on Petitioner, or he fell off a wall. He may have injured his neck with a whiplash injury after the fall. He would experience low back pain with a radicular component about once a year, but this would usually resolve in a week. On direct examination, Petitioner testified that he had prior treatment by Dr. Rinella. No records regarding this prior treatment were submitted by either Party.

Before January 30, 2014, Petitioner was able to perform his job duties as a carpenter. He worked all through 2013 with no lost time due to his back condition.

Richard Kasmer testified at the request of Petitioner. He lives across the street from Petitioner and his wife and he has known them for 7 to 8 years. He has never seen Petitioner shovel his driveway. Kasmer is retired and he clears Petitioner's driveway with his snow blower when he cleans his own driveway. Kasmer could not recall specifically if he cleared Petitioner's driveway on January 30, 2014. He could not recall exactly the weather around that time, but he did remember that there was a lot of snow at the end of January, 2014.

Amber Owens testified at the request of Petitioner. She worked for Respondent as a laborer on January 30, 2014. She remembered that there was a lot of snow that week. Employees were instructed to shovel snow off of the work area and into dumpsters. Owens saw Petitioner shoveling snow on January 30th. The next day, Petitioner told her that he hurt his back shoveling snow. Owens noticed that Petitioner was walking slower. On cross examination, Owens said that she worked all week from January 27 to January 31, 2014. This is inconsistent with Respondent's records, as the job was shut down from January 27-January 29, due to bad weather.

Joseph Gura testified at the request of Petitioner. He is a carpenter and he worked with Petitioner at the WERC site and at the parking garage. He recalls shoveling snow with Petitioner at the end of January of 2014. Gura recalled seeing Petitioner having trouble performing his work duties around February 4, 2014. Petitioner told him that he had hurt his back when they were shoveling snow. Gura saw Petitioner and the foreman on the parking garage job, Abel Segura, interacting several times. Segura asked Gura if he knew anything about Petitioner getting hurt and Gura advised Segura that Petitioner told him that he had hurt his back while they were shoveling snow. Gura was unsure of the exact dates in February of 2014 that these events occurred. Respondent's records appear to show that Gura's last day at WERC was January 31, 2014 and that Petitioner continued to work at WERC until February 22, 2014. It was possible that a supervisor or foreman might move employees around on the paperwork for budget or quota reasons. Respondent's Exhibit 14 shows that Petitioner worked at WERC on February 4, 2014. Gura, like Owens, testified that he worked the entire week of January 27-January 31, 2014. Respondent's documents show that the job was shut down from January 27-January 29, 2014, due to weather conditions.

On the second day of trail, Petitioner's wife, Beth Janus-Doyle, testified at the request of Petitioner. She is employed as a high school teacher. During spring break in 2014 (around March 24-28, 2014), she went to Respondent's job office and picked up Petitioner's tools. Janus-Doyle had a conversation with Carolyn McCoy and McCoy said that she hoped that Petitioner would get better and that everything would go right with his case. Janus-Doyle also talked with Jason Ramirez and Abel Segura, although neither Party attempted to elicit testimony about these conversations. Janus-Doyle testified that her family does not shovel their driveway, as their neighbor, Richard does.

Respondent presented the testimony of Jorge Moreno, who appeared in response to a subpoena. Moreno is a carpenter. He currently is employed by McHugh Construction. Moreno was Petitioner's foreman at the WERC jobsite. At the end of January, 2014, they had to shovel snow in order to do work. On Friday, January 31, 2014, Moreno noticed that Petitioner was having trouble walking and straightening up. Moreno testified that he asked Petitioner what was wrong, did he have an injury?; did something happen at work? Petitioner said that he had hurt his back shoveling at his house. Petitioner said that he was going to see a doctor. Moreno offered to send Petitioner to the Company doctors and Petitioner declined. Moreno wrote up a statement of this interaction with Petitioner, dated April 2, 2014. (RX 7) After January 30th, Petitioner worked for Moreno for several weeks and Moreno noticed that sometimes Petitioner looked better and sometimes he looked worse. Petitioner was performing heavy work during that time. One of Moreno's job duties is to document injuries. He would be disciplined if he did not do so. There was no reason for him to not report an injury. Moreno's statement says that Moreno asked Doyle "if he had fallen or got hurt during work hours, if he did we should make a report and go to the doctor to get him checked." Per the statement, Doyle responded: "no nothing happened at work, I was cleaning snow off my driveway and I hurt my back and I've been going to therapy and I'll be fine." "After that I notified the Superintendent at WERC named Steve Likins what was happening." (RX 7)

Respondent next presented the testimony of Joe Curiel. He appeared in response to a subpoena. Curiel is a carpenter and is currently employed by McHugh Construction. He worked with Petitioner at the WERC site. At some point in time (either before or after January 30, 2014), he saw Petitioner having trouble tying his shoes. Petitioner said that his back was hurting him from an old injury sustained when his brother dropped a wall on him. Petitioner said that he had a herniated disc and he was going to a chiropractor. Curiel confirmed that there was a lot of snow on the job in January of 2014 and the workers did a lot of shoveling. Curiel wrote a statement for Respondent, dated April 2, 2014. (RX 9)

Carolyn McCoy testified for Respondent. She is a field job site administrator, a position she held with Respondent in 2014 and at the time of the hearing. She did not continuously work for Respondent from March of 2014 to present. She appeared in response to a subpoena. McCoy had a conversation with Petitioner on March 19, 2014 in the office. She asked Petitioner if he injured his back "here" and he said "no-he had been shoveling snow." McCoy created a written statement, dated April 1, 2014, regarding the conversation. (RX 8)

Jason Ramirez testified at the request of Respondent, in response to a subpoena. Ramirez currently is employed by MJ Electric as a Regional Safety Director. On January 30, 2014, Ramirez was employed by Respondent as a Safety Specialist. Ramirez was in charge of safety at the WERC site and the parking garage. No one reported any accident or injury involving Petitioner around January 30, 2014. The first time that Ramirez heard about any injury involving Petitioner was around March 14, 2014. Ramirez heard that Petitioner was having problems with his back. There was no injury reported. Ramirez checked with the Superintendent and the Foreman, who denied that any injury was reported. Moreno told Ramirez that Petitioner said that he hurt his back shoveling snow in his driveway at home. In a later conversation with Petitioner over the phone, Petitioner asked Ramirez if they could put the claim through as workers' compensation and Ramirez declined. Ramirez did not want to take part in a fraudulent claim. Ramirez typed up a statement documenting these events on March 26, 2014. (RX 6) Ramirez denied telling Petitioner that he had screwed himself by not reporting the injury in January. Such a statement would be unprofessional.

Steve Likins testified at the request of Respondent, having received a subpoena. He was the Superintendent on the projects that Petitioner worked on. He has worked for Respondent as a superintendent for 3½ years. Likins first learned that Petitioner was claiming an accident on March 18, 2014, after Petitioner reported back problems to Jason Ramirez. Likins was not aware of any injury that Petitioner suffered on January 30, 2014. Likins did not learn that Petitioner was claiming a work injury occurring on January 30 or January 31, 2014 until several

weeks after January 31, 2014. Likins testified that no work was done at WERC on January 27, 28 or 29, 2014. Limited work was done on January 30, 2014. Respondent's documents do not show that Petitioner shoveled snow on January 30, 2014. They do show that other workers were assigned to shoveling. On April 3, 2014, Likins signed a statement saying that during construction operations, Doyle never told him about an injury at WERC. Jorge Moreno told Likins about Doyle's condition and that Doyle was injured shoveling snow at home. "The next day I approached Hugh Doyle and asked if he was ok-he informed me that he was fine." (RX 11)

Derek Patton testified at the request of Respondent. He is employed by Respondent as Vice President and General Manager and has worked for Respondent since 2008. Respondent monitors weather conditions on job sites daily and archives that information. Weather events may impact construction progress and Respondent will have to notify clients regarding weather delays. There was no documentation of any significant snowfall on January 29, 2014 or January 30, 2014. Patton did not recall whether he was at the WERC site during the week in question.

Dr. David Robertson testified for Petitioner, via evidence deposition, on January 28, 2016. He is a board certified orthopedic surgeon, now primarily engaged in a forensic practice. His forensic practice is about 95% for defense clients. In this case, he was asked to be Petitioner's §12 examiner and to provide a PPI rating.

Dr. Robertson examined Petitioner on March 31, 2015. Petitioner gave a history of lifting a shovel full of snow at work, turning to the side to throw the snow, felt a pop in his back and having significant low back pain. Petitioner reported that he had had back pain episodes in the past that had resolved on their own, but since he had no radicular pain, he continued working. Dr. Robertson testified that Petitioner complained of significant pain at limits of extension and flexion and low back pain aggravated by heavy work. After the exam and a review of Petitioner's medical records, Dr. Robertson's diagnosis was left-sided L4-5 disc herniation caused by lifting and rotating shovels full of snow. He further opined that Petitioner's medical treatment was reasonable and necessary and that Petitioner sustained a permanent disability (final impairment rating 11% of the back) and will possibly need a fusion in the future.

On cross examination, Dr. Robertson testified that he only reviewed Petitioner's records subsequent to January 30, 2014. The only knowledge that he had of Petitioner's prior medical history was given by the patient as described above. Respondent led Dr. Robertson through medical records prior to the accident date indicating a history of low back pain and he testified that they did not change his opinions as authored. Dr. Robertson testified that Petitioner did have a left leg discrepancy and prior degenerative disc disease that could have contributed to his injury, but the final mechanism of the injury was the lifting and turning the shovels full of snow. Dr. Robertson did not agree with Dr. Sampat's chart note stating that the patient was asymptomatic prior to the injury of January 30, 2014. Petitioner's condition could have presented without trauma. (PX 9)

Petitioner submitted the evidence deposition of Dr. Chintan Sampat, taken on August 1, 2016. Dr. Sampat is a board certified orthopedic surgeon specializing in spinal disorders at Parkview Orthopaedic Group in New Lenox.

Dr. Sampat first saw Petitioner on April 1, 2014 at the referral of Dr. Mikaitis. He testified that Petitioner presented with low back pain, numbness, weakness, and pain radiating down his leg after shoveling snow on the job site on January 30, 2014. He further stated that Petitioner told him he felt a pop in his back while shoveling, thought it was a strain but the pain worsened. Petitioner tried some epidural steroid injections and chiropractic treatments with only temporary relief. Dr. Sampat also testified that Petitioner, at that time, could not "stand, walk, bend, or perform activities of his daily living without pain." (P. 7)

Dr. Sampat reviewed an MRI of Petitioner's low back and the findings included a left-sided L4-5 herniated disc. He testified that he recommended a microdiscectomy right away due to the fact that Petitioner had already undergone conservative treatment with no relief and enough time had gone by and he still had a lot of pain, numbness, and weakness. Dr. Sampat performed a microdiscectomy on April 5, 2014. After exploring the disc space and removing two large loose fragments of disc material he opined that, due to the fact that the disc was still soft, the herniation was recent. He testified that his findings were consistent with a January 30, 2014 back injury. Dr. Sampat testified to causal connection (over Respondent's Ghere objection, which was overruled). Dr. Sampat saw Petitioner for the last time on May 27, 2014 (Petitioner denied back pain or radicular pain at that time.), and released him to work as of June 2, 2014, PRN.

On cross examination, Dr. Sampat agreed that Petitioner did not provide much of a prior medical history—he was asymptomatic and doing fairly well prior to the injury. (PX 10)

Neither Dr. Sampat nor Dr. Robertson reviewed the 2007 lumbar MRI.

Dr. Avi Bernstein examined Petitioner at Respondent's request on June 22, 2015. Petitioner gave a history of injuring his back at work on January 30, 2014, when he lifted snow and turned. He had a past history of intermittent low back pain since 2004. The medical records did not support causation. Petitioner has made a fine recovery from surgery and can work at full duty. He was at MMI. He has a chronic condition of the lumber spine that remains symptomatic. Petitioner had a PPI rating of 8%. (RX 3 & 4)

Respondent submitted an Addendum Report from Dr. Bernstein dated April 13, 2016. Dr. Bernstein reviewed the Lumbar MRI films of March 4, 2014 and August 13, 2007. There was no material change in the scans; the same small left sided herniated disc was depicted on both films. The herniated disc was chronic and not related to a work incident. (RX 5)

Both Parties submitted evidence regarding the weather during the last week of January of 2014.

After considering the testimony of all of the witnesses and the documentary evidence, the Arbitrator believes that the temperatures were very cold and the winds were strong the last week of January, 2014. There was snow present on the WERC job site on January 30 and January 31, 2014, such that Tribco employees had to shovel snow. Petitioner engaged in snow shoveling on January 30, 2014 while working for Respondent.

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) To be compensable under the Act, an injury need only be a cause of an employee's condition of ill-being, not the sole or primary causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 205 (2003) 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:

After carefully considering all of the evidence adduced, The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 30, 2014. Perhaps Petitioner did experience a tweak in his back when shoveling as he described. The event was not significant enough to cause Petitioner to stop working and seek immediate medical care. He continued to work through the end of his shift. He did not report the injury. He did not answer "Y" in the injury column on the Attendance Log. He went home and returned to work the next day. He worked all day and again signed out without marking "Y" in the injury column.

Jorge Moreno noticed Petitioner having problems on the job on January 31. Moreno testified that he asked Petitioner about an injury at work and Petitioner said that he hurt his back shoveling at his house. Petitioner testified that he told Moreno that he injured his back "yesterday, shoveling snow." Owens said that she noticed Petitioner having problems on January 31 and he told her that he hurt his back shoveling when they were shoveling snow on the job. Gura thought that on February 4, 2014, Petitioner told him that he was hurt shoveling at WERC. Gura is likely mistaken about the date because Petitioner did not work at the parking garage until later in February.

Moreno offered Petitioner the chance to seek medical attention at the company clinic. Petitioner, an experienced tradesman, refused. He was aware of Work Rule Number 1- report all injuries and that he was not being truthful on the Attendance Log by marking "N" if he had been injured on the job. Petitioner was also aware of Rule Number 2- post accident chemical screen, which he may have considered in declining to fill out a report and go to the occupational clinic. An examination by a competent occupational doctor the day after the accident might have supported Petitioner's case, but it did not occur.

Here, we have Petitioner first getting treatment from a chiropractor, Dr. Burkhart, on February 4, 2014, some 5 days after the accident and 3 days after Petitioner needed help getting up from bed on a non-work day (per his uncorroborated testimony). Petitioner's testimony was that he had treated with Dr. Burkhart before, but Homer Chiropractic Clinic only had records from 2/4/2014 forward. Petitioner's testimony was that he was seen by Dr. Burkhart on February 3, 2014, but the records confirm that the first visit was February 4, 2014. The history was of a low back injury suffered on February 1, 2014, shoveling snow. Petitioner was not working for Respondent on February 1, 2014. The records of Homer Chiropractic Clinic do not contain any mention of an injury at work. Petitioner was next seen by Dr. Mikaitis, his PCP, on February 20, 2014. Petitioner testified that he told Dr. Mikaitis of the injury at work, shoveling snow, when he was seen by Dr. Mikaitis on March 4, 2014. There was a mention of low back pain for 3 weeks, but no history of a work injury, or a shoveling injury when he was seen on February 20. The chart from March 4, 2014 shows that Petitioner complained of left foot and calf pain times one week, low back pain for months. Again, there is no mention of an injury at work.

"It is presumed that a declaration to a treating physician as to one's physical condition and the cause thereof is true because the patient will not falsify such statements to the one from whom he expects to get medical aid." Shell Oil Co. v. Industrial Comm'n, 2 Ill.2d 590, 602 (1954) Here, the history of an injury at work does not appear until more than a month after the date of the alleged accident and after he has seen Chiropractor Burkhart and his PCP several times.

The failure to report the injury immediately; the failure to seek immediate medical attention; the failure to document an injury on the Attendance Logs; the lack of a history of a work injury in the initial medical documents; and the reasons set forth below regarding the issue of causation persuade the Arbitrator that the correct finding on the issue of accident is that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 30, 2014.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner did give timely Notice, in accordance with §6 of the Act. This is established by the testimony of Petitioner and Moreno, as to their conversation of January 31, 2014. Further, Petitioner's testimony that he informed Segura in February of 2014 that he injured his back shoveling on the WERC job is unrebutted.

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

As the Arbitrator has found that Petitioner did not sustain accidental injuries, arising out of and in the course of his employment by Respondent on January 30, 2014, the Arbitrator needs not decide this issue, but the Arbitrator finds that there has been a failure of proof on the issue of causation as well and believes that the basis for that finding should be explained.

In addition to the evidence relied upon for the Arbitrator's finding regarding accident, above, it is noted that Petitioner has a long history of low back pain, for which he was receiving monthly prescriptions of opiod medication. Second, as noted above, Petitioner continued to work for Respondent doing a heavy physical job for 1½ months after the alleged injury, never marking that he had an injury on the Attendance Logs. Third, Dr. Bernstein's opinion on causation (that there is none) is persuasive and best comports with the evidence in this case, especially since he was able to view both the 2007 and the 2014 MRI scans and opine that there was no change (Dr. Robertson and Dr. Sampat did not view the 2007 MRI).

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; ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE; AND ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 30, 2014 and failed to prove that his current condition of ill-being regarding his low back is causally related to the injury, the Arbitrator needs not decide these issues.

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

Miguel Herrera,
Petitioner,

vs.

No: 15 WC 19779

Estes Express Lines,
Respondent.

18IWCC0527

DECISION AND OPINION ON REVIEW

Through a Petition for Review, Respondent's counsel has, in practical effect, moved for clarification of the §19(b) decision filed by the Arbitrator on February 22, 2017 as it may regard the issue of thoracic outlet syndrome. The Commission provides this clarification as discussed below and otherwise affirms and adopts the Arbitrator's decision.

Background

Petitioner, a 39-year-old laborer, asserted that he developed complex regional pain syndrome (CRPS) after two fingers in his left hand were fractured when a propane tank fell on it during a slip-and-fall on March 3, 2015. At hearing, Respondent argued that Petitioner did not have CRPS and that, whatever his current condition of ill-being, it did not arise from the (undisputed) work-related hand crush injury. The Arbitrator decided in favor of Petitioner, finding that he sustained work-related CRPS and thus was entitled to the sought-after temporary total disability compensation, medical bills, and prospective medical treatment, including an MRI of the brachial plexus. Following the hearing, Respondent had a change of position and now appears to have conceded that Petitioner has work-related CRPS. By the time of its July 17, 2017 filing of its Statement of Exceptions and Supporting Brief, as stated by Respondent therein, it had paid the entire award as ordered by the Arbitrator.

Regarding the instant Petition for Review, Respondent asserts in its brief that the petition is "limited to the Arbitrator's findings with regard to thoracic outlet syndrome." Respondent argues that the Arbitrator's decision "should be reversed as to the issue of causation in regard to thoracic outlet syndrome, because Petitioner failed to prove by a preponderance of the credible evidence that this alleged condition is causally related to the work accident of March 3, 2015." However, Respondent's allusion to "findings" made by the Arbitrator as it concerned the "issue of causation in regard to thoracic outlet syndrome" is problematic insofar as the Arbitrator made no findings whatsoever as to whether Petitioner has thoracic outlet syndrome. Respondent may have read an ambiguity in the Arbitrator's decision where none really exists, and, perhaps in an (over)abundance of caution, has filed what is essentially a motion for clarification.

The issue of thoracic outlet syndrome (TOS) arose in the context of the opinions rendered by the parties' experts. As mentioned above, at the time of hearing, Respondent's position was that Petitioner did not have CRPS and that, whatever his current condition of ill-being, it was not causally related to the accident of March 3, 2015. In support of this position, Respondent had presented the opinions of Section 12 examiner Dr. Kenneth Candido, who excluded the diagnosis of CRPS on grounds that Petitioner's symptoms were inconsistent with CRPS. (RX 1 at 13). Dr. Candido opined that Petitioner's "present condition is most consistent with some type of anterior scalene syndrome [or thoracic outlet syndrome], which bears absolutely no relationship whatsoever to that crushed hand injury" of March 3, 2015. (RX 1 at 13). Dr. Candido added that Petitioner's likely thoracic outlet syndrome as well would bear no relationship to any trauma to the back that Petitioner might have experienced in his slip-and-fall. (RX 1 at 15; RX 2 at 37-39). As to treatment plan, Dr. Candido's recommendations included an MRI of the left brachial plexus. This MRI study would be to "look for a brachial plexopathy," which findings would then suggest further treatment. (RX 1 at 14; RX 2 at 34-35).

Petitioner presented the opinions of Dr. John Prunskis, who opined that Petitioner's condition was CRPS and that this CRPS developed due to the fractures to his fingers. To address Petitioner's continuing CRPS symptoms, Dr. Prunskis recommended additional medical treatment in the form of one or two more sympathetic nerve plexus blocks and a spinal cord stimulator trial. (PX 17 at 32-33). Dr. Prunskis disagreed with Dr. Candido's diagnosis of TOS, opining that Petitioner's advanced symptoms were easily distinguishable from that of TOS. (PX 17 at 30 -31). However, he added, "I would like to say it would be helpful to definitively rule out thoracic outlet syndrome to obtain an MRI of his brachial plexus area." (PX 17 at 12). He later testified as follows:

Q: For the thoracic outlet syndrome, you are recommending that an MRI brachial plexus be performed in order to definitely determine whether or not he suffers from that; is that correct?

A: That would be helpful; however, again, there's already findings that are very substantial to indicate complex regional pain syndrome.

Q: Okay. Assuming, if you will, that there is a find – that there is an MRI that's ordered by the judge and there is a finding of thoracic outlet syndrome, do you have an opinion whether or not that was caused by, aggravated, or exacerbated by the fall on or about March 3rd, 2015?

A: Yes.

Q: What is that opinion?

A: Since he by history states he never had any similar symptoms his whole life it would have to be directly related to the injury sustained at work on the date you just mentioned.

(PX 17 at 31-32).

Arbitrator's Decision

The Arbitrator in the first paragraph of his decision noted the parties' stipulation that Petitioner's finger fractures arose out of and in the course of his employment, and that Respondent "disputes that Petitioner now suffers from complex regional pain syndrome." (Arbitrator's decision at 1). The Arbitrator later summarized Dr. Prunskis' evidence deposition testimony. (Arbitrator's decision at 2-3). In pertinent part, the Arbitrator wrote:

> "Dr. Prunskis also testified that he does not believe Petitioner suffers from thoracic outlet syndrome. Dr. Prunskis testified that Petitioner's symptoms are overwhelmingly consistent with CRPS. However, Dr. Prunskis testified that if Petitioner does suffer from thoracic outlet syndrome, it would be related to his work injury since Petitioner was asymptomatic before the date of accident. An MRI of the brachial plexus is necessary to rule out thoracic outlet syndrome."

(Arbitrator's decision at 3). The Arbitrator also described and addressed Dr. Candido's opinion testimony, noting that Dr. Candido did testify that fractures to the fingers could cause CRPS. (Arbitrator's decision at 4, citing PX 2 at 61-62). In the end, the Arbitrator deemed Petitioner to be credible, and also wrote that he "found Dr. Prunskis' causation testimony persuasive." (Arbitrator's decision at 4). The Arbitrator's award included the prospective MRI of the brachial plexus as recommended by Dr. Prunskis (and Dr. Candido). As indicated in its review brief, Respondent has authorized this MRI.

Discussion

Regarding the Arbitrator's statement that he "found Dr. Prunskis' causation testimony persuasive," Respondent worries, "Although it is reasonable to presume that the Arbitrator was referring only to the diagnosis of CRPS in Petitioner's left upper extremity and not the possible diagnosis of thoracic outlet syndrome, the Arbitrator did not make such a distinction in his decision." (Respondent's review brief at 5-6). Respondent goes on to criticize Dr. Prunskis' opinions as to TOS and argues that "with respect to the issue of causation in regard to the possible diagnosis of thoracic outlet syndrome, it is clear that Dr. Candido presented the more reasonable and logical explanation as to how this condition developed." (Respondent's brief at 7). It ultimately requests that the Commission "reverse" the "aspect of [the Arbitrator's] decision regarding the issue of causation as to thoracic outlet syndrome." (Respondent's brief at 7).

Any such "reversal" is unwarranted as the Arbitrator's decision contains no finding whatsoever that Petitioner suffers from TOS. The Commission notes that the Arbitrator unambiguously wrote that he "concludes that Petitioner's current condition of ill-being, specifically the fractures to his left middle and ring fingers and CRPS to his left upper extremity, are related to his March 3, 2015 work accident." (Arbitrator's decision at 5). In agreeing with Dr. Prunskis' recommendation of an MRI of the brachial

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plexus to rule out TOS, the Arbitrator acknowledged only the possibility that Petitioner's current condition of ill-being is or includes TOS.

Insofar as Respondent seeks a clarification (or confirmation) that the Arbitrator's decision does not include a finding that Petitioner currently certainly -- as opposed to possibly -- suffers from TOS and/or scalenus anticus syndrome, the Commission so clarifies. The Arbitrator's decision is otherwise affirmed and adopted. The Commission also emphasizes that, in affirming and adopting the Arbitrator's decision with the above clarification, it makes no finding as to the existence and/or the causal relatedness regarding the potential diagnoses of thoracic outlet syndrome and/or scalenus anticus syndrome. The Commission awards payment for an MRI as recommended by both Dr. Prunskis and Dr. Candido for diagnostic purposes. Any finding as to thoracic outlet syndrome and/or scalenus anticus syndrome and causation regarding the same may be addressed in a future hearing/decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is clarified as discussed above, and is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter is remanded to the Arbitrator for proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

IT IS 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 $38,700.00. 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 2 1 2018

Joshua D. Luskin

Charles J. DeVriendt

o-06/27/18
jdl/ac
68

L. Elizabeth Coppoletti

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

HERRERA, MIGUEL
Employee/Petitioner

Case# **15WC019779**

ESTES EXPRESS LINES
Employer/Respondent

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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:

4883 LAW OFFICE ROBERTO ACEVEDO
511 EICHLER DR
SUITE 204
WEST DUNDEE, IL 60118

0560 WIEDNER & McAULIFFE LTD
PATRICK MORRIS
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)

MIGUEL HERRERA
Employee/Petitioner

v.

ESTES EXPRESS LINES
Employer/Respondent

Case # 15 WC 019779

Consolidated cases: ___

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An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **January 27, 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. ☒ 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 ___

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FINDINGS

On the date of accident, **3/3/15**, 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 **$50,274.12**; the average weekly wage was **$966.81**.

On the date of accident, Petitioner was **39** 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 **$24,860.82** for TTD, **$658.14** for TPD, **$0** for maintenance, and **$0** 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 Petitioner temporary total disability benefits of $644.54/week for 99-3/7 weeks, commencing March 3, 2015, through January 27, 2017, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD paid to date and the periods Petitioner returned to work.

Respondent shall pay Petitioner any outstanding medical expenses incurred through January 27, 2017, including, but not limited to those contained in PX 5, PX 6, PX 9, PX 11, PX 13, PX 14, PX 15 and PX 16, as provided in Sections 8(a) and 8.2 of the Act, subject to the Fee Schedule.

Respondent shall pay Petitioner prospective medical treatment consisting of the additional 1-2 injections, the spinal cord stimulator trial and MRI brachial plexus recommended by Dr. John Prunskis, as provided in Sections 8(a) and 8.2 of the Act, subject to the Fee Schedule.

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

2/21/17
Date

FEB 22 2017

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FINDINGS OF FACT

The parties stipulated that on March 3, 2015, Petitioner slipped and fell, and that an empty propane tank fell on Petitioner's left hand. The parties stipulated Petitioner sustained fractures to his left middle and ring fingers. The parties further stipulated that Petitioner's injuries to his left middle and ring fingers arose out of and in the course of his employment with Respondent. Respondent disputes that Petitioner now suffers from complex regional pain syndrome (CRPS).

Respondent is a freight truck company with locations throughout the United States and Illinois. Petitioner works out of Respondent's Elgin, Illinois, facility. Petitioner's responsibilities were to load and unload the freight trucks. Petitioner used a propane-operated forklift to perform his job.

On March 3, 2015, Petitioner was unloading a truck when he noticed the forklift's propane tank was near empty. Petitioner stopped unloading the truck and parked the forklift. Petitioner removed the propane tank from the forklift and placed it over his shoulders. Petitioner described the empty tank as 2-2½ ft. x 1-1¼ ft. and weighing 25-30 lbs. Petitioner used both arms to hold and carry the tank.

Petitioner testified that Respondent stored the propane tanks outside. Petitioner walked outside carrying the empty tank over his shoulders. Petitioner testified it was snowing lightly for 1-2 hours. As Petitioner approached the storage area, he slipped on snow and ice. Petitioner fell onto an asphalt surface. Petitioner testified his back and head hit the surface. Petitioner described the impact to his back and head as heavy. In addition, Petitioner testified the tank he was carrying landed on his left hand. He described the impact on his left hand as heavy.

Petitioner got up and walked inside Respondent's facility. A co-worker removed Petitioner's left hand glove. Petitioner noticed his left middle and ring fingers swollen. Petitioner testified his middle finger was also crooked.

Petitioner was taken to Presence St. Joseph Hospital in Elgin where x-ray images revealed comminuted articular fractures to the proximal phalanx third digit and fourth metacarpal. (PX 1 at 7) Petitioner testified he was instructed by Presence St. Joseph Hospital to follow-up with Associates in Orthopaedic Surgery.

Three days later, on March 6, 2015, Petitioner saw Dr. Michael Berkson of Associates in Orthopaedic Surgery. (PX 2, at 71) On March 9, 2015, Petitioner underwent surgery. (*Id.* at 21-22) Dr. Berkson performed open reduction and internal fixations. (*Id.*) Petitioner had three pins inserted into his middle finger and two pins into his ring finger. (*Id.*) Petitioner treated with Dr. Berkson through July 2, 2015. (PX 2)

From March 6, 2015, thru July 2, 2015, Petitioner complained of pain to his left hand. (PX 2) Dr. Berkson also noted allodynia, stiffness, limited range of motion and swelling. (*Id.*) On April 16, 2015, Dr. Berkson diagnosed Petitioner with reflex sympathetic dystrophy of the left upper extremity. (*Id.* at 60) Petitioner's symptoms were "quite pronounced." (*Id.*)

On May 14, 2015, Petitioner reported "significant pain symptoms." (PX 2 at 55) Dr. Berkson returned Petitioner to work with a 30-40 lbs. lifting restriction. (*Id.* at 56) Petitioner testified he worked with pain. On June 4, 2015, Petitioner was "still quite symptomatic." (*Id.* at 52) Dr. Berkson returned Petitioner to work without restrictions. Petitioner testified he continued to work with pain when he returned to work without restrictions.

On July 13, 2015, Petitioner followed up with Dr. Marc Fajardo of Hinsdale Orthopaedics. (PX 5 at 14) Petitioner testified, and the medical records show, he wanted a second opinion. (*Id.* at 15) Petitioner was concerned that his pain was not going away.

From July 13, 2015, thru June 1, 2016, Petitioner treated with Dr. Fajardo. (PX 5) Petitioner complained of severe pain over his left wrist and hand. (*Id.*) Dr. Fajardo noted Petitioner's pain to be grossly out of proportion. (*Id.* at 9) Dr. Fajardo also noted swelling and erythema. (PX 5) On August 17, 2015, Dr. Fajardo diagnosed Petitioner with CRPS. (*Id.* at 12) Dr. Fajardo recommended physical therapy, imposed work restrictions and referred Petitioner for stellate ganglion blocks. (*Id.*) Petitioner testified he was referred to Elmwood Park Surgery.

From August 31, 2015, thru October 27, 2015, Petitioner received pain management treatment at Elmwood Park Surgery. (PX 6) Petitioner complained of pain during this period. (*Id.*) The medical records show Petitioner also exhibited allodynia, decreased range of motion, mottling of the skin with definite color changes and hyperalgesia. (*Id.*)

At Elmwood Park Surgery, Petitioner was treated and examined by Dr. Amit Mehta, Dr. Amish Patel and Dr. Sunavo Dasgupta. (PX 6) All three pain management physicians diagnosed Petitioner with CRPS of the left upper extremity. (*Id.* at 29, 64 71) Petitioner received three stellate ganglion blocks. (PX 6) Petitioner's symptoms improved 15 to 40 percent following the injections. (*Id.* at 35, 76)

On February 19, 2016, Petitioner followed up with Illinois Pain Institute, a different pain management facility. (PX 9 at 22, 24) Petitioner testified he was worried that he was not getting full relief [from the injections]. Petitioner testified Dr. Fajardo referred him to Illinois Pain Institute for a second opinion. From February 2016 through December 2016, Petitioner received pain management treatment at Illinois Pain Institute. (PX 9) Petitioner was treated and examined by Dr. Chadi Yaacoub, Dr. Andrew Yu and Dr. John Prunskis. All three pain management physicians diagnosed Petitioner with CRPS of the left upper extremity. (*Id.* at 13, 17, 24) On February 19, 2016, Petitioner stated his pain was constant and made worse with cold weather. (PX 9 at 22) Petitioner stated nothing was working to relieve his pain. (*Id.*) Petitioner also exhibited hyperalgesia, allodynia, erythema, swelling, tenderness and limited range of motion. (PX 9) Also, on April 5, 2016, Dr. Yaacoub measured Petitioner's hands temperature. (*Id.* at 20) Petitioner's right hand was 86°F and his left hand was 83°F. (*Id.*) From April 5, 2016, thru December 29, 2016, Petitioner received six injections from Illinois Pain Institute, four thoracic sympathetic plexus blocks and two stellate ganglion blocks. (PX 9) Petitioner testified, and the medical records show, that his symptoms improved up to 50 percent following the injections. (*Id.* at 17-18)

Petitioner testified he has not worked since July 15, 2015. Petitioner testified he was unable to work due to his pain and work restrictions. Petitioner testified he had no prior injuries to his left hand, arm or neck. Petitioner also testified he has not suffered any trauma to his left hand, left fingers or neck since March 3, 2015. Petitioner testified he is still in pain. His pain is constant. His pain goes from his left fingers to his left elbow. Petitioner testified that any pain to his neck was from the injections he received for his CRPS symptoms. Petitioner denied that his pain radiated up his left bicep, left shoulder or neck.

At the conclusion of the arbitration hearing, the Arbitrator viewed Petitioner's left hand and noted swelling in the left hand above the knuckles when compared to the right hand.

On September 26, 2016, Dr. John Prunskis testified via evidence deposition. (PX 17) Dr. Prunskis testified he reviewed Petitioner's medical records from Presence St. Joseph Hospital, Associates in Orthopaedic Surgery and Hinsdale Orthopaedics. (*Id.* at 14-15) Dr. Prunkis has been a pain management physician since 1982. (PX 17 at 8) He is a Fellow of Interventional Pain Practice, Board Certified with Added Qualifications in Pain Medicine, Board Certified by the American Board of Anesthesiology and Certified by the American Academy of Pain Management. (*Id.* at 6)

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Dr. Prunskis has diagnosed and treated over 100 patients with CRPS. (*Id.* at 8) Dr. Prunskis testified that CRPS can develop from fractures to the fingers. (*Id.* at 10) Dr. Prunskis testified Petitioner's symptoms included pain, hypersensitivity, swelling, limited range of motion and erythema (discoloration). (PX 17 at 19-20) Petitioner's pain is aggravated with cold weather. (*Id.* at 23) Dr. Prunskis testified that CRPS can create a decreased blood flow to the affected area which leads to a colder hand. (*Id.* at 23-24)

Dr. Prunskis testified there are two types of injections that can be given to treat CRPS. (PX 17 at 21-22) The first is stellate ganglion block done in the front neck near C6-C7. (*Id.*) The second is thoracic sympathetic plexus block administered in the upper back near T2-T3. (*Id.*) Dr. Prunskis testified that Petitioner's symptoms improved up to 50 percent following the injections. (*Id.* at 26-27)

Dr. Prunskis testified that Petitioner suffers from CRPS. (PX 17 at 29) Dr. Prunskis testified that Petitioner's CRPS developed due to the fractures to his fingers. (*Id.* at 31) Dr. Prunskis recommended 1-2 additional injections[1] and spinal cord stimulator trial since the blocks are not giving Petitioner long-term relief. (*Id.* at 33) Dr. Prunskis testified that all treatment was medically necessary and appropriate. (*Id.* at 34) Dr. Prunskis testified that Petitioner could work without the use of his left upper extremity. (*Id.* at 35)

Dr. Prunskis also testified that he does not believe Petitioner suffers from thoracic outlet syndrome. (PX 17 at 30) Dr. Prunskis testified that Petitioner's symptoms are overwhelmingly consistent with CRPS. (*Id.* at 31) However, Dr. Prunskis testified that if Petitioner does suffer from thoracic outlet syndrome, it would be related to his work injury since Petitioner was asymptomatic before the date of accident. (*Id.* at 32) An MRI of the brachial plexus is necessary to rule out thoracic outlet syndrome. (*Id.* at 31)

On January 3, 2017, Dr. Kenneth Candido testified via evidence deposition. (RX 2) At Respondent's request, Dr. Kenneth Candido performed a Section 12 examination. Dr. Candido testified he is self-employed and President/CEO of Chicago Anesthesia Associates with the subsidiary Chicago Anesthesia Pain Specialists. (RX 2 at 4) He has been practicing medicine in Illinois for 30 years. (*Id.* at 5) On December 1, 2015, Dr. Candido examined Petitioner. (RX 2 at 10) Petitioner reported no prior injuries to his left hand. (*Id.* at 12) Petitioner reported left hand pain of 7/10 while at rest and 10+/10 with activity. (*Id.* at 10) Petitioner reported pain from his left fingers to left elbow. (*Id.* at 15, 39-40) Petitioner exhibited allodynia (i.e., pain to light touch) at the left wrist and left upper extremity. (*Id.* at 18-19) Petitioner had some limitations with his left wrist flexion and left hand extension. (*Id.* at 19) Dr. Candido measured Petitioner's biceps temperature. The right bicep temperature was 88°F. The left bicep temperature was 87°F. (*Id.* at 19) Dr. Candido believes Petitioner is injured and not malingering. (*Id.* at 45) Dr. Candido found Petitioner's pain to be "totally out of proportion." (*Id.* at 22)

Dr. Candido does not believe Petitioner suffers from CRPS. Dr. Candido believes Petitioner possibly suffers from scalenus anticus syndrome or thoracic outlet syndrome. (RX 2 at 60) The scalenus anticus syndrome or thoracic outlet syndrome would not be related to Petitioner's work injuries. (*Id.* at 29) Dr. Candido believes the scalenus anticus syndrome or thoracic outlet syndrome likely "developed remotely in an unrelated fashion." (*Id.* at 38)

Dr. Candido testified that scalenus anticus syndrome could be caused by trauma. It could be due to hyperextension of the neck or a sudden rotation of the neck. (RX 2 at 27) Dr. Candido described a motor vehicle collision as the type of trauma that could lead to scalenus anticus syndrome. In a rear-end collision, a sudden rotational injury to the upper neck on the affected side or rotating the head away from the affected side could cause scalenus anticus syndrome. Also, a blow directly over the scalene muscles could lead to scalenus anticus syndrome. (*Id.* at 30) Dr. Candido testified he does not have evidence that Petitioner was symptomatic in his

[1] Petitioner received the 1-2 injections recommended before the arbitration hearing date.

upper extremities before the date of injury. (*Id.* at 75) Dr. Candido also testified he does not have evidence that Petitioner suffered any trauma before or after the work injury date. (*Id.* at 75-76)

Dr. Candido did not ask Petitioner what body part(s) he landed on, the type of surface he fell on, the level of impact to Petitioner's back and head, or if Petitioner's head rotated swiftly in the fall. Dr. Candido also did not ask about the size and weight of the tank that fell on Petitioner's left hand. (RX at 46-47, 50) Dr. Candido agreed that there is trauma and some force created when a person falls on their back. (*Id.* at 54)

Dr. Candido testified that scalenus anticus syndrome and thoracic outlet syndrome are "pretty rare" conditions. (RX 2 at 58, 86) In his 30 years of practice, he has only diagnosed 4 or 5 patients with scalenus anticus [syndrome]. (*Id.* at 58) Dr. Candido testified he has never lectured or published anything on scalenus anticus syndrome or thoracic outlet syndrome because they are both rare conditions. (*Id.* at 86)

Dr. Candido testified that fractures to the fingers could cause CRPS. (RX at 61-62) Dr. Candido would expect to see CRPS symptoms develop on Petitioner's left upper extremity since the fractures were to his left hand. (*Id.* at 62) Dr. Candido testified that CRPS symptoms include:

i. Pain (*Id.* at 87);
ii. Allodynia (sensitivity to light touch) (*Id.* at 63, 74-75)
iii. Hyperalgesia (hyper-exaggerated response to noxious stimulus) (*Id.* at 63)
iv. Swelling (*Id.* at 65)
v. Skin color change (*Id.* at 65)
vi. 1.5^{oF} or greater temperature change of the affected area (*Id.* at 65)
vii. Decreased range of motion (*Id.* at 42, 65)

Dr. Candido testified that pain is the primary or characteristic symptom of CRPS. (RX 2 at 87) He testified that the patient's pain symptoms will tend to be "out of proportion." (*Id.*) Allodynia is also one of the hallmarks of CRPS. (*Id.* at 23) Not all symptoms need to be present for an individual to suffer from CRPS (*Id.* at 65-66) and not every presentation of CRPS is identical. (*Id.* at 41)

Finally, Dr. Candido testified that stellate ganglion blocks are used for CRPS. (RX 2 at 68) Dr. Candido testified that someone who suffers from CRPS is more likely to get relief from a stellate ganglion block. (*Id.* at 71-72) A stellate ganglion block will not provide relief to someone who suffers from scalenus anticus syndrome or thoracic outlet syndrome. (*Id.* at 71) Dr. Candido testified that Dr. Mehta performed three stellate ganglion blocks that did not provide Petitioner any relief. (*Id.* at 13) Dr. Candido testified Petitioner could work but with left upper extremity restrictions. (*Id.* at 36)

CONCLUSIONS OF LAW

1. With regard to 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 Petitioner's credible testimony and the medical evidence. The Arbitrator also found Dr. Prunskis' causation testimony persuasive on this issue. The parties stipulated that Petitioner suffered fractures to his left middle and ring fingers following an undisputed fall at work. Petitioner's injuries were significant enough to require open reduction and internal fixations. Both Dr. Prunskis and Dr. Candido testified that CRPS can develop due to finger fractures. CRPS symptoms can include pain, allodynia, hyperalgesia, swelling, skin color change, temperature change and decreased range of motion. According to Dr. Candido, pain is the primary symptom of CRPS. It is unrebutted and undisputed that Petitioner has had pain since the date of accident. Moreover, Dr. Candido testified pain symptoms tend to be "out of proportion." Fittingly, Dr. Candido himself [and Dr. Fajardo] noted that Petitioner's pain was "out of proportion." The medical records are also replete with Petitioner having

allodynia, hyperalgesia, swelling, mottling, decreased range of motion and temperature change to the left hand. Of note, Dr. Candido measured Petitioner's temperature change at the biceps, not the hands.

Both Dr. Prunskis and Dr. Candido testified that stellate ganglion blocks are used to treat CRPS. According to Dr. Candido [and Dr. Prunskis], a person who suffers from CRPS is more likely to get relief from stellate ganglion blocks. More importantly, Dr. Candido testified that a person who suffers from scalenus anticus syndrome or thoracic outlet syndrome will not get relief from stellate ganglion blocks. Dr. Candido testified Petitioner received no relief from the stellate ganglion blocks. However, this is not supported by the evidence. Dr. Prunskis and Petitioner testified that Petitioner received up to 50 percent relief from the stellate ganglion blocks. In addition, the medical evidence clearly shows Petitioner received relief from the stellate ganglion blocks at both Elmwood Park Surgery and Illinois Pain Institute.

Finally, Petitioner testified he had no prior injuries or symptoms to his left hand, arm or neck. Petitioner also testified he has not suffered any trauma to his left hand, left fingers or neck since March 3, 2015. There was no evidence presented to the contrary. Moreover, Dr. Candido testified that scalenus anticus syndrome and thoracic outlet syndrome are "pretty rare" conditions.

Accordingly, the Arbitrator concludes that Petitioner's current condition of ill-being, specifically the fractures to his left middle and ring fingers and CRPS to his left upper extremity, are related to his March 3, 2015, work accident.

2. With regard to the issue of medical expenses, the Arbitrator finds that the Petitioner has met his burden of proof. It is undisputed that Petitioner fell and suffered significant injuries to his left middle and ring fingers. Within days of the accident, Petitioner underwent open reduction and internal fixations to repair his fractures. The Arbitrator finds, based on the medical evidence, that Petitioner's treatment to his left middle and ring fingers was medically reasonable and necessary.

   As for Petitioner's CRPS treatment, Dr. Prunskis and Petitioner testified that Petitioner received relief from the injections. In addition, the medical evidence shows Petitioner received relief from the injections. Finally, Dr. Prunskis provided unrebutted testimony that Petitioner's CRPS treatments to alleviate his symptoms were reasonable and appropriate. Respondent presented no testimony to the contrary.

   Accordingly, the Arbitrator awards all related medical expenses incurred as result of Petitioner's fractured fingers and CRPS symptoms, including: Hinsdale Orthopaedics (PX 5), Elmwood Park Surgery (PX 6), Illinois Pain Institute (PX 9), SummitSurg Procedure Center (PX 11), Barrington Pain & Spine Institute (PX 13), Pinnacle Anesthesia (PX 14), Provena Medical Group (PX 15), and Injured Worker Pharmacy (PX 16), subject to the provisions of Section 8(a) and Section 8.2 of the Act with credit for payments made by Respondent.

3. With regard to the issue of TTD, the Arbitrator find Petitioner has proven entitlement to TTD benefits from March 3, 2015, through January 27, 2017. This finding is supported by both the Petitioner's credible testimony and the medical evidence indicating he was taken off work either with restrictions that Respondent did not accommodate or taken off work completely. There was no evidence offered to show Petitioner was capable of working without restrictions during this period.

   The parties stipulated that Respondent has paid TTD benefits from March 3, 2015, through February 9, 2016. Accordingly, the Arbitrator awards the Petitioner the TTD he seeks, less the TTD Respondent has already paid from March 3, 2015, through February 9, 2016.

18IWCC0527

4. With regard to the issue of prospective medical treatment, the Arbitrator finds that Petitioner has proven his need for prospective medical care for his CRPS. This finding is supported by Petitioner's testimony, Dr. Prunskis' testimony and the medical evidence. Petitioner is clearly still in pain and symptomatic. Previous injections have provided Petitioner only temporary relief. Dr. Prunkis testified that Petitioner requires 1-2 additional injections, a spinal cord stimulator trial (since the injections were not providing long-term relief), and possibly an MRI of the brachial plexus. Respondent presented no testimony to rebut Dr. Prunskis' recommendations. Accordingly, the Arbitrator awards the Petitioner the treatment that was recommended by Dr. Prunskis of the 1-2 injections, the spinal cord stimulator trial and MRI of the brachial plexus.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Clarence Ed Brisbin,
Petitioner,

vs. No. 13 WC 13779

Federal Companies,
Respondent.

18IWCC0528

DECISION AND OPINION ON REVIEW

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

The Arbitrator awarded Petitioner six weeks of TTD (December 11, 2012 through January 21, 2013), and 3% person-as-a-whole under §8(d)2 for his bilateral inguinal hernias, but denied his medical expenses, along with his claim for additional TTD and TPD benefits.

The underlying facts of this claim were laid out in the Arbitrator's Decision, which is incorporated herein by reference. While moving boxes at work on July 23, 2012, Petitioner felt a sharp abdominal pain. His primary physician, Dr. Shepherdson, diagnosed inguinal hernias and referred him to the Shouldice Hospital in Toronto, Canada, one of the few hospitals which offered a hernia repair procedure under local anesthesia. Petitioner wished to avoid the standard hernia procedures under general anesthesia which Respondent's utilization review physicians had certified, as he suffered adverse reactions from general anesthesia. Petitioner underwent hernia surgeries at Shouldice on December 12 and 14, 2012. He testified that his companion, Sharon, paid $8,700 on his behalf to Shouldice Hospital for those surgeries.

18IWCC0528

The Commission finds Petitioner's decision to have the Shouldice hernia procedures was reasonable. Surgery of one sort or another was required to repair his hernias, and Respondent offered no proof that Petitioner's surgeries at Shouldice Hospital was more expensive than the procedure which its utilization review physician approved, and which it was willing to pay.

For this reason, the Commission modifies the Arbitrator's award and finds Petitioner entitled to $8,700.00, subject to §8.2 of the Act, for his causally related medical expenses.

The findings and awards of the Arbitrator regarding MMI, temporary total disability, temporary partial disability, permanent partial disability and penalties were well supported by the evidence adduced, and are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 15, 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 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 $16,600.00. 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 2 1 2018

o-07/31/18
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRISBIN, CLARENCE ED
Employee/Petitioner

Case# **13WC013779**

18IWCC0528

FEDERAL COMPANIES
Employer/Respondent

On 11/15/2016, 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 0.62% 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:

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

0358 QUINN JOHNSTON HENDERSON ETAL
CHRIS CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Clarence Ed Brisbin
Employee/Petitioner

v.

Federal Companies
Employer/Respondent

Case # 13 WC 13779

Consolidated cases: n/a

18IWCC0528

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 13, 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 July 23, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $39,856.44; the average weekly wage was $766.47.

On the date of accident, Petitioner was 60 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $1,021.96 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,021.96.

Respondent is entitled to a credit of $1,109.75 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $510.98 per week for six weeks commencing December 11, 2012, through January 21, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $459.88 per week for 15 weeks because the injury sustained caused the three percent (3%) loss of use of the person as a whole as provided in Section 8(d)2 of the Act.

Petitioner's Petition for penalties and attorneys' fees is denied.

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

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

William R. Gallagher, Arbitrator

November 12, 2016
Date

ICArbDec p. 2

NOV 15 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 July 23, 2012. According to the Application, Petitioner sustained an injury "In the course of employment" to the "MAW" (Arbitrator's Exhibit 2). There was no dispute that Petitioner sustained a work-related accident and that his condition of ill-being was causally related to same. The primary dispute in this case was whether the medical treatment obtained by Petitioner was medically reasonable and necessary. Other disputed issues were whether Petitioner was entitled to payment of temporary partial disability and temporary total disability benefits as well as payment of travel expenses. Petitioner also claimed that he was entitled to penalties and attorneys' fees (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent on June 19, 2011, as a level "B" truck driver. Petitioner testified that on July 23, 2012, he and a crew were in the process of moving a residence. While Petitioner was in the process of moving boxes on a dolly, he felt a sharp pain in his lower abdomen. The accident was reported in a timely manner to Respondent.

Petitioner initially sought medical treatment on July 27, 2012, from Dr. John Shepherdson, his family physician. At that time, Petitioner had increased bulging and tenderness in the lower abdomen. Dr. Shepherdson suspected that Petitioner had an inguinal hernia and referred Petitioner to Dr. Brian Heywood, a surgeon (Petitioner's Exhibit 1).

Dr. Heywood evaluated Petitioner on August 6, 2012, and diagnosed Petitioner with an umbilical hernia. He recommended that Petitioner have corrective surgery with mesh (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Dru Hauter, an internist, on August 6, 2012. Dr. Hauter opined that Petitioner had bilateral inguinal hernias which were aggravated by work. He opined that surgery was indicated and imposed work/activity restrictions (Respondent's Exhibit 10; Deposition Exhibit 3).

On September 12, 2012, Petitioner was seen by Randall Wilcoxen, a Physician's Assistant. At that time, Petitioner advised that he had continued to work and that he was waiting for approval to proceed with surgery (Respondent's Exhibit 10; Deposition Exhibit 3).

On September 24, 2012, a note was prepared by Dr. Heywood's office which noted that Petitioner's surgery had been approved; however, Petitioner was unsure about proceeding with surgery. It noted that Petitioner had been looking into another procedure "up north" that did not use mesh (Petitioner's Exhibit 2).

At trial, Petitioner testified that he declined to undergo the surgery that had been recommended because, had he done so, he would have been required to undergo a general anesthetic. Petitioner stated that he previously had undergone general anesthesia on two separate occasions. One was approximately 20 years ago and the other was more recent. Petitioner stated that subsequent to having a general anesthetic he was totally disoriented for about one week and had some other

problems. At trial, Petitioner did not tender any evidence that he had sought medical treatment because of those symptoms. Petitioner did some research on the Internet about other surgical procedures and found a surgery that would only require a local anesthetic. Petitioner stated that this was called a "Shouldice" procedure, but that it was only performed in Toronto, Canada.

At the direction of Respondent, Dr. Peter Lopez, a general surgeon, did a utilization review on October 30, 2012. The question posed to Dr. Lopez was whether the Shouldice procedure or a standard hernia repair was medically appropriate. Dr. Lopez opined that Petitioner had bilateral inguinal hernias which required surgery. However, Dr. Lopez also opined that it was not medically necessary to have them repaired by the Shouldice method because it was equivalent to the mesh repair done in the United States (Respondent's Exhibit 1).

At trial, Petitioner tendered into evidence correspondence dated October 26, 2012, from Arthur Gelber, CEO, of Clinical Care Insight, LLC, a licensed utilization review company, directed to Robert Gates, Respondent's General Counsel and Vice President of Human Resources. In this correspondence, Gelber stated that he was the "authorized representative" of Petitioner, but did not state whether he was an attorney at law or a physician conducting a utilization review. The correspondence referenced provisions of the Workers' Compensation Act and stated, at length, various reasons why the Shouldice procedure was appropriate and should be authorized (Petitioner's Exhibit 8).

Petitioner requested an appeal of the utilization review performed by Dr. Lopez. On December 5, 2012, Dr. Robert Payton, a general surgeon, performed an assessment of the utilization review performed by Dr. Lopez. Dr. Payton agreed that Petitioner was in need of a hernia repair; however, he also opined that there was no indication that a Shouldice procedure was any better than a standard surgical repair of a hernia (Respondent's Exhibit 2).

Petitioner continued to work for Respondent on light duty. At trial, Petitioner testified that he did continue to work a full 40 hour work week for Respondent. On November 7, 2012, Robert Gates sent Petitioner correspondence which advised that Petitioner's light duty period would and on December 7, 2012. On December 7, 2012, Robert Gates sent Petitioner correspondence which confirmed that Petitioner's light duty assignment had ended as of December 7, 2012, but that Petitioner was eligible for FMLA leave (Petitioner's Exhibit 7). Petitioner did not return to work for Respondent anytime after December 7, 2012.

Petitioner was subsequently seen at Shouldice Hospital in Toronto, Canada, on December 11, 2012. Petitioner had surgical repairs of the left and right hernias performed on December 12, and December 14, 2012, respectively. Following surgery, Petitioner was released to return to light duty work effective January 28, 2013, and full duty as of March 18, 2013 (Petitioner's Exhibit 3).

In connection with Petitioner's FMLA application, Dr. Shepherdson prepared a report dated December 4, 2012. In that report, he noted that Petitioner should have been capable of returning to work on light duty approximately two weeks after surgery (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. Hauter on February 26, 2014. When seen by Dr. Hauter, Petitioner had minimal complaints and advised that he had been

released return to work without restrictions. Dr. Hauter opined that Petitioner had zero percent (0%) impairment based upon the AMA guidelines (Respondent's Exhibit 3).

Dr. Hauter was deposed on August 20, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Hauter's testimony was consistent with his medical report and he reaffirmed his opinion that there was zero (0%) impairment. He also testified that typically after hernia surgery, patients are released to return to work at light duty after two weeks and then to full duty after six weeks (Respondent's Exhibit 10; p 10).

At trial, Petitioner had minimal complaints and agreed that he had been released return to work without restrictions. Petitioner did not return to work for Respondent and stated that he was doing some type of freelance work that did not involve any physical labor.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did sustain a hernia for which corrective surgery would have been appropriate; however, the medical services provided to Petitioner in connection with his travel to Toronto, Canada, for the Shouldice surgery was not reasonable and necessary

In support of this conclusion the Arbitrator notes the following:

There was no question that Petitioner sustained a bilateral hernia as result of the accident of July 23, 2012, and that corrective surgery was appropriate.

Petitioner's family physician, Dr. Shepherdson, referred him to Dr. Heywood, a surgeon who opined that Petitioner needed hernia surgery with mesh.

The primary basis for Petitioner declining to undergo the hernia surgery as recommended by Dr. Heywood was that he would have to undergo a general anesthetic and that he previously had reaction to general anesthetic on two prior occasions. However, Petitioner presented no evidence that he sought medical treatment because of those prior symptoms.

Respondent obtained a utilization review from Dr. Lopez who opined that Petitioner had bilateral inguinal hernias, but opined that the Shouldice procedure was not medically necessary. This opinion was subsequently reviewed by Dr. Payton who agreed that the Shouldice procedure was not medically necessary.

There was no expert medical opinion contrary to those of Dr. Lopez or Dr. Payton. The correspondence from Arthur Gelber purports to state various reasons supportive of the propriety of the Shouldice procedure; however, Arthur Gelber was not identified as a physician. For that matter, Arthur Gelber presented arguments that one might have presented if he was an attorney at law; however, there was likewise no evidence that Arthur Gelber was an attorney at law.

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

The Arbitrator concludes that Petitioner is not entitled to any payment of temporary partial disability benefits.

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits for six weeks commencing December 11, 2012, through January 21, 2013.

In support of these conclusions the Arbitrator notes the following:

During the time Petitioner was working light duty, he testified that he continued to work a full 40 hours per week.

The award of six weeks temporary total disability benefits is based upon the opinion of Dr. Hauter that the typical recovery time following hernia surgery to return to full duty was six weeks.

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

The Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of three percent (3%) as a result of the accident of July 23, 2012.

In support of this conclusion the Arbitrator notes the following:

Dr. Fowler opined that Petitioner had an AMA impairment rating of zero percent (0%). The Arbitrator gives this factor moderate weight.

Petitioner worked for Respondent as a truck driver who also helped individuals move. Based upon the Petitioner's testimony his occupation required him to engage in lifting and moving objects. In regard to Petitioner's current occupation, there is little information other than the fact that it does not involve any physical labor. The Arbitrator gives this factor moderate weight.

Petitioner was 60 years of age at the time of the accident. There was no evidence that Petitioner's age had any effect on the injury. The Arbitrator gives us factor no weight.

There was no evidence that the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

All of the medical records for treatment Petitioner received and utilization reviews clearly indicated Petitioner had bilateral inguinal hernias for which corrective surgery would be required. While Petitioner was released to return to work without restrictions, he testified he is presently engaged in employment that does not require any physical labor. The Arbitrator gives us factor moderate weight.

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

Based upon the Arbitrator's conclusions of law that the denial of the Shouldice surgery was not vexatious or in bad faith; therefore, the Arbitrator concludes that Petitioner is not entitled to penalties or attorneys' fees.

William R. Gallagher, Arbitrator

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WENDY SKORNIA,

Petitioner,

vs. NO: 12 WC 24518

SCHOOL DIST. U-46,

Respondent.

18IWCC0529

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, nature and extent, and "evidentiary hearing", 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.

We begin our analysis by addressing the *Ghere* objection made by Respondent's attorney during the deposition of Petitioner's treating neurosurgeon, Dr. John Brayton, when he was giving his causation opinion regarding facet joint syndrome. The Arbitrator sustained that objection but we find this was error and the objection should have been overruled.

The Appellate Court has found that Section 12 of the Act applies to treating physicians "to prevent the employee from springing surprise medical testimony on the employer." *Ghere v. IC*, 278 Ill.App.3 840, 845 (1996). In *Ghere*, the claimant attempted to introduce deposition testimony from decedent's treating physician on the issue of whether decedent's work activities or work environment could have precipitated his heart attack. *Id. at 842*. The arbitrator had excluded the testimony under Section 12 because this causation opinion was not disclosed to the employer at least 48 hours prior to the deposition. *Id.* In finding that the arbitrator properly excluded the testimony, the Court noted that decedent's physician had never even treated him for any heart condition and there was nothing in the physician's records to put the employer on

notice that he had a causation opinion regarding the heart attack. *Id. at 846.*

In *Homebrite Ace Hardware v. IC*, the Court reiterated, "The purpose of having the claimant's physician send a copy of his or her records to the employer no later than 48 hours prior to the arbitration hearing is to prevent the claimant from springing surprise medical testimony on the employer." 351 Ill. App. 3d 333, 337 (2004). However, the Court rejected the employer's argument "that the Commission must strictly adhere to *Ghere* and thus any undisclosed opinion testimony must be deemed as surprise and be barred", *Id. at 339*, stating:

> We find no indication in *Ghere* that its holding must be so strictly interpreted. The *Ghere* court examined the physician's records and treatment history to determine whether the employer was put on notice regarding the possibility that the physician might provide causation testimony. The court did not set forth a bright-line rule or presumption that undisclosed opinion testimony constitutes surprise. Furthermore, *Ghere* is factually distinguishable because the physician in *Ghere* had never treated the employee's heart condition, whereas Dr. Heffner did treat claimant for his neck problems. Dr. Heffner's records contain details about his treatment of claimant's neck complaints and therefore the records put employer on notice that Dr. Heffner might testify as to a causal relationship between the neck condition and claimant's work accident. Indeed, the only contested issue at arbitration was claimant's cervical injury. Employer's suggestion that Dr. Heffner's testimony should have been excluded is not well taken under these facts. *Id.*

Similarly, in *Kishwaukee Community Hosp. v. IC*, the Appellate Court found that despite no "report" having been issued notifying the employer as to what the causation opinion of claimant's treating physician would be, the "records contain details about his treatment of claimant's bilateral carpal tunnel syndrome and basilar joint arthritis" and "the employer could not have been surprised by [the doctor's] opinions regarding causation...." 356 Ill. App. 3d 915, 923 (2005).

Applying these principles here, Respondent's argument in support of its *Ghere* objection was that it did not receive a "written explanation of what the doctor's opinion would be on this so I could properly prepare for cross-examination on this issue, and there has never been anything tendered to me, nor has any letter from counsel been tendered saying anything about what the basis of this opinion would be." *Px4 at 13.* We note that Respondent is not arguing that it never received Dr. Brayton's treating records at least 48 hours prior to his deposition. To the contrary, there are indications in the transcript that Respondent did, in fact, have them in a timely manner. Respondent's attorney stated, "I issued a subpoena for your chart, which I assume is going to be going into evidence at some point." *Id. at 18.* At one point in questioning, Respondent's attorney corrected Petitioner's attorney regarding a date when Petitioner had seen Dr. Brayton (November 13th instead of October 14th). *Id. at 11.* In addition, Respondent's attorney was prepared enough to bring her own diagram illustrating Petitioner's various cervical conditions, including a herniated disc, degenerative uncovertebral joint, and degenerative facet joint. *Id. at 22; Depx2.* Respondent's attorney cross-examined Dr. Brayton extensively using this diagram, including on the issue of the facet pain syndrome, and the following exchange took place:

A: This is the most perfect diagram you could have possibly have picked.
Q: Thank you. I searched high and low for that.
A: Because it shows the whole case here. It shows the issue. *Id. at 26.*

Based on the applicable case law, we find that *Ghere* should not be "so strictly interpreted" and a formal causation "report" was not required to be tendered to Respondent. Dr. Brayton's records reflect his diagnosis, treatment, and discussions of Petitioner's facet joint syndrome following her fusion surgery. Although his records do not explicitly state that this condition remained causally related to her work injury, Respondent had adequate notice that Dr. Brayton could give such an opinion and the transcript shows that Respondent was, in fact, prepared to cross-examine him about such an opinion. Based on the information contained in Dr. Brayton's medical records, which Respondent had, we find that it cannot reasonably claim that it was surprised by his causation opinion testimony. Therefore, Respondent's *Ghere* objection should have been overruled.

Deposition Testimony of Dr. John Brayton

Dr. John Brayton testified via deposition on April 28, 2016. He is a board-certified neurosurgeon and first saw Petitioner, on referral from Dr. Popp, on March 21, 2014. *Id. at 5-6.* He discussed the history of Petitioner's work injury in May 2012 while restraining a child and her treatment, including a C5-6 arthroplasty that was performed by Dr. Popp on December 17, 2012. *Id. at 6.* He testified that Petitioner subsequently developed progressive C6 distribution radiculopathy and scapular pain more pronounced on the right than the left. *Id. at 7.* Dr. Brayton discussed Petitioner's treatment prior to her seeing him, which included physical therapy, injections, a CT myelogram, and an examination with Respondent's Section 12 physician. *Id.*

Dr. Brayton testified that, on examination, Petitioner had severe scapular pain, paraspinous spasm and sensory motor radiculopathy in the C6 distribution on the right. *Id.* He personally reviewed the films from the February 12, 2014 CT myelogram. The disc arthroplasty was in good position but there was increasing sclerotic change and osteophyte formation posterior to the disc arthroplasty implant at the position of the posterior vertebral body endplate and uncovertebral joints, which was causing significant ventral effacement of the spinal canal and compression of the neural elements as well as severe neuroforaminal compression. *Id. at 8.* Dr. Brayton's diagnosis was recurrent compressive C6 radiculopathy after disc arthroplasty that was performed appropriately. *Id.* He believed there was a cause and effect relationship between the accident and her condition based on her history, imaging studies, preceding medical records prior to my initial visit and subsequent imaging studies including the CT myelogram. *Id. at 9.*

Dr. Brayton recommended a removal of the arthroplasty and cervical fusion surgery, which was performed on May 19, 2014. She followed up with him on July 14, 2014. On September 11, 2014, Petitioner had persistent pericervical spasm but no radicular deficit or myelopathy so "her pre-operative C6 radiculopathy had resolved." Px4 at 9-10.

Petitioner underwent an MRI on November 4th, which Dr. Brayton reviewed at the visit on November 13th. *Id. at 11.* He felt there was patent decompression at the operated level with restoration of normal alignment and complete alleviation of the ostophyte and other compression lesion but "there was significant facet hypertrophy and arthropathy at both C5-6 and C6-7, especially on the right." *Id.* He testified that Petitioner had developed some recurrent radicular symptoms in the right upper extremity and recurrent neck pain and stiffness primarily on the right. On examination, Petitioner was tender to palpation over the right-sided articular facets and cervical region without radicular deficit and there was paracervical spasm with limited cervical range of motion. *Id. at 12.* He testified that the spasm is an objective finding, which he could palpate and feel, and that based on the MRI scan findings and examination, Petitioner was suffering from facet pain syndrome. He recommended she be sent to a pain doctor for facet injections and possibly a medial branch radiofrequency rhizotomy for facet ablation to treat her facet pain syndrome. *Id.*

Dr. Brayton explained that the articular facets are posterior and lateral in the spine. They are not fused as part of an anterior fusion and sometimes become a competent source of pain independent of nerve root compression or other contributing factors. When they do and they become refractory producers of pain, it's termed facet pain syndrome. *Id. at 13.* He testified that there was a cause and effect relationship between Petitioner's injuries and accident in 2012 and her development of facet pain syndrome. *Id. at 14.* His opinion was based on "correct symptomatology, appropriate level of pathology, correction of compression by osteophyte and foraminal stenosis and persistence of facet hypertrophy and arthropathy causing pain on examination." *Id.* He prescribed an EMG to be sure there was not electrophysiologic evidence of persistent radiculopathy but this was never done because they never received authorization. *Id. at 15.*

Dr. Brayton testified that he last saw Petitioner on February 2, 2015, and she was still having facet pain. Examination revealed persistence of severe tenderness to palpation over the articular facets and crepitus over the facets with neck motion. He was able to assess the crepitus by palpation and inspection with neck movement. He testified that crepitus is caused by irregularity of the joint surface. *Id. at 16.* Dr. Brayton's opinion was Petitioner had facet pain syndrome based on the diagnostic criteria for facet pain syndrome and the imaging criteria. He recommended she be referred for pain management to proceed with facet injections to confirm or refute the clinical suspicion of facet pain syndrome and to afford symptomatic relief. He opined that, because her treatment had not been initiated, she was not ready to return to gainful employment at that time. *Id. at 17.*

On cross-examination, Dr. Brayton was shown the diagram Respondent's attorney had brought and he stated:

> This is a deceased [sic: diseased] cervical spine. This is actually a perfect representation for this patient, absolutely perfect. It couldn't be better because this person in this diagram has a large herniated disc. *Id. at 22.*

He identified a "big red arrow" on the diagram pointing to a disc herniation and stated it looked similar to Petitioner's condition. Dr. Brayton testified that the disc arthroplasty, which Petitioner

previously underwent, removed the offending disc and replaced it with an artificial disc system. *Id. at 23.* Although the entire disc was removed, Dr. Brayton marked the "offending part" on the diagram with an "X". He testified that Petitioner also had some degree of degenerative uncovertebral joint, which was not removed as part of the arthroplasty because it would not be stable. *Id. at 24.* Dr. Brayton identified another "big red arrow" on the diagram pointing to a "degenerative uncovertebral joint," which is the osteophyte and which is similar to Petitioner's condition. *Id.*

Dr. Brayton testified that by the time he saw Petitioner, the herniation was gone since it had been treated by the disc arthroplasty. *Id. at 25.* However, the degenerative uncovertebral joint osteophyte had gotten worse so it was now compressing her nerve. Id. Dr. Brayton drew a circle around the degenerative uncovertebral joint and testified that the CT myelogram revealed that was where her compression was. *Id.* He testified that the only way to treat that is to remove the disc arthroplasty, remove the uncovertebral joint osteophytes, and perform a fusion. *Id.*

Dr. Brayton testified, "we've treated the X by virtue of the disc arthroplasty. We've treated the circle by virtue of the fusion. What we haven't treated is what then became symptomatic, which is what we also see on this beautiful diagram, which we can put a box around, the degenerative facet joint." *Id.* Dr. Brayton explained, "we don't fuse the facets" in an anterior fusion. *Id. at 28-29.* He testified, "Most of the time when someone develops facet pain syndrome after an anterior cervical fusion, we do not have to fuse the facet joint to mediate the condition. It's generally treated without fusing the facet." *Id.* He testified that the anterior side of the spine is where the fusion was, the posterior vertebral body osteophytes are behind the disc, and the facets as on the back on the posterior side of the spine. *Id. at 29-30.* He explained that the facets cannot be addressed anatomically from the front of the neck and one would have to do a separate surgical procedure posteriorly. *Id. at 30.* The following questions were asked:

Q: Got it.

So when you went in to do the surgery, you were worried about things that were happening more anterior and in the middle of the spinal column than you were about the things on the posterior portion of the spinal column, right?

A: Well, this goes back to asking about the neuroforamen. The neuroforamen is where the nerve leaves. It's flanked by the facet complex posteriorly, the lateral mass above and below, the uncovertebral joint and disc medially and in front.

But when we remove this disc to do a fusion, under the microscope we can see the posterior aspect of the vertebral body in front of the spinal cord and in front of the nerve root and remove an osteophyte there. What we cannot do is remove an osteophyte on a facet joint.

Q: Got it. Because you can't see that?

A: Right. But if we adequately restore patency of the neuroforamen, in other words, take the pressure off the nerve from the front, this would be the front, and then we have something wrong with the facet, usually we don't have to do the same thing to the facet joint because we have enough patency of the neuroforamen.

And this goes back to the other question about the EMG. Part of diagnosing facet pain syndrome is to prove that you don't' have an ongoing nerve root compression or an ongoing radiculopathy. It would be nice to have an EMG

before we make a definitive statement that the patient has facet pain syndrome.

If we have an examination that fits, plus we have electrophysiologic studies, being an EMG and nerve conduction velocity studies, that tells us there's no problem now with the nerve, then we have as much evidence as we possibly can that the patient is suffering from facet pain syndrome. After all the treatment when she had recurrent symptoms, that's why I wanted the EMG. But even without the EMG, I was convinced she was suffering from facet pain syndrome. *Id. at 30-31.*

Dr. Brayton agreed that Petitioner's initial symptoms in 2012 were related to the herniated disc and to some extent the osteophytes around the posterior vertebral body and the uncovertebral joint. *Id. at 32.* That was the reason the first surgery, to put in the artificial disc, was done. *Id.* The second surgery was to address the uncovertebral joint and fuse the spine. *Id.*

Dr. Brayton testified that when he initially saw Petitioner in March 2014, he did not address the facets. The primary cause of her problems and pain at that time was recurrent compression of the nerve roots, not from facet pain syndrome. Id. at 32-33. He testified:

Q: Did you check the facets at that time in March of 2014 to see if there was tenderness to palpation, for example?
A: Well, she had paraspinous spasm, but primarily her finding was that of sensory motor radiculopathy which correlated with recurring compression of her C6 nerve root from that osteophyte.
Q: So when you saw her, she had symptoms that were consistent with that problem that you addressed in the second surgery, correct?
A: Yes.
Q: Okay. Because the spasm is not specific to the facets, it's specific to injury or ongoing pathology in the spine, correct?
A: Correct. *Id. at 33-34.*

Dr. Brayton then gave the following testimony:

Q: Okay. So when she came back to you on [11/13/14], she told you she had a recent recurrence of her right-sided neck pain; is that right?
A: Yes.
Q: When there's an acute aggravation of a facet pain, symptoms can be similar to symptoms that you would get from a herniated disc, right?
A: Yes.
Q: So her recurrent complaints started sometime in the beginning of November or maybe the end of October; is that correct?
A: Yes.
Q: What physical activities was she performing outside of your office in the beginning of November or the end of October, if you know?
A: I don't know.
Q: And up to that point, had you seen anything that would have pointed to an ongoing problem with facet joint pain?

A: When we looked through her post-operative visits, she was doing the best July 14th. She had complete resolution in radiculopathy, dramatic improvement in neck pain and so forth. The next visit was September 11th, and at that point she had recurrent stiffness and soreness in her neck. She was attributing it to a flu-like prodrome which caused increasing aching and soreness. But I think in retrospect, that was the beginning of facet pain syndrome.
Q: Can you say that without speculating though?
A: Well, I think it makes more sense than it being a flu prodrome causing the pain because she went on to have increasing pain. So it evolved to become facet pain syndrome. *Id. at 34-35.*

Regarding other potential causes of Petitioner's condition, he was asked:

Q: You testified you don't know what she was doing though in October or November. She could have been lifting weights or something like that, and that could have caused it, right?
A: She could have been, yes.
Q: So if she was lifting – Let's just say she was lifting something in excess of 20 pounds above her head, you know, a few times a day, could that also cause this kind of facet pain?
A: Yes.
Q: Okay. Now, when you see her in November of 2014, she shows exquisite tenderness to palpation of those facet joints; is that correct?
A: Yes.
Q: Is that consistent with something acute?
A: Yes.
Q: And you testified that there was no clear-cut evidence of radiculopathy any longer; is that right?
A: Correct. *Id. at 35-36.*

Dr. Brayton reviewed Petitioner's November 4, 2014 film again and testified:

A: Yes, this is the [11/4/14] film.

These are axial views and sagittal views. These are the screws for the fusion. These are the neuroforamen. They're completely open, completely free of any compression on both sides. That's the level below. That's the level above. These are the artifacts from the fusion; hardware, little screws. The only thing that I see is this facet hypertrophy here.
Q: What do you mean by hypertrophy?
A: It's thickened, the facet joint.
Q: So it's getting spurs?
A: Right.

So it goes back to your model, the thing I drew a box around, the degenerative facet. It shows that on that [11/4/14] film. So in my opinion now, that's the cause of her condition.
Q: Can that be asymptomatic?

A: Yes.
Q: And if you were to lift something heavier than you're used to lifting, perhaps that kind of thing can aggravate that so it becomes symptomatic?
A: Yes. *Id. at 36-37.*

Dr. Brayton did not recall seeing records reflecting facet pain between 2012 and 2013. *Id. at 38.* He opined that the injury to Petitioner's disc is what caused the progression of the osteophyte formations that were indicted by the "circle" on the diagram. *Id.* He agreed with the radiologist that there was not a significant change in Petitioner's degenerative changes between the films from 2012 and April 2013. *Id.* He testified that he had no criticism of the disc arthroplasty having been performed but, if it were him, he would not have done the arthroplasty and would have "gone straight to the fusion." *Id. at 39.*

Dr. Brayton testified that he had not seen Petitioner in over a year and he deferred further treatment to pain management. *Id.* He stated that the results for performing a radiofrequency neurotomy for cervical facet joints "are considered fair." *Id. at 40.* Dr. Brayton did not have personal knowledge of Petitioner's current complaints or work capacity and, after his February 2015 work status report, he would defer to Dr. Wilson regarding Petitioner's restrictions. *Id. at 40.* He testified that part of the basis of his causation opinions were the history Petitioner gave him and, if that history was inaccurate or incomplete, that "could or might" change his opinion. *Id.*

On redirect examination, Dr. Brayton stated that he would have to know what that history is in order to change his opinion. Id. at 41. He testified that he would receive updates from ATI regarding Petitioner's physical therapy. Id. at 42. On the discharge summary, dated October 9, 2014, Petitioner's primary complaint was right upper extremity and neck pain with little to no improvement over the last few weeks and "feels that [therapy] always flares her up." *Id.* The previous progress note was from September 22, 2014, which indicated a primary complaint of numbness and tingling and pain all the way down the right arm into the hand and a muscle spasm at the bra line. *Id. at 43.* He testified that regarding whether lifting something overhead could make the facet joints symptomatic, he would have to know the frequency and the weight of the object. *Id.* Dr. Brayton testified:

Q: You testified that the facet arthritis was pre-existing the accident?
A: I think there was some degree of facet arthropathy prior to the injury but that it progressed significantly until the final MRI that I saw on 11/4/14.
Q: Why would it progress, Doctor – or do you have an opinion as to why it progressed?
A: I think it's a consequence to the injury and treatment. *Id. at 44.*

The Commission next addresses other objections made by Respondent during the deposition. On re-cross examination, Respondent's attorney asked questions about how long degenerative problems take to develop, whether the facet arthropathy had progressed since the time of the injury, and the amount of progression that occurred. The following exchange took place:

Q: Okay. And then between the 2013 and 2014 studies, not a significant change. Is that what you're saying? Other than the fusion being put in.
A: Right. Well, I mean the osteophytes were removed at the time of the fusion. So those osteophytes that were present on that CT myelogram were surgically removed as part of the fusion operation.
Q: How about the facet ones though?
A: Oh, no. The facet ones, no. With respect to the facet joint sclerosis, I think there's some progression in the facet arthropathy from the time of injury to the time of the last MRI scan. But it's a very small amount.
Q: Okay. So for the facets, small amount of change?
A: Right. But I think symptomatically they became worse. But anatomically they did not change very much.
Q: And the reason you're saying that the current complaints of facet pain are related to the original injury in 2012 is because she's telling you that this pain has existed since 2012, right?
A: Well, that and because the level of injury was the correct level to correlate with that facet joint, the anatomy of the injury was correct to correlate with facet pain syndrome and the history, those things.
Q: But she didn't have any facet pain, at least that you were worried about, until she came back with this new or recent recurrence that you testified was consistent with an acute process?
A: Well, I think the primary cause for concern originally was the compression of the nerve root and the sensory motor radiculopathy, confirmed by EMG and documented by imaging studies showing compressed nerve. Then when she has recurrent pain without radiculopathy and imaging studies that show there's no more pressure on the nerves, then the cause of her condition is basically a diagnosis of exclusion corroborated by her physical examination having pain and crepitus over the painful tender facets.
Q: In July that wasn't the case in 2014 though, right?
A: Yes.
Q: In August she didn't call you about complaints of facet pain, right?
A: Well, I think going between her post-operative visits, she one time has flu-like symptoms and achiness and soreness, it was difficult to tell exactly what was the cause until her final two visits where she clearly had facet pain.
Q: That was acute, right?
A: Yes.
Q: And you also testified that given her degenerative facet disease, lots of activities of daily living could cause that to become symptomatic, correct?
A: Yes.
Q: Including, let's say, lifting a 20-pound child above her head and out into a vehicle and that sort of thing, correct?
A: Yes. *Id. at 48-50.*

On further re-direct examination, Petitioner's attorney asked:

Q: Going back to the physical therapy notes from November of 2014 that I asked you about. At the discharge summary of [10/9/14] where she's complaining of right upper extremity and neck pain, little to no improvement over the last several weeks, where do you think that pain was coming from? *Id. at 51.*

Respondent's attorney made objections based on "out of the scope and calls for speculation," which were sustained by the Arbitrator. *Id.* Dr. Brayton answered:

A: I think she didn't have evidence on examination of radiculopathy. Part of the diagnosis of facet pain syndrome is that we want to exclude radiculopathy as a cause, but we didn't get to have an EMG at that time. On examination her radiculopathy was resolved. She didn't have – On examination she did not have dysfunction of the C6 nerve root.

He was then asked:

Q: Do you have an opinion as to whether that was facet pain that she was complaining about?

Respondent's attorney again objected:

R-atty: Objection. Out of the scope.
P-atty: You just spent ten minutes talking about facet pain and during that period of time, so that's my response.
R-atty: And my response is, I didn't talk anything about the physical therapy records.
P-atty: Okay. You can't limit the scope that narrowly, but the arbitrator will rule.
A: I think that -
R-atty: Objection. Calls for speculation also. *Id. at 51-52.*

These objections were again sustained by the Arbitrator. Dr. Brayton's answer was:

A: Based on her examination, the data we have and the information and progression in her clinical course, that pain, in my opinion, represented facet pain syndrome.
Q: And how about at the previous progress note of, I think, September 22nd? *Id. at 52.*

Respondent's same objections were again sustained by the Arbitrator. Dr. Brayton opined:

A: I think that's facet pain syndrome.
Q: And the basis for that opinion?
A: The same reason; the absence of radiculopathy or improvement of radiculopathy, imaging studies that showed adequate decompression of the nerves without recurrent compression and persistent pain with an examination suggesting that the origin that the pain was facet joint pain. *Id.*

The Commission finds that the scope of Respondent's re-cross examination included the

timing of the onset of Petitioner's facet joint pain. The fact that Respondent's attorney did not ask specifically about the physical therapy records, does not preclude questioning by Petitioner's attorney about records that are also related to when Petitioner developed facet joint pain. Therefore, the questioning by Petitioner's attorney on further redirect should not have been so narrowly limited as to prevent him asking about Dr. Brayton's opinion regarding the source of Petitioner's pain, as documented on the October 9, 2014 physical therapy discharge summary and the September 22nd progress note.

We further do not find Dr. Brayton's opinion to be speculative. He testified that his opinion, that Petitioner's pain as documented in those physical therapy records was due to facet pain syndrome, was based on Petitioner's examination, the progression in her clinical course, the absence or improvement of radiculopathy, imaging studies that showed adequate decompression of the nerves without recurrent compression, and persistent pain with an examination suggesting that the origin of the pain was facet joint pain.

On further re-cross examination, Dr. Brayton was asked:

Q: Could babysitting and lifting a 20-pound child in the ways that I've described out above the head cause all of those symptoms in September and October had she been doing those activities then?
A: Yes. *Id. at 53.*

On further redirect examination, Dr. Brayton testified:

Q: And equally it could not have?
A: Yes. *Id.*

We next address two findings by the Arbitrator relating to Dr. Brayton's testimony, which we believe require clarification. First, the Arbitrator found, "Dr. Brayton testified facet hypertrophy, which was on the opposite side of the spine, was now the cause of her condition in later-2014. (PX4, pp. 36-37)". Arb Decision at 5. It is not clear how the Arbitrator interpreted Dr. Brayton's testimony as suggesting that Petitioner's facet hypertrophy was on the "opposite side of the spine." However, the citation to those pages in the deposition transcript appears to refer to the following testimony:

A: Yes, this is the [11/4/14] film.
These are axial views and sagittal views. These are the screws for the fusion. These are the neuroforamen. They're completely open, completely free of any compression on both sides. That's the level below. That's the level above. These are the artifacts from the fusion; hardware, little screws. The only thing that I see is this facet hypertrophy here.
Q: What do you mean by hypertrophy?
A: It's thickened, the facet joint.
Q: So it's getting spurs?
A: Right.

> So it goes back to your model, the thing I drew a box around, the degenerative facet. It shows that on that [11/4/14] film. So in my opinion now, that's the cause of her condition. *Id. at 37.*

The Commission notes that Respondent's illustrated diagram did show an example of a degenerative facet joint on the opposite side from the herniation and degenerative uncovertebral joint *on the diagram. Px4-DepX2.* However, Dr. Brayton never testified that the facet hypertrophy *in Petitioner* was on the "opposite side of the spine." In fact, he had earlier testified that he reviewed the November 4, 2014 MRI and:

> I felt that there was patent decompression at the operated level, restoration of normal alignment and complete alleviation of the osteophyte or other compression lesion, but **there was significant facet hypertrophy and arthropathy at both C5-6 and C6-7, especially on the right**. *Id. at 11 (Emphasis added).*

We note that Petitioner's primary complaints since the time of her original injury have been to the right side of the neck and right upper extremity. There is no basis to find that Petitioner's facet arthropathy or hypertrophy are now on the "opposite side" of the spine.

Second, the Arbitrator wrote, "Dr. Brayton also admitted there was no significant change at the facets when comparing the 2013 imaging to that from 2014. (PX4, p.48)". *Arb. Decision at 5.* Dr. Brayton actually testified that there was "some progression in the facet arthropathy from the time of the injury to the time of the last scan. But it's a very small amount." *Px4 at 48.* However, he continued:

> Q: Okay. So for the facets, small amount of change?
> A: Right. **But I think symptomatically they became worse.** But anatomically they did not change very much.
> Q: And the reason you're saying that the current complaints of facet pain are related to the original injury in 2012 is because she's telling you that this pain has existed since 2012, right?
> A: Well, that and because the level of injury was the correct level to correlate with that facet joint, the anatomy of the injury was correct to correlate with facet pain syndrome and the history, those things. *Id. at 48-49 (Emphasis added).*

In other words, Dr. Brayton testified that although there was only a small change seen on the films, the facets did become more symptomatic and he gave the basis of that opinion.

Deposition Testimony of Dr. Alexander Ghanayem

We next weigh the causation opinion of Dr. Brayton against that of Respondent's Section 12 board-certified orthopedic surgeon, Dr. Alexander Ghanayem. He testified that he examined Petitioner on three occasions: November 5, 2012, January 9, 2014, and December 15, 2014. *Rx1 at 6-8.* He stated:

> In short, she hurt her neck at work. Had a disc problem that needed surgery. She

> underwent an operation that didn't really give her the relief that she needed or looking for. It had to be revised which was the subject of my second report and I agreed with the revision. *Id. at 7.*

He testified that his third examination, on December 15, 2014, was after the revision surgery. He was given the following history:

> In May of that year, she had the disc replacement removed and had the spine fused at that level. She was doing well until she started therapy and developed some recurrent right-sided neck pain with referral into the shoulder blade. She finished her therapy in October. She was also taking Tylenol for residual symptoms. Also used a TENS unit.
>
> There was some concern that perhaps – there was – I am not going to call it concern. There was an appropriate recommendation for another x-ray to make sure that the screws were okay from her revision surgery and there had been some talk of additional injections. *Id. at 8-9.*

During Petitioner's examination, Dr. Ghanayem found:

> She stood and walked normally. She had almost normal cervical ROM. She had limitations which I term being consistent with a one-level cervical fusion which is about loss of 6, 7 percent of your range of motion in all planes. The foraminal compression and Lhermitte sign were both negative. She had some pain with palpation in the right side of her muscles in the neck. Neurologically she had no motor or sensory deficits. The reflexes were normal and Hoffman sign was normal. *Id. at 9.*

He testified he reviewed the November 2014 cervical MRI and it showed, "The levels adjacent to her fusion both above and below showed some age appropriate spondylosis. There was no disc herniations above or below her fusion. No neurologic compression. The technical aspects of the surgery looked fine on the MRI scan." *Id. at 10.* Dr. Ghanayem testified that he reviewed a surveillance disk and was asked:

> Q: And can you tell the arbitrator do you recall what was on that surveillance disk?
> A: Well, I looked at it again today so I am assuming you've been accurate in providing me the same disk on both occasions. The surveillance disk had nothing. There is no smoking gun on it. Just showed her behaving in a normal manner.
> Q: And in terms of lifting just so the arbitrator knows kind of what your basis is in terms of surveillance, do you see the petitioner lifting at all?
> A: I mean gas station, some type of not grocery store. Store, bending in the car, lifting, you know normal every day stuff. Nothing crazy.
> Q: And she's lifting a child at some point, correct?
> A: Yes. There is a kid there. Like I said, nothing out of the ordinary. *Id. at 10-11.*

Dr. Ghanayem was asked about his impression and opinion:

> Q: And what was that opinion?

A: Assuming that the fusion was healed. I did leave an allocation to get the appropriate x-ray on the revision case that I felt that she had no adjacent level disease and that it would be reasonable for her to get back to regular work activities as a bus driver.
Q: And in terms of the MRI, did you find any structural issues?
A: No. *Id. at 11-12.*

Dr. Ghanayem testified that he had qualified his opinion regarding maximum medical improvement and agreed with the recommendation of Petitioner's treating physician for an X-ray "to make sure everything was okay. That was a completely reasonable recommendation and I would have had an interest in looking at that just to make sure things are okay." *Id. at 12.* He felt Petitioner could return to work "providing the X-ray was fine." Id.

Dr. Ghanayem testified that he was provided with X-rays, dated January 23, 2015, and he prepared a report, dated March 19, 2015. He testified that the "surgery did a nice job. Incision was healed and there was no issues." *Id. at 13.* He felt that Petitioner could return to regular work as a bus driver. *Id.*

On cross-examination, Dr. Ghanayem testified that he did not know what medical records he had reviewed:

Q: And what medical records did you review prior to writing your report of [12/15/14], and I'm requesting – my question just pertains to records from the time of your last exam, [1/9/14]?
A: I don't know what records they would have been and whatever was sent I would have reviewed.
Q: And am I correct in saying that you did not indicate in your report what records you did review?
A: I did not.
Q: Other than the MRI scan?
A: I choose to memorialize the MRI scan because I thought that was important. The rest of the medical records that I had there was nothing out of the ordinary in them.
Q: Do you recall if you reviewed the physical therapy records?
A: I don't recall. I mean if they were there I would have reviewed them. If I didn't, if I didn't have them, I wouldn't have seen them. *Id. at 14-15.*

Dr. Ghanayem testified that he did note in his report that Petitioner did well until she started physical therapy and then developed recurrent right-sided neck pain. *Id. at 15.* He had indicated that she finished her therapy in October. *Id.* He was asked:

Q: And do you know if she finished therapy or she was discharged from therapy?
A: What I dictated was finished her therapy. So that's what I have dictated. *Id.*

He testified that Petitioner's lack of 6 to 7 percent range of motion in all planes "was appropriate in terms of what she demonstrated." *Id. at 16.* He did find pain with palpation on the right

paracervical musculature but stated, "After a fusion you can have some muscular neck pain in your neck. It's not inappropriate." *Id.* Dr. Ghanayem then testified:

Q: Okay. You said "her MRI does not reveal, and I'm sure you meant to say any structural problems that need ongoing treatment." What structural problems are you referring to?
A: So, for example, a disc herniation or bone spurs that are causing neurologic compression, you can sometimes see signal change around the fusion if the fusion isn't healed. The pattern of bone on the MRI will not be normal. There is no malalignments. The only thing that's hard to assess on the MRI scan is screws and the plates.
Q: And there was no adjacent disc?
A: There was no adjacent disc problems that required treatment.

Dr. Ghanayem was asked about the surveillance video, which was less than two minutes, which showed Petitioner lifting a child. *Id. at 17-18.* He stated that he did not want to guess the child's age or weight. *Id. at 18.* He didn't notice specifically whether Petitioner carried the child on her left shoulder. *Id.* He testified, "She used normal mechanics. It wasn't like she did something wrong." The video was labeled "10/24 and 11/3/2014". *Id. at 19.* He stated that the "11/3" video was after Petitioner was discharged from physical therapy because she had told him she had finished that in October. He stated that the "10/24" video "could be either way." *Id.* Dr. Ghanayem did not recall if he was given a job description other than that Petitioner drives a school bus. *Id.*

On redirect examination, Dr. Ghanayem testified:

Q: … Counsel asked you a few questions on physical therapy records, if you saw them, if you didn't see them. If you did see them and saw something that was important, you would put it in your report, correct?
A: What I chose to memorialize in my report are things that I thought were appropriate and important. There were no smoking guns or things out of the ordinary in the therapy reports.
Q: And in terms of the patient's job duties, if the patient had to check under a bus hood or check some fluid as part of her normal checkout for driving the bus, would that be something that she could do following your examination?
A: I mean anybody that drives occupationally would typically do some sort of rudimentary safety check of their vehicle. Beyond that, that would be my expectation. If there is something more specific, you know I am not aware of it.

On re-cross, Dr. Ghanayem stated that if he saw the therapy records and had seen something "significant…on an objective basis," he would have put it in his report. *Id. at 21.*

The Commission questions whether Dr. Ghanayem was even aware that the disputed issue in this case was causation regarding Petitioner's facet joint syndrome. He was never specifically asked any questions about the facet joints and did not give a specific opinion about them. Furthermore, Dr. Ghanayem testified that he did not know which records he reviewed

prior to writing his December 15, 2014 report and he did not list them in his report. *Rx1 at 14.* Therefore, it is not clear whether Dr. Ghanayem ever reviewed Dr. Brayton's post-fusion records to know that Petitioner was being treated for facet joint syndrome. Significantly, it also unknown whether Dr. Ghanayem reviewed any of the physical therapy records from September and October 2014, or the records of Dr. Popp during that period, reflecting her recurring symptoms. Although Dr. Ghanayem did find, during his examination, that Petitioner had pain with palpation on the right paracervical musculature, he related that to "not inappropriate" "muscular" pain after a fusion. *Rx1 at 16.* In contrast, Dr. Brayton found this pain on palpation to be related to facet pain syndrome (*Px4 at 12*) and Dr. Ghanayem did not specifically address whether that would be a reasonable diagnosis or a competent source of Petitioner's complaints.

But, we know Dr. Ghanayem noted Petitioner had facet joint arthritis when he wrote in his previous January 19, 2014 report:

> I felt that a fusion would be best because of the retrolisthesis at C5-6, **as well as the facet arthritis**. Disc replacement just causes more motion, and **in the face of facet joint arthritis, this problem can in fact sometimes grow worse**. *Px2 (Emphasis added).*

Dr. Ghanayem never testified that the subsequent fusion surgery somehow corrected Petitioner's facet joint arthritis. In contrast, Dr. Brayton testified that the facets were not fused during surgery. *Px4 at 28-29.* He also testified that an osteophyte on a facet joint cannot be removed during an anterior fusion. *Id. at 30.* Dr. Brayton testified that there was "some degree of facet arthropathy prior to the injury but that it progressed significantly until the final MRI" that he saw on November 4, 2014. *Id. at 44.* He causally related this progression to "a consequence to the injury and treatment." *Id.*

We find that the most logical explanation for Dr. Ghanayem's opinion is that he was focused on whether Petitioner's spine was solidly fused and whether she had developed adjacent segment disease. Even Dr. Brayton testified that the November 2014 MRI showed "patent decompression at the operated level, restoration of normal alignment and complete alleviation of the osteophyte or other compression lesion." *Px4 at 11.* So, it appears that both doctors agree on this issue. However, Dr. Brayton testified that the MRI did reveal, "significant facet hypertrophy and arthropathy at both C5-6 and C6-7, especially on the right." *Id.* We note that Dr. Ghanayem never specifically addressed this aspect of Dr. Brayton's opinion.

It is possible that Dr. Ghanayem was opining that he saw no *surgical* anatomical issues, which would agree with Dr. Brayton's testimony that, "Most of the time when someone develops facet pain syndrome after an anterior cervical fusion, we do not have to fuse the facet joint to mediate the condition. It's generally treated without fusing the facet." *Id. at 29.* This is why Dr. Brayton referred Petitioner to pain management for facet injections "to afford symptomatic relief." *Id. at 17.*

Based on all of the above, and since Dr. Ghanayem did not specifically address Petitioner's facet joint syndrome, we find the causation opinion of Dr. Brayton most persuasive on this issue.

Video Surveillance

We now turn to Respondent's video surveillance (Rx2). Regarding a possible

intervening accident, the Arbitrator found:

> The onset of Petitioner's new, facet-related complaints temporally correlate with the surveillance video demonstrating Petitioner lifting and carrying her 16 to 20 pound granddaughter. (RX2). This explanation appears to be reasonable given the development of right-sided pain while Petitioner was not working. Dr. Brayton testified he did not know what physical activities Petitioner performed outside of his office during that time, and admitted that if Petitioner lifted 20 pounds a few times per day, this could cause the facet pain. (PX4, p.35). Dr. Brayton also admitted that lifting something heavier than she was used to lifting could cause the degenerative facet pathology to become symptomatic. (PX4, p.27). Given all this, the Arbitrator finds the facet pain syndrome described by Dr. Brayton is not sequelae of Petitioner's work-related herniated disc. *Arb. Decision at 5.*

We make several comments regarding these findings. First, the video surveillance on October 24, 2014 does not show Petitioner lifting a child but only carrying a child on her left hip and then putting her into a car. On November 3, 2014, Petitioner is seen lifting and carrying a child and putting her into a car. However, contrary to Respondent's assertions, we find that Petitioner is not seen lifting the child "above her head." The child's head was momentarily above Petitioner's head while in the process of being lifted but this hardly shows Petitioner lifting "above" her head.

Second, Dr. Brayton, who had not seen the video surveillance, was asked:

Q: So if she was lifting – Let's just say she was lifting something in excess of 20 pounds above her head, you know, a few times a day, could that also cause this kind of facet pain?
A: Yes. *Px4 at 35.*

He was also asked, on re-cross examination:

Q: And you also testified that given her degenerative facet disease, lots of activities of daily living could cause that to become symptomatic, correct?
A: Yes.
Q: Including, let's say, lifting a 20-pound child above her head and out into a vehicle and that sort of thing, correct?
A: Yes. *Id. at 50.*

Dr. Brayton never "admitted" that merely lifting "20 pounds a few times a day" could cause facet pain. He first testified that lifting *in excess* of 20 pounds *above her head* a few times per day could do so. He later testified that lifting a 20-pound child "above her head and out into a vehicle" could cause degenerative facet disease to become symptomatic. As we have already found, the video does not show Petitioner lifting the child above her head.

Third, there is no evidence that the child Petitioner is seen lifting weighs 20 pounds or more. Petitioner's testimony is uncontradicted that the child weighed approximately 16 pounds

at the time of the video surveillance. *T.52.*

Fourth, we find that Petitioner's facet related complaints *most closely* correlate with her increased activities in physical therapy. The surveillance video was taken after Petitioner's physical therapy and medical records already reflect an increase in her pain. The July 14, 2014 letter from Dr. Brayton indicates that, after her fusion on May 19th, Petitioner had "done very well with dramatic improvement in neck pain and near-complete resolution in radiculopathy." He recommended that she initiate physical therapy and to taper out of her cervical collar. The July 17th physical therapy evaluation indicates a primary complaint of tingling into her right upper extremity during daily tasks especially overhead reaching and during lifting. She also complained of some soreness in her neck after wearing the soft brace post-surgery. At this time, Petitioner reported her pain as "0-4". On August 15, 2014, Dr. Popp noted Petitioner was "overall doing well." She had started physical therapy but was "somewhat hesitant to do any sort of work-related activities at this point." Petitioner's arm pain was "much better" and her neck was feeling better. He recommended continued therapy and sedentary work restrictions. On September 11th, Dr. Brayton wrote:

> She was doing well until several days ago when she developed flu-like symptoms which incited an increase in stiffness and tingling dyesthesias, but these are now improving again.
> ...
> Overall, it appears that [Petitioner] is doing well, but reading through her [therapy] notes, it appears that she is not yet ready to return to her premorbid occupation as a bus driver. *Px2.*

Dr. Brayton testified that although Petitioner was, at that time, attributing her symptoms to a "flu-like prodrome," he stated, "in retrospect, that was the beginning of facet pain syndrome" because "it makes more sense than it being a flue prodrome causing the pain because she went on to have increasing pain. So it evolved to become facet pain syndrome." *Px4 at 34-35.*

By the time of the September 22, 2014 physical therapy progress note, Petitioner was now complaining of increased "7/10" pain, which we note had only been "0-4" two months prior. On September 26th, Dr. Popp wrote, "has been doing really well, but physical therapy seems to aggravating her neck on the right side and down the right arm." He noted, "On the right side, there is almost like a trigger point that reproduces her pain that goes down the arm." He recommended continued therapy to work out the trigger point.

The ATI physical therapy discharge summary on October 9, 2014, indicates Petitioner continued to complain about numbness and tingling in her right upper extremity and neck pain. The notation includes, "Little to no improvement over the last several weeks. Feels that physical therapy always flares her up." Petitioner's pain was again 7/10. This record concludes by stating, "Upon conferring with pt's orthopedic surgeon, plan is to discontinue PT at this time to allow some rest time as pt reports consistent pain aggravation following PT sessions."

On October 24, 2014, the same day as the first surveillance video, Dr. Popp noted Petitioner was still having right arm symptoms and, "She is widely decompressed surgically but

just got worse. This is a similar type of thing to what happened last time when she had her previous neck surgery. She has this slowly increasing pain." He recommended a repeat MRI.

We acknowledge that, in response to questions by Respondent's attorney, Dr. Brayton testified that Petitioner's recurrent pain started at the end of October or in November 2014 (*Px4 at 34*) and the exquisite tenderness to palpation of Petitioner's facet joints on November 13, 2014, was consistent with something "acute" (*Id. at 36, 50*). However, we note that Dr. Brayton was never asked to define what he considered "acute." Also, despite his having agreed that Petitioner's recurrent pain started at the end of October or in November, when considering his entire testimony, we find that his opinion was that Petitioner's facet pain syndrome had actually begun to progress by early September 2014. At the time, it was thought to possibly be flu-related but "it was difficult to tell exactly what was the cause until her final two visits where she clearly had facet pain." *Id.* We find Dr. Brayton's answers to Respondent's questions about whether Petitioner's symptoms were "acute" in November 2014, do not undermine his clear opinion that Petitioner's facet joint syndrome was causally related to her "injury and treatment." *Id. at 44.* Dr. Brayton's opinion is supported by the medical and physical therapy records reflecting an increase in Petitioner's complaints during the time she was engaged in therapy, which is prior to any activities depicted on the surveillance video.

Fifth, the Arbitrator's decision ignores the testimony of Respondent's own Section 12 physician, Dr. Ghanayem, on this issue. He was the only physician who actually viewed the surveillance video and he testified:

A: ... The surveillance disk had nothing. There is no smoking gun on it. Just showed her behaving in a normal manner.
Q: And in terms of lifting just so the arbitrator knows kind of what your basis is in terms of surveillance, do you see the petitioner lifting at all?
A: I mean gas station, some type of not grocery store. Store, bending in the car, lifting, you know normal every day stuff. Nothing crazy.
Q: And she's lifting a child at some point, correct?
A: Yes. There is a kid there. Like I said, nothing out of the ordinary. *Rx1 at 10-11.*

On cross-examination, he testified:

Q: And did you note when she picks up the child she squats down so she doesn't have to lift the child so high?
A: She used normal mechanics. It wasn't like she did something wrong. *Id. at 18-19.*

The Commission finds that there are numerous, credible references in the physical therapy and physician records to indicate that Petitioner's condition and symptoms progressed during her physical therapy activities in September and October 2014, which was prior to the video surveillance. Based on those records and the causation opinion of Dr. Brayton, it is more likely than not that Petitioner's activities in physical therapy were a contributing factor in worsening her facet condition. We find that Petitioner has proven her current condition of ill-being, including the facet joint syndrome, is causally related to her work injury as the sequalae of

her post-fusion physical therapy treatment and not some intervening accident.

Temporary Total Disability

We affirm the Arbitrator's award of temporary total disability (TTD) from May 17, 2012 through February 18, 2013 and February 25, 2013 through March 23, 2015. The Arbitrator terminated TTD based on the opinion of Dr. Ghanayem. However, based on our causation finding, we extend that second period of TTD through June 12, 2015, when Dr. Brayton released Petitioner to regular duty.

We are aware that there is a reference in the March 11, 2016 note of Dr. Joanna Barclay indicating, "Meanwhile, the patient returned to work in March 2015, and she is having a hard time working and just in the past few days pain has gotten worse." However, Dr. Barclay's note contains multiple incorrect dates. For example, she wrote that Petitioner underwent a diagnostic facet nerve block on April 19, 2015. This was actually performed on April 9, 2015. This record also, in the first paragraph, states that Petitioner underwent the radiofrequency neurolysis procedure on March 13, 2015. Later in the report, this was clarified as having been performed on May 13, 2015. Dr. Barclay noted, "It resulted in excellent relief of pain until it wore off about a month ago." *Px8.*

On February 2, 2015, Dr. Brayton recommended pain management for Petitioner's facet pain syndrome. *Px2.* Dr. Wilson performed a cervical epidural steroid injection on March 26, 2015, which provided no relief for Petitioner, so he performed facet joint and medial branch blocks on April 9, 2015. *Px6.* On May 13, 2015, Dr. Wilson noted the branch blocks gave Petitioner an 80% decrease in pain so he performed the radiofrequency rhizotomy. On June 11, 2015, Dr. Wilson wrote, "she received 100% relief with the exception of an occasional burning sensation." He also wrote, "She wants to return to work as school bus driver." The next day, Dr. Brayton released her to return to work. *Px6.*

Petitioner testified she brought Dr. Brayton's work-release note to Respondent and gave it to "Carlos." *T.59.* She subsequently submitted an online application for re-employment with Respondent but she was not contacted. *T.61.* Petitioner testified that, ultimately, she started driving a school bus in Huntley on September 14, 2015.

Based on the above, we find that Dr. Barclay's reference to Petitioner having returned to work in March 2015 is unreliable and inconsistent with the other evidence. We therefore find that Petitioner is entitled to TTD through June 12, 2015, and award a total of 159-3/7 weeks under Section 8(b) of the Act.

Medical Expenses

Dr. Brayton testified that he referred Petitioner to pain management "to confirm or refute the clinical suspicion of facet pain syndrome and to also afford symptomatic relief. And it was my statement in this letter that it was my strong medical opinion that that was necessary." *Px4 at 17.* The Arbitrator's decision contains a good description of Petitioner's subsequent treatment with Dr. James Wilson and Dr. Joanna Barclay and the significant reduction in symptoms Petitioner obtained from those procedures. (Arb. Decision at 4-5). We find Petitioner's treatment was reasonable, necessary, and causally related to her work injury and find Respondent liable for the following disputed medical bills:

Dr. James Wilson (Px10)

3/26/15	Cervical Epidural Steroid Injection	$ 210.00
		1,347.00
		378.00
		841.00
		1,265.00
		378.00
		150.00
		100.00
4/9/15	Facet joint and medial branch block	1,472.00
		963.00
		963.00
		615.00
5/13/15	Medial Branch Nerve RF Rhizotomy	1,400.00
		2,280.00
		275.00
6/11/15	Office Visit	176.00
11/24/15	Office Visit	176.00

Total Px10 charges: $12,989.00

Kendall Pointe Surgery Center (Px11)

5/13/15	Medial Branch Nerve RF Rhizotomy	$3,078.00

Advocate Sherman Hospital (Px12 and Px13)

3/11/16	Office Visit with Dr. Barclay	$ 316.00
4/1/16	RF facet neurolysis with Dr. Barclay	$ 246.00

Total Bills: $16,629.00

The above amounts are the total charges reflected on the bills. Respondent's liability is limited subject to the medical fee schedule in Section 8.2 of the Act.

Permanent Partial Disability

Petitioner sustained accidental injuries arising out of and in the course of her employment on May 15, 2012, which is after September 1, 2011, so the five factors in Section 8.1b of the Act

apply in determining permanent partial disability:

(i) - A.M.A. Impairment Rating

Neither party submitted an A.M.A. Impairment Report so this factor is given no weight.

(ii) - Occupation

Dr. Brayton released Petitioner to work regular duty as a bus driver on June 12, 2015. Petitioner testified that she submitted an application for re-employment with Respondent but nobody contacted her. *T.67.* She testified that she filled out five applications for other bus driving jobs. She received her first offer from Woodstock and had interviews with three others but she chose a job driving a school bus in Huntley, IL, working 30 hours per week, because it was the closest to her house with the highest pay. *T.67-69.* This job started on September 14, 2015. *T.67.* She testified she was driving a mid-size preschool bus with 19 children and she had to lift about half of them and put them in car seats (and take them out) four times a day. *T.70-71.* Petitioner noticed her pain and headaches returning and her right arm was "tingling with pain shooting down it." *T.71-72.* On November 24, 2015, she returned to Dr. Wilson who recommended repeat injections. *T.72.* However, with the Huntley job, Petitioner's insurance company was an H.M.O., so she chose a doctor within her plan, Dr. Barclay. *T.73.* Dr. Barclay performed the injections on March 17, 2016 and Petitioner had good relief from those. *T.74.* This is supported by Dr. Barclay's April 1, 2016 note indicating Petitioner was "doing much better" and reported a zero-out-of-ten pain level. *Px8.* Petitioner testified she continued driving the school bus for the remainder of the 2015/16 school year but the pain in her neck and headaches started to return and she again had symptoms at her bra line on the right side. *T.74.* Petitioner testified that after the current school year ended on June 4, 2016, she did not work again until July 11, 2016. She testified that during that time, her pain was going away and she did not have the "throbbing like it was when I was driving." *T.75.* Petitioner testified that she resumed driving on July 11, 2016, the Monday prior to the hearing. *Id.* She now drives a mid-size wheelchair bus with one student in a wheelchair, five "boosters" and ten "lap kids, with a seat belt." The students weigh between 20 and 35 pounds. *T.75-76.* Petitioner testified that, since she returned to work, "the pain is back…in my head with the headache, my neck, all the way down to my bra line on my arm on my right side." *T.76.* She testified that she has a referral to see Dr. Barclay and plans to call her on Monday (following the hearing). *T.77.*

The Commission gives significant weight to this factor. Petitioner has been released to regular duty and she continues to work as a bus driver, which would be a mitigating factor. However, Petitioner credibly testified, and the medical records support, that her symptoms tend to increase when she is performing this job and decrease when she is not. Fortunately, she has been able to obtain complete but seemingly temporary relief of those symptoms with the facet procedures. On balance, we find this factor weighs towards an increased award.

(iii) - Age at Time of Injury

Petitioner was 41 years old at the time of her injury. There was no evidence presented regarding how her age might affect her disability so we give this no weight.

(iv) - Future Earning Capacity

Petitioner testified that on her date of accident, the hourly pay at her job with Respondent was $22.01 and she worked 42-plus hours per week. *T.70.* She testified that, when she started her job in Huntley in September 2015, she was earning $18.27 per hour and only drove 30 hours per week. *T.69.* However, we note that Petitioner did not testify about how much she was earning or how many hours a week she was driving at the time of the hearing on July 15, 2016. On cross-examination, Petitioner testified she had been terminated by Respondent in 2013 because she was unable to take the physical exam to get her Commercial Driver's License (CDL) updated. *T.96-97.* When she was released to full-duty work by Dr. Brayton in June 2015, she submitted an online application with Respondent without having a current CDL. *Id.* Petitioner testified Respondent had three job openings but she did not know how many other applicants there were or how her qualifications compared to theirs. *T.98.* In addition to the job in Huntley, which she accepted, she had been offered two other jobs. *T.102.* Her job with Respondent was similar to her current job in that buses are assigned on the basis of seniority. *T.100.*

The Commission finds that Petitioner failed to prove that her alleged reduction in earnings is due to her current physical condition or any disability. She has no work restrictions and received multiple job offers. We give this factor some weight as a mitigating factor.

(v) - Evidence of Disability Corroborated by the Treating Medical Records

We incorporate our findings and analysis under factor (ii) here as well. The medical records indicate that Petitioner underwent a medial branch nerve radiofrequency rhizotomy with Dr. Wilson on May 13, 2015. *Px6.* On June 11, 2015, Dr. Wilson noted she had a "perfect" result and "she received 100% relief with the exception of an occasional burning sensation." However, he also indicated, "We may need to repeat the procedure if the pain returns." Petitioner testified that her pain did return and, on November 24, 2015, she saw Dr. Wilson who noted that the previous procedure gave Petitioner "100% relief" until September when the pain began to come back. He recommended another radiofrequency procedure. Due to insurance issues, Petitioner began seeing Dr. Barclay on March 11, 2016. Dr. Barclay recorded a history of Petitioner having received "excellent relief of pain" from the radiofrequency procedure with Dr. Wilson "until it wore off about a month ago." She also recommended a repeat radiofrequency neurolysis procedure, which was performed on March 17, 2016. The last record in evidence is Dr. Barclay's April 1, 2016 note indicating Petitioner was "doing much better" and reported a zero-out-of-ten pain level. *Px8.*

At the hearing on July 15, 2016, Petitioner testified that her symptoms have returned since she started driving for the current school year, which started on July 11, 2016. *T.75-77.* She testified that she has a referral to see Dr. Barclay and plans to call

her on Monday (following the hearing). *T.77.*

There is no current medical recommendation for further treatment in Dr. Barclay's last office note. However, Petitioner's testimony that her pain is returning is corroborated by the medical records reflecting that Petitioner has gotten excellent but temporary relief from these facet procedures. We give some weight to this factor but have already incorporated this "evidence of disability" in factor (ii) above, which we find most significant on the issue of permanent partial disability.

Based on the above, we find Petitioner is entitled to 112.5 weeks of permanent partial disability, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 22½% loss of Petitioner as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $509.17 per week for a period of 159-3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $458.25 per week for a period of 112.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 22½ % loss of Petitioner as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $16,629.00 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.

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

DATED: AUG 23 2018

Charles J. DeVriendt

Joshua D. Luskin

Deborah L. Simpson

SE/
O: 6/27/18
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SKORNIA, WENDY
Employee/Petitioner

Case# **12WC024518**

SCHOOL DISTRICT U-46
Employer/Respondent

18IWCC0529

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:

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

2461 NYHAN BAMBRICK KINZIE & LOWRY
AMY E BILTON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

18IWCC0529

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

WENDY SKORNIA,
Employee/Petitioner

Case # **12 WC 24518**

v.

Consolidated cases:

SCHOOL DISTRICT U-46,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GERALD GRANADA**, Arbitrator of the Commission, in the city of **WHEATON**, on **July 15, 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 18IWCC0529

On 5/15/2012, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is, in part,*** causally related to the accident. ***Her facet condition is not related to the work accident.***

In the year preceding the injury, Petitioner earned $39,715.00; the average weekly wage was $763.75.

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

Respondent shall be given a credit of $74,629.81 for TTD, $0 for TPD, $0 for maintenance, and $287.60 for other benefits, for a total credit of $ 74,917.41 .

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 $509.17/week for 148 weeks, commencing 5/17/2012 through 2/18/2013 and from 2/25/2013 through 3/23/2015, as provided in Section 8(b) of the Act, subject to the credit outlined below.

Respondent shall pay Petitioner permanent partial disability benefits of $ 458.25 /week for 75 weeks, because the injuries sustained caused the 15 % loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

8/23/16

Date

AUG 25 2016

18IWCC0529

FINDINGS OF FACT

This case involves a Petitioner alleging injuries she sustained while working for the Respondent on May 14, 2012. The parties are disputing the following issues: 1) causal connection with regard to the Petitioner's facet condition; 2) medical expenses; 3) TTD; and 4) nature and extent.

Petitioner, was hired as a bus driver for Respondent in 2001. She initially drove a full size school bus, but thereafter, chose to drive a smaller, special needs bus. In addition to the usual pre-trip inspection, driving, and cleaning duties associated with operating a school bus, Petitioner testified she had additional job duties by virtue of her route including special needs children. Specifically, once the child's parent brought him or her to the top of the bus steps, Petitioner assisted the child into his or her seat. The level of assistance she provided depended on the child's physical needs. Some children sat in booster seats and Petitioner would have to lift them into the seat. She testified she had three children in booster seats in 2012, weighing between 20 and 40 pounds. Other children needed to have their harness secured to the seat. Prior to 2012, Petitioner worked with children in wheelchairs on her route, but had not worked with such children in more than one year before her date of accident. A bus aide, Lois, accompanied Petitioner on her route every day and Lois was responsible for some of the children.

The parties agreed that Petitioner sustained an accidental injury arising out of and in the course of her employment on May 14, 2012 when she tried to restrain an unruly student. (Arb Exh 1) Petitioner testified: "And I am there hugging him and he is climbing the seat with his feet pushing me backwards into the back of the seat. And all of a sudden after that for a little bit my whole right side just turned numb and pain from my head to toe and I dropped him." (T. 29)

Petitioner worked the next two days but testified to pain from her neck to her bra line all the way down her right arm. She initially presented to Provena St. Joseph Occupational Health Services and was later seen on June 22, 2012, by Dr. Popp. Dr. Popp opined Petitioner had right-sided carpal tunnel syndrome and cervical radiculopathy, ordered a cervical spine MRI and took Petitioner off work. (PX 2)

The recommended MRI of the cervical spine on July 10, 2012 showed a C5-6 degenerated disc with endplate changes, broad-based dorsal right and left paracentral disc osteophyte complex that completely effaced the ventral subarachnoid space and contacted the ventral surface of the cord slightly greater on the left with resultant narrowing of the central canal, and large osteophytes extending into the foramina bilaterally, right greater than left with mass effect of the exiting nerve roots with at least a moderate degree of neuroforaminal stenosis. At C6-7, there was mild dorsal bulge that moderately thins the ventral subarachnoid space and minimal uncovertebral osteophytes. (PX 2). Dr. Popp reviewed the MRI report on July 12, 2012, concluding Petitioner had radiculopathy associated with a disc herniation at C5-6 and degenerative changes at C5-6.

Dr. Popp referred her to pain specialist Dr. Christopher Siodlarz, who administered a right-sided cervical epidural steroid injection at C5-6 which provided only short-term relief. Her neck pain returned causing Dr. Popp to order an EMG, which was suggestive of a right C5 radiculopathy. (PX 2). Dr. Popp then recommended an anterior cervical discectomy and disc replacement. (PX 2).

Respondent had Petitioner evaluated by Dr. Alexander Ghanayem pursuant to Section 12 of the Act on November 5, 2012. Dr. Ghanayem concluded Petitioner aggravated her cervical spondylosis and possibly sustained a new disc herniation at C5-6 from the work injury. He opined she failed a reasonable course conservative care and it was appropriate to proceed with surgical intervention. As to which procedure, he

explained an anterior cervical discectomy and fusion at the C5-6 level was indicated: "There has been some talk about a cervical disc replacement, but given the radiographic changes at C5-6, I do not believe that would be appropriate. The procedure should be a discectomy and fusion." (RX1, Group DepX3)

On December 17, 2012, Petitioner was admitted to Delnor Hospital and Dr. Popp nonetheless performed anterior cervical discectomy at C5-6 with disc replacement at C5-C6. The post-operative diagnosis was herniated nucleus pulposus at both C5-6 and C6-7. (PX 2)

Post-operatively Petitioner initially did well. By February 15, 2013, she was doing very well with no pain or discomfort so Dr. Popp released her to return to full-duty work. (PX 2)

Ms. Skornia testified she returned to work on February 18, 2013. (T. 38) As she drove the bus over that week, her headaches and the pain radiating down the right side of her neck and right arm returned. (T. 39). On February 25, 2013, Ms. Skornia told Dr. Popp she been doing very well until her return to work. Her exam findings were all normal, but Dr. Popp opined her radiculopathy had returned, taking her off work and ordering another four weeks of physical therapy. (PX 2). Dr. Popp recommended a repeat cervical MRI, CT myelogram of the neck, an EMG and a bone scan. Dr. Popp diagnosed mild chronic C5-6 radiculopathy on her right and authorized her off work. (PX 2)

Petitioner testified she was unable to take the necessary test to renew her license when it came due in August, 2013. Because she no longer had a valid CDL license, her employment was terminated on August 21, 2013. (T. 42)

On September 26, 2013, Dr. Siodlarz administered the right cervical facet injection at C5-6. (PX 2) Petitioner claimed the injection made her symptoms worse. Noting Petitioner developed some bone spurs and foraminal narrowing at the surgical level, Dr. Popp recommended posterior foraminotomies and fusion at C5-6. (PX 2)

At Respondent's request, Dr. Ghanayem re-evaluated Petitioner on January 9, 2014. With respect to the initial surgery, the doctor reiterated he had recommended the anterior cervical discectomy and fusion in 2012 and now recommended a salvage type procedure given the failure of the disc arthroplasty to give her relief of symptoms. (RX 1, Group DepX3)

Dr. Popp recommended an anterior fusion procedure with decompression, which he felt would require a combined approach with neurosurgical assistance, and referred Petitioner to Dr. John Brayton. (PX 2) Dr. Brayton saw Petitioner on March 21, 2014, when she gave a consistent history of the injury and treatment to date. Petitioner reported dramatic relief after the disc replacement until she returned to work February 21, 2014. On review of the February 12, 2014 CT scan, Dr. Brayton noted the disc arthroplasty system was in good position but identified increasing sclerotic changes and osteophyte formation at the posterior vertebral body and uncovertebral joints causing significant ventral effacement of the canal and neural elements as well as severe foraminal compression. Dr. Brayton opined Petitioner developed osteophytes posterior and posterolateral to the disc arthroplasty, agreeing with the recommendation to remove the arthroplasty, decompress the osteophytes and perform a fusion. (PX 3)

On May 19, 2014, co-surgeons Drs. Brayton and Popp performed an anterior cervical re-exploration, removal of disc arthroplasty system, resection of recurrent posterior vertebral body and uncovertebral joint osteophytes, bilateral anterior micro-foraminotomies, and decompression of fusion with trestle titanium anterior cervical

plating at C5-6. The post-operative diagnosis was recurrent osteophyte and spondylosis C5-6 after previous disc arthroplasty. (PX 3)

Petitioner returned to see Dr. Popp 15 days following her neck surgery. She reported feeling a lot better with only occasional minor arm pain. X-rays showed the bone graft and hardware in good position. (PX 2) Physical therapy was ordered and commenced at ATI on June 17, 2014. (PX 5) On June 26, 2014, Petitioner again reported doing quite well. The ATI therapy daily subjective reports through September support that Petitioner's pain was improving, she was feeling better and her symptoms were resolving. (PX 5) On August 28, she stated she was "better all the time" with no flare ups after therapy, just upper extremity soreness which she associated with being weak. On September 3, she reported an onset of right side symptoms that morning which she could not explain but thought might be due to the increased time between therapy visits due to the holiday weekend. By September 5, she was again feeling better, "much better than last time" with just minor soreness in the back of her neck in the morning.

Petitioner's pain complaints changed as of September 11, 2014. That day, she complained of feeling worse and reported her right upper extremity was "really hurting today, thinks it might be from being sick all week." (PX 5) Petitioner returned to see Dr. Brayton on September 11, 2014. Ms. Skornia claimed she had been doing well until several days prior when she developed flu-like symptoms which incited an increase in stiffness and tingling dysesthesias. Examination revealed persistent paracervical spasm but no evidence of radicular deficit or myelopathy. Dr. Brayton opined Petitioner was doing well but recommended more physical therapy before transitioning to work hardening. (PX 3)

On September 26, 2014, Petitioner followed up with Dr. Popp. She advised she had been doing really well, but claimed physical therapy seemed to aggravate her neck on the right side and down the right arm. The doctor found "almost like a trigger point" that reproduced her pain down the arm. She experienced little improvement over the next several weeks. (PX 5)

Respondent obtained surveillance video of Petitioner in late October and early November. A CD of video filmed on October 24, 2014 and November 3, 2014 was offered into evidence as Respondent's Exhibit Number 2. Ms. Skornia was seen hoisting a toddler from the ground to a level above her shoulder, then carrying the toddler around at waist height. Ms. Skornia completed the lift fluidly and without difficulty and demonstrated no pain or guarding behaviors. (RX 2) At trial, Ms. Skornia conceded she was the individual on the surveillance footage. (T. 51) She explained the child in the video is her granddaughter who was a year and a half at the time and weighed approximately 16 pounds. (T. 51)

When Petitioner saw Dr. Popp on October 24, 2014, she reported right arm symptomatology. Dr. Popp noted she was "widely decompressed surgically" and recommended a repeat cervical spine MRI to rule out a new disc herniation below. (PX 2) The repeat MRI performed on November 4, 2014 showed the nerves were well decompressed. While Dr. Popp identified a new small herniation at C6-7, it was not thought to be responsible for the new symptoms. Dr. Brayton suspected facet pain and recommended an EMG to confirm the diagnosis. (PX 2) Though the EMG was not done, Dr. Brayton concluded Ms. Skornia was now symptomatic from facet arthropathy, on the opposite side of the spine from the surgical procedures, which had not before been treated and which was now symptomatic. (PX4 p. 26)

Dr. Ghanayem re-examined Petitioner on December 15, 2014 and agreed that Petitioner did not have symptomatic adjacent level disease causing neurologic compression, and opined her MRI showed no structural problems in need of ongoing treatment. Dr. Ghanayem recommended a cervical x-ray to assess the solidity of

the fusion but opined that if the x-ray showed good positioning of the hardware, she could return to regular work as a bus driver given her normal neurologic exam, lack of adjacent level pathology, solid cervical fusion, and the results of her surveillance showing her moving normally. (RX1 pp. 8-12)

Petitioner next saw Dr. Brayton on February 2, 2015, when the doctor noted her radicular findings were improved, with no sensory or motor deficits, but severe tenderness to palpation of the articular facets and crepitus on neck motion and rotation. Dr. Brayton noted it appeared Petitioner's radicular symptoms were improving but her facet pain syndrome persisted and had worsened. Therefore, he recommended returning to the plan of pain management, facet injections, possible radiofrequency rhizotomy, and reconditioning physical therapy. (PX 3)

The updated x-rays were forwarded to Dr. Ghanayem for his review, and on March 19, 2015, he confirmed the fusion had healed and reiterated she could return back to regular work duty as a bus driver. (RX 1, p. 13) Based on Dr. Ghanayem's report, Respondent terminated TTD on March 23, 2015.

On March 26, 2015, Petitioner consulted with Dr. James Wilson of Interventional Pain Specialists. The doctor's records indicate Petitioner complained of a three year history of cervical and right arm pain and had been referred by Dr. Brayton. Following an examination and review of the MRI report, Dr. Wilson recommended an occipital nerve block and cervical epidural steroid injection, both of which he administered that day, and neither of which provided any relief. (PX 6) Dr. Wilson then performed cervical facet joint and medial branch blocks, followed by right cervical C3, C4, C5, C6 and C7 medial branch nerve radiofrequency rhizotomies for her facet syndrome. (PX 7)

When Petitioner saw Dr. Wilson on June 11, 2015, she reported 100% relief with the exception of an occasional burning sensation. Dr. Wilson documented Petitioner had a "PERFECT result." Petitioner asked to return to work as a school bus driver and reported she felt well enough to return to that position. Dr. Wilson indicated that unless Dr. Brayton disagreed, she could return to that job. (PX 6) The very next day, Dr. Brayton authored a work status report releasing Petitioner to return to work as a bus driver. (RX 3)

Petitioner testified she brought the work release note in to U-46. (T. 59-60) Petitioner testified she completed an application for employment but was not contacted by Respondent. (T. 66-67) She started looking for other bus driving jobs and applied for five positions. She interviewed for four jobs and received more than one offer. She ultimately accepted the job in Huntley because it is the closest to her house with the highest pay. (T. 69) She started driving a bus there on September 14, 2015. (T. 67) Petitioner's hourly rate in September, 2015 was $18.27 and she drives 30 hours a week. (T. 69)

Petitioner returned to Dr. Wilson on November 24, 2015, and reported her last radiofrequency ablation in May had given her 100% relief until September, when the pain returned. Dr. Wilson recommended repeating the intervention and Petitioner was to be scheduled for a radiofrequency ablation right C3-C7 medial branch nerve radiofrequency neurotomy. (PX 6)

On March 11, 2016, Petitioner consulted with Dr. Joanna Barclay at Advocate Sherman Hospital's Pain Management Clinic. The doctor noted Petitioner's treatment history included a right radiofrequency neurolysis procedure at C3 down to C7 in March of 2015 which resulted in excellent relief of pain until approximately one month prior. Examination revealed increased pain with right lateral bending motion and flexion maneuver with range of motion as well as a positive facet tenderness without neurological deficits in the upper extremities. Dr. Barclay's impression was post-laminectomy syndrome with cervical facet arthropathy condition. She

recommended a repeat cervical radiofrequency neurolysis procedure, as this had helped her for more than six months. (PX 8)

On March 17, 2016, Petitioner presented to Advocate Sherman Hospital and Dr. Barclay performed right C3, C4, C5, C6, and C7 facet neurolysis using radiofrequency generator with fluoroscopic guidance. The post-operative diagnosis was cervical facet arthropathy with previous response to the diagnostic facet nerve block. (PX 9)

When Petitioner followed up with Dr. Barclay on April 1, 2016, she reported it took three days before she had any improvement but she was now doing much better. Documenting the repeat cervical radiofrequency neurolysis procedure had helped Petitioner's pain nearly completely, Dr. Barclay indicated Petitioner did not need a work excuse or any pain medications and discharged her to return as needed. (PX 8)
Petitioner testified that she currently works as a bus driver for a different school district in Huntley. In that job, she drives a mid-sized wheel-chair accessible bus for kids who require booster seats and set belts. In her current job, she has to lift kids weighing 20 to 35 lbs. into booster seats. She has occasional complaints of pain and headaches. She has given up on recreational activities which included water skiing, skating, lawn work and snow blowing – activities she performed prior to her accident.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof in connection with Petitioner's disc herniation and osteophyte formation requiring surgical intervention. However, the Arbitrator further finds that the Petitioner has failed to meet her burden of proving her facet pain syndrome is causally related to her work accident. In support of this finding, the Arbitrator relies on the medical evidence and the testimony presented at trial. Dr. Brayton testified that Petitioner's symptoms starting in 2012 originated from her herniated disc and osteophytes around that disc. (PX4, p.32) After the disc replacement, she developed further osteophytes and degeneration, necessitating removal of the artificial disc and C5-6 fusion. (PX4, p. 25) She did well post-fusion, had complete resolution of her radicular pain by July 14, 2014, and according to Dr. Brayton experienced "dramatic improvement in neck pain and so forth." (PX4, pp. 34-35). While Petitioner was off work, on November 13, 2014, Petitioner told Dr. Brayton she was "doing very well, but recently, had a recurrence in right-sided neck pain." (PX4). Dr. Brayton testified her physical examination findings in November, 2014 were consistent with an acute, not chronic, injury. (PX4, 36) Her MRI from November, 2014, demonstrated complete decompression of the surgically-treated disc and osteophyte pathology, and now demonstrated only a thickened and degenerative facet joint, which was responsible for her new pain. (PX4, p. 37). Dr. Brayton testified facet hypertrophy, which was on the opposite side of the spine, was now the cause of her condition in later-2014. (PX4, pp. 36-37) Dr. Brayton also admitted there was no significant change at the facets when comparing the 2013 imaging to that from 2014. (PX4, p. 48)

The onset of Petitioner's new, facet-related complaints temporally correlate with the surveillance video demonstrating Petitioner lifting and carrying her 16 to 20 pound granddaughter. (RX2). This explanation appears to be reasonable given the development of right-sided pain while Petitioner was not working. Dr. Brayton testified he did not know what physical activities Petitioner performed outside of his office during that time, and admitted that if Petitioner lifted 20 pounds a few times per day, this could cause the facet pain. (PX4, p.35) Dr. Brayton also admitted that lifting something heavier than she was used to lifting could cause the degenerative facet pathology to become symptomatic. (PX4, p. 27). Given all this, the Arbitrator finds the facet pain syndrome described by Dr. Brayton is not sequelae of Petitioner's work-related herniated disc. The Arbitrator also finds Petitioner reached maximum medical improvement for her work accident no later than

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March 19, 2015, the date Dr. Ghanayem confirmed her fusion had healed and no further treatment was required as a consequence of Petitioner's nerve compression injury. As such, the Arbitrator finds Petitioner's current condition of ill-being with regard to her facet pain syndrome is not causally related to her work accident.

2. Based on the Arbitrator's findings with regard to the issue of causation, the Arbitrator finds that the Petitioner's medical treatment to address her work-related condition involving disc herniation and osteophyte formation that ultimately required surgical intervention was reasonable, related and necessary. Therefore, the Arbitrator awards all of Petitioner's medical expenses limited to the treatment of her disc herniation and osteophyte formation. However, the medical treatment related to Petitioner's cervical facet pathology and rendered after March 23, 2015 was not reasonable and necessary, given the Arbitrator's finding that the facet condition was not related to her original work accident. Accordingly, the medical expenses stemming from the treatment of the Petitioner's cervical facet pathology are denied.

3. Regarding the issue of TTD, the Arbitrator finds that the Petitioner was temporarily and totally disabled from May 17, 2012 through February 18, 2013 – as stipulated to by both parties. The dispute in TTD relates to the period from February 25, 2013 through September 13, 2015. For this disputed period, the Arbitrator finds that the Petitioner was temporarily and totally disabled through March 23, 2015 – the date upon which Dr. Ghanayem's report indicating Petitioner was at maximum medical improvement was provided to Petitioner. Accordingly, the Arbitrator awards the Petitioner TTD from May 17, 2012 through February 18, 2013, and from February 25, 2013 through March 23, 2015.

4. On the issue of nature and extent, Petitioner's work accident occurred after September 1, 2011; therefore, Section 8.1b applies. Section 8.1b requires permanent partial disability be determined following consideration of five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. 820 ILCS 305/8.1b(b). The Arbitrator will address each factor in turn.

(i) – PPD impairment report

Neither party submitted a §8.1b(a) PPD impairment report. The Arbitrator notes the appellate court recently rejected the notion that such a report is a prerequisite to an award of PPD benefits. Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission, 2016 IL App (3d) 150311WC, ¶47. As such, the Arbitrator assigns no weight to this factor and Petitioner's PPD will be assessed based upon the remaining enumerated factors.

(ii) – occupation of the injured employee

Dr. Brayton released Petitioner to return to full-duty work. (RX3) Dr. Ghanayem concurred that Petitioner could return to full-duty work earlier, as of March, 2015. (RX1, p. 13) Petitioner returned to her pre-injury occupation as a bus driver without any work restrictions. The Arbitrator finds Petitioner's resumption of her usual occupation is indicative of a good recovery and, by extension, reduced impairment. The Arbitrator places significant weight on this factor.

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

Petitioner was 41 years old on the date of her accidental injury. While relatively young, no evidence was presented as to how Petitioner's age might affect her disability. As such, the Arbitrator places no emphasis on this factor.

(iv) - future earning capacity

Petitioner's rate of pay at Respondent was $22.01 per hour and she worked approximately 42 hours per week. Petitioner no longer works for Respondent, however, the Arbitrator emphasizes this is due to the lapse of Petitioner's CDL license during her recovery process, not a consequence of any current physical disability. Petitioner has no physical restrictions precluding her from the full capacities of a bus driver. Moreover, once Petitioner's treating physicians released her to full duty work in June of 2015, she quickly obtained employment as a bus driver in Huntley. The Arbitrator notes Petitioner testified she had multiple job offers and chose the position in Huntley because it was closest to her house with the highest pay. Her current position pays $18.27 per hour and she drives 30 hours per week. Although Petitioner's hourly rate and workweek are reduced as compared to her position with Respondent, the evidence demonstrates this is not a function of any permanent physical disability causing a deleterious effect on her earning capacity but rather is solely the result of Petitioner being on the bottom of the seniority ladder, a situation which the Arbitrator infers will improve the longer Petitioner works. As such, the Arbitrator finds no evidence of a negative impact on Petitioner's future earning capacity, a fact to which the Arbitrator assigns great weight.

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

Following an unsuccessful course of conservative treatment, Ms. Skornia underwent two surgical interventions: first, an anterior cervical disc arthroplasty at C5-6 (PX 2), and thereafter revision surgery in the form of an anterior cervical re-exploration, removal of disc arthroplasty system, resection of recurrent posterior vertebral body and uncovertebral joint osteophytes, bilateral anterior micro-foraminotomies, and decompression of fusion with trestle titanium anterior cervical plating at C5-6. (PX 3) Post-operatively, Dr. Popp documented Petitioner's nerves were "widely decompressed surgically." (PX 2) On November 7, 2014, Dr. Popp noted the latest diagnostic studies established the nerves remained well decompressed. (PX 2) On February 2, 2015, Dr. Brayton documented Petitioner's most recent CT and MRI scans revealed complete resolution of the compression and osteophyte as well as evidence of stable osseus arthrodesis at its early phases. The doctor further noted Petitioner's radicular findings were improved and there was no focal deficit of sensor or motor function. (PX 3) Although not a treating record, the Arbitrator notes Dr. Ghanayem concurred with the treating physicians' interpretation of the objective data and concluded Petitioner had a normal neurologic exam, no adjacent level pathology that required treatment, and a solid cervical fusion.

The medical records show the fusion surgery was successful, Petitioner's nerves remain "widely open" and decompressed, and she has no adjacent level disease. The Arbitrator finds these facts evidence a positive surgical result and assigns significant weight to this factor.

Upon consideration of the above, the Arbitrator finds Petitioner sustained a 15% loss of the person as whole pursuant to §8(d)2.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HENRY E. TOLER,

Petitioner,

vs. NO: 15 WC 19096

CONTINENTAL TIRE THE AMERICAS, LLC,

Respondent.

18IWCC0530

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, 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 analyzing factor iv, future earning capacity, the Arbitrator noted a weekly wage loss of $140.72 from Petitioner's pre-accident average weekly wage to his Tire Sorter wages; the Arbitrator then used that figure to perform a wage differential calculation, found it equivalent to 23.38% loss of the person as a whole, and afforded significant weight to that factor. The Commission finds the Arbitrator's discussion of wage differential benefits is improper. The Commission emphasizes §8(d)1 benefits are not calculated based on a claimant's average weekly wage but rather on the average amount a claimant is able to earn presently in the pre-injury job. Therefore, in the present matter, a wage differential would be based on the current rate for the Tire Builder position. The Commission notes the current Tire Builder wage rate is not contained in the record; as Petitioner emphasizes in his Statement of Exceptions, having expressly waived recovery under §8(d)1, there was no need for Petitioner to offer this information into evidence. The Commission strikes the factor iv analysis and replaces it with the following:

The evidence unequivocally demonstrates Petitioner's undisputed injury and the resultant

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significant permanent restrictions have negatively affected his future earning capacity. The Commission finds this weighs heavily in favor of increased permanent disability.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $502.96 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 40% loss of use of the person as a whole.

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 23 2018

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/mck

O: 8/1/18

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Charles J. DeVriendt

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TOLER, HENRY
Employee/Petitioner

Case# **15WC019096**

CONTINENTAL TIRE THE AMERICAS LLC
Employer/Respondent

18IWCC0530

On 3/9/2018, 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 1.83% 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:

5274 HASSAKIS & HASSAKIS PC
JAMES M RUPPERT
206 S NINTH ST SUITE 201
MT VERNON, IL 62864

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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
NATURE AND EXTENT ONLY

HENRY TOLER
Employee/Petitioner

v.

CONTINENTAL TIRE THE AMERICAS, LLC
Employer/Respondent

Case # 15 WC 19096

Consolidated cases: _____

18IWCC0530

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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **September 7, 2017**. By stipulation, the parties agree:

On the date of accident, **November 5, 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 **$43,490.04**, and the average weekly wage was **$838.27**.

At the time of injury, Petitioner was **52** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $- for TTD, $- for TPD, $- for maintenance, and **$6,369.75** for other benefits, for a total credit of **$6,369.75**.

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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 $502.96/week for a further period of 200 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 40% loss of use of the body as a whole.

Respondent shall receive credit for advanced PPD benefits in the amount of $6,369.75.

Respondent shall pay Petitioner compensation that has accrued from February 9, 2017, through September 7, 2017, 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

March 7, 2018
Date

ICAbDecN&E p.2

MAR 9 - 2018

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

HENRY TOLER
Employee/Petitioner

v.

18IWCC0530

Case #: 15 WC 19096

CONTINENTAL TIRE THE AMERICAS, LLC
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on November 5, 2014, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in an injury to his low back. The parties further stipulated that the only issue in dispute is the nature and extent of Petitioner's permanent partial disability. The record reveals and the parties agreed that as a result of his injuries Petitioner is now under permanent work restrictions, and that Respondent has accommodated those restrictions by moving him into a different position. That position pays a lesser hourly wage than Petitioner's pre-injury position. Petitioner specifically waived a wage differential award and elected to receive an award under Section 8(d)2 of the Act.

On the date of accident, Petitioner was 52 years old, married, and had one dependent child. He was employed by Respondent as a Passenger Tire Builder and had been so employed since 2012. He described the job duties as, "Assembling various components to make a car tire, putting material in the machines and changing out materials, changing from specific tire to a different tire when job changes came up." He reviewed Petitioner's Exhibit 4, identified it as Respondent's job description for the position of Passenger Tire Builder, and testified it was an accurate description of the job. The parties stipulated that Petitioner earned an average weekly wage of $838.27 as a Passenger Tire Builder. AX1, PX3, RX1.

The Arbitrator notes that Petitioner did not testify as to specifics of how he was injured on November 5, 2014, only that he hurt his back and had surgery in August 2015. Petitioner testified that he eventually reached maximum medical improvement and was given permanent restrictions of no lifting, pushing, or pulling more than 25 pounds, and no repetitive bending or twisting. As a result of those restrictions, he was unable to return to his former position and was assigned to the position of Passenger Tire Sorter. He described the job duties as, "I'll sit in a chair. I have a computer screen that's up above me and a conveyor runs down beside me, and when a tire stops

beside me I'll look at the computer screen to check the tire code and see what kind of marking the tire is supposed to get, and I'll put it on the tire and hit enter and let the tire go on and do the next one." He reviewed Petitioner's Exhibit 5 and identified it as Respondent's work instructions for the position of Passenger Tire Sorter, which he obtained from the company website. He also reviewed Petitioner's Exhibit 3, identified it as Respondent's job description for the position of Passenger Tire Sorter, and testified it was an accurate description of the job. Petitioner testified that although the job description indicates a requirement to be able to lift "in excess of 50 pounds", he does not do so. He explained that Respondent has instructed him not to exceed the restrictions imposed by his doctor, and that co-workers assist him in those tasks that require such activities.

On cross-examination, Petitioner testified that he had been in the Tire Sorter position since July 2016 and that it is a full-time position. He acknowledged that he continues to receive bonuses, overtime, and shift differential pay. Evidence reflects that Petitioner currently earns an average weekly wage of $697.55 as a Tire Sorter. RX3.

Following the accident, Petitioner presented to the Orthopaedic Center of Southern Illinois on December 30, 2014. The New Patient History Form indicates he was referred to the facility by Dr. Byler. PX2. The Arbitrator notes that records from Dr. Byler were not proffered at trial. Petitioner was evaluated by Dr. Don Kovalsky, who noted he had been injured when he was pushed into a cart in back of him, injuring his mid and low back. On examination, there was tenderness to palpation at the thoracolumbar junction and in the area of L3-4 and L4-5, range of motion was limited and painful, and strength and sensation were normal. Dr. Kovalsky reviewed lumbar CT scan and x-rays previously performed and noted evidence of a small wedge deformity of T12, which he believed was an old injury, and a non-displaced pars defect at L5 which was clearly old. Dr. Kovalsky recommended a lumbar MRI, prescribed a Prednisone taper, Mobic, and Zanaflex, and placed Petitioner on restrictions of no lifting more than 30 pounds. PX2.

On January 8, 2015, Petitioner underwent a lumbar MRI. It revealed (1) mild multilevel degenerative changes; (2) T12 mild anterior wedging with superior and inferior endplate Schmorl's nodes; and (3) no evidence of bone edema or fracture. Petitioner returned to Dr. Kovalsky on January 14, 2015, and reported continued back pain with some radiation into his left buttock and leg. Dr. Kovalsky reviewed the MRI and opined that it showed mild dehydration at L4-5 with an annular tear but no neural compression and Schmorl's nodes and degeneration at T11-12, T12-L1 without herniations. He did not believe Petitioner was a surgical candidate based on the study, noting that "the only way to fix this surgically would be to…do probably a lumbar disc replacement". He recommended physical therapy, with the hope that Petitioner could resume his regular job duties within two or three months. PX2.

Petitioner returned to Dr. Kovalsky on February 19, 2015, and reported more back than leg pain. He noted he had been attending physical therapy and working light duty and had begun to see improvement in strength, flexibility, and pain. On examination, he had significant back pain with flexion and extension. Dr. Kovalsky reiterated that he did not believe surgery was in Petitioner's best interest "because he has a rather minor injury and the only surgery to fix this would either be an anterior fusion or a disc replacement which is a very large operation". He recommended bilateral transforaminal epidural steroid injections at L4-5 and increased physical therapy to include work conditioning, circuit weight training, and cardiovascular exercises. PX2.

On March 4, 2015, Petitioner presented to Dr. Aiping Smith and underwent bilateral transforaminal epidural steroid injections at L4-5. He underwent repeat injections on March 18, 2015. Diagnosis was L4-5 degenerative disc disease, annular tear, and disc herniation. PX2.

Petitioner followed up with Dr. Kovalsky on April 1, 2015, and reported that the injections had improved his leg pain to the point that it was almost completely resolved. He also reported some improved back pain. Dr. Kovalsky maintained Petitioner on his current restrictions and medications and noted he may put him back into physical therapy or work conditioning after he returned in five weeks. PX2.

On May 6, 2015, Petitioner returned to Dr. Kovalsky and reported continued symptoms which were tolerable only when he did not do any physical activity. It was noted he had undergone five or six months of conservative treatment consisting of injections, physical therapy, medication, and restricted work. It was also noted that he had been wearing a lumbosacral orthosis. Petitioner expressed frustration and a desire to "having this problem fixed". Dr. Kovalsky reviewed the MRI with Petitioner and discussed various surgical options. He recommended a disc replacement at L4-5 and noted, "...this should resolve his back pain and not put any additional stress on the contiguous levels." PX2.

Petitioner underwent a second lumbar MRI on August 12, 2015. It revealed mild degenerative changes grossly similar to the previous study. There was no evidence of spinal or foraminal stenosis. PX2.

On August 18, 2015, Petitioner underwent surgery by Dr. Kovalsky. It consisted of L4-5 (1) anterior lumbar discectomy; (2) epidural decompression; (3) removal of annulus; and (4) total disc arthroplasty. The operative report indicated that the annular tear at L4-5 was at least 1.5 cm wide, there was disc material in the epidural space, and the posterior longitudinal ligament was torn. Petitioner was seen in post-op follow up on September 2, 16, October 1, 29, and December 29, 2015. It was noted on several occasions that he was to continue to wear TLSO brace and avoid lifting, bending, and twisting. On October 1, he was given a release to sedentary work. PX2.

Petitioner returned to Dr. Kovalsky on January 6, 2016, and reported he was still having some lower back pain and right buttock pain. He was taking four to six Tramadol a day and advised that for the most part that was controlling his pain. It was noted that he may have some right SI joint dysfunction and had been in therapy for that and for general conditioning and work conditioning. Dr. Kovalsky's impression was significant improvement in low back pain and radicular leg pain post-operatively, with a "new onset of right buttock pain and some right posterior thigh pain". He recommended an MRI to rule out disc herniation at L5-S1. Petitioner was to continue therapy and use of Tramadol. He was allowed to return to work with restrictions of no lifting more than 15 pounds, no standing or walking more than an hour at a time, ability to change positions about every 10 minutes, and no standing or walking more than a total of 6 hours in an 8-hour work shift. PX2.

Petitioner underwent a third lumbar MRI on January 27, 2016. It showed post-operative changes at L4-5, but no evidence of disc herniation at L5-S1. Dr. Kovalsky reviewed the MRI

with Petitioner on February 4, 2016, and agreed with the radiologist's interpretation. He diagnosed right SI joint dysfunction, status post total disc arthroplasty at L4-5, and recommended physical therapy specifically for the SI joint dysfunction. He discussed a possible SI injection if problems persisted following therapy. PX2.

On March 3, 2016, Petitioner returned to Dr. Kovalsky. He had continued tenderness over the SI joint with positive Fortin finger pointing and provocative testing. Dr. Kovalsky noted that Petitioner's right buttock/SI pain was what was limiting his functional abilities at that point, rather than his lumbar spine. He noted this was a problem sometimes seen after patients have lumbar surgery. He referred Petitioner for a diagnostic injection and kept him on light duty work. Petitioner followed up on April 21, 2016, and continued to complain of right buttock pain. He reported that he had not had the injection or the physical therapy, as neither had been approved, and that he would be attending an independent medical examination. PX2.

On June 9, 2016, Petitioner returned to Dr. Kovalsky and reported that he had been seen for an IME with Dr. Gornet (misidentified as "Garnett"), who believed that his pain was coming from the L5 pars defect. Dr. Kovalsky opined that it was possible that the pars defect was causing the right buttock pain, but he believed "we should try and diagnose the etiology of his pain". He agreed that the previous x-rays and CT scan showed a pars defect on the right at L5, but did not believe it was clinically significant since it had been there since Petitioner was a teenager. He recommended a diagnostic injection in the pars interarticularis at L5 on the right and, if that did not provide relief, then he would recommend an injection into the right SI joint. Petitioner was to continue taking Tramadol and continue working full time with a 30-pound lifting restriction. PX2.

Petitioner returned to Dr. Kovalsky on August 4, 2016, and reported continued pain over the right SI joint. It was noted that Dr. Gornet did not believe Petitoner's symptoms were related to his SI joint and that he recommended a permanent 25-pound lifting restriction. Dr. Kovalsky again noted that Petitioner had never undergone any SI joint injections. In discussing Petitioner's current job duties, Dr. Kovalsky noted that he was doing work that was "in excess of what he should be doing". He placed permanent restrictions on Petitioner of no lifting more than 25 pounds and no pushing or pulling more than 25 pounds if an item is on a flat conveyor belt rather than a cart. Petitioner was to continue taking Tramadol and Tylenol. Dr. Kovalsky suggested Petitioner "talk to his attorney about settling with Work Comp" and follow up with him under his private insurance. He was to return in six months. PX2.

On February 9, 2017, Petitioner returned to Dr. Kovalsky and advised he was continuing to work within his restrictions and taking four to six Tramadol a day. He denied any increase in low back pain, but did note he was having some unrelated upper thoracic and lower cervical pain. Dr. Kovalsky noted, "He had some sort of injury about 10 years ago. I've never really evaluated him for that problem." On examination, he had some pain with lumbar extension, negative straight leg raise, minor discomfort over the left SI joint, and normal strength and sensation. X-rays showed the disc replacement was well-positioned with no signs of subsidence. Clinical impression was "excellent outcome status post total disc arthroplasty at L4-5". Petitioner was to continue working with restrictions and taking Tramadol for symptoms, and return in six months. PX2. The Arbitrator notes this is the final treatment record.

The parties did not offer any testimony from Petitioner's medical providers or Dr. Gornet, Respondent's independent medical examiner. Respondent did not offer Dr. Gornet's report.

Petitioner's attorney arranged for a vocational evaluation with Thomas D. Upton, Ph.D. on August 16, 2016. Dr. Upton testified by way of deposition on January 11, 2017. Respondent's attorney objected to any opinions set forth in Dr. Upton's report, arguing they were not relevant to the proceedings to the extent that Petitioner continued to work for Respondent. Dr. Upton is a professor at Southern Illinois University and is a Certified Vocational Rehabilitation Counselor. He testified that he helps people by assessing individuals to understand how they can go back to work, and then puts them into a system to either get them back to work or find them another job. He received his bachelor's degree in Rehabilitation Services Education, his master's degree in Rehabilitation Counseling, and his Ph.D. in Rehabilitation Counseling Education. PX1.

Dr. Upton met with Petitioner on August 16, 2016, and produced a vocational evaluation report and a regional labor market survey. He reviewed medical records from Dr. Kovalsky and Dr. Gornet concerning Petitioner's permanent restrictions, as well as Petitioner's work history, education history, employment history, and military service career. He performed cognitive testing on Petitioner and found he had reading and writing skills of a 12th grader and math skills of an 8th grader. He opined that this indicated Petitioner was only able to perform unskilled work. Dr. Upton performed a transferrable skills analysis and opined that Petitioner did not have any transferrable skills, nor were there jobs to which he could transfer the skills he had obtained through his prior jobs. From this analysis, Dr. Upton opined that Petitioner would have to compete for employment alongside other applicants for entry-level work. PX1.

Dr. Upton concluded and testified that (1) Petitioner's functional limitations impacted his work opportunities; (2) he was unable to return to his former job as a tire builder; and (3) he sustained a wage loss due to his new employment as a tire sorter. Dr. Upton opined it was appropriate to determine what Petitioner was capable of doing and earning in terms of employment based on his age, education, past work history, and injuries. PX1.

Dr. Upton performed a regional labor market survey by looking for jobs within a 50-mile radius of Petitioner's home over the course of one month. He found jobs Petitioner could perform in different sectors, including service, food preparation, cleaning, and housekeeping, and opined that these jobs fell into the sedentary, light, and medium demand levels. He testified that Petitioner was only qualified for entry-level positions due to his lack of transferrable skills and other factors. As such, he focused on job opportunities that were entry-level when performing his labor market survey. Based on his results, Dr. Upton opined that Petitioner should try to remain a tire sorter with Respondent, as it was unlikely he would earn as much elsewhere, given his permanent restrictions. He noted that Respondent was "one of the better employers in the area in terms of wages". He opined that Petitioner's earning capacity elsewhere was $8.25 to $9.00 an hour. He testified that even though Petitioner was currently earning $17.00 an hour, it did not affect his opinion regarding his earning capacity, as he was considering what Petitioner could earn if he was looking for a new job. PX1.

On cross-examination, Dr. Upton confirmed that he was only capable of offering opinions to a degree of vocational certainty, and not medical certainty. He testified that he spends only one

day a week doing vocational rehabilitation for people and the other days he works as a professor. He further testified that 70 to 80 percent of his vocational rehabilitation is done for Petitioners or Plaintiffs. He confirmed that in this case he was not hired to find Petitioner a new job or to help him develop additional skills. He testified that he thought it was "kind of different" that he was asked to generate a report, because Petitioner was working and similar situations had not occurred very many times over his sixteen years of vocational services. Despite multiple objections from Petitioner's counsel, which were overruled, Dr. Upton confirmed that his opinions regarding Petitioner's future earning capacity were speculative. PX1.

At arbitration, Petitioner testified that he held various jobs elsewhere prior to being hired by Respondent. He testified that, based on his current work restrictions, he would not be capable of returning to those jobs. With regard to his current complaints, Petitioner testified that his back pain is constant and varies in intensity. It sometimes shoots down into his buttocks, legs, and calves. He is able to do only a little bending, and usually squats to pick things up. Twisting back and forth make his back pain worse. He testified that he is unable to perform certain activities with his daughter, such as playing basketball, wrestling on the floor, or teaching her how to defend herself. He testified that the longer he drives, the more his condition gets agitated. He continues to ride his motorcycle, but for shorter periods of time.

Petitioner was wearing a visible back brace at trial. He testified he has two braces, one that goes under his clothes so it is not as noticeable, but does not provide as much support. The other brace goes over his clothes and provides more support. He testified that he wears a brace when his back is bothering him, and wears it more often at home or outside of work, rather than while at work. He testified that he continues to take prescription Tramadol and Tylenol on a daily basis. Petitioner denied having any lower back problems prior to his work accident and denied having any low back injuries subsequent to his work accident.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of trial was the nature and extent of permanent partial disability. Petitioner specifically waived a wage differential award and elected to receive an award under Section 8(d)2 of the Act. With regard to the nature and extent of disability for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although Petitioner's date of accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to Subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals that Petitioner was employed as a Passenger Tire Builder at the time of his injury but was unable to return to that position. He was treated for his injury and released to return to work with permanent

restrictions of no lifting more than 25 pounds and no pushing or pulling more than 25 pounds if the item is on a flat conveyor belt. These restrictions prevented Petitioner from returning to his former position as a Passenger Tire Builder.

Petitioner now works as a Tire Sorter and is not required to exceed his restrictions. The job descriptions for both positions are contained within the record and they demonstrate that the Tire Sorter position is much less physically demanding than the Tire Builder position. The Arbitrator notes, however, that the Tire Sorter position requires the ability to lift up to 50 pounds. Respondent does not allow Petitioner to perform this particular task, and Petitioner testified that when the need arises, he gets assistance from a co-worker. Petitioner testified that his current job requires him to sit in a chair and look at a computer screen to check the tire code and see what kind of marking the tire requires. He then marks the tire and hits "enter" on the computer. Evidence reflects that Petitioner will be capable of performing this job as a Tire Sorter for the remainder of his working career.

The Arbitrator notes that Petitioner's work injuries and resulting restrictions preclude him from returning to his former job as a Passenger Tire Builder or any of his other former occupations, resulting in a loss of trade. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 52 years old at the time of the injury and is currently 55 years old. He has approximately 12 work years ahead of him before reaching retirement age, during which he must deal with his disability. Over time, his condition could improve, stay the same, or get worse. The Arbitrator gives greater weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, the record is clear that Petitioner's injury and permanent restrictions resulted in diminished wages. At the time of his accident, Petitioner earned an average weekly wage of $838.27 as a Tire Builder. He currently earns an average weekly wage of $697.55 as a Tire Sorter, resulting in a wage loss of $140.72 per week. The Arbitrator notes that if Petitioner had elected an award under Section 8(d)1, the differential payments would be $93.81 per week ($838.27 - $697.55 = $140.72 x 2/3 = $93.81). This differential would be paid until Petitioner reaches ages 67, an annual amount of $4,878.12 for approximately 12 years, for a total of approximately $58,537.44.

Petitioner opted out of a wage differential award and elected to receive an award under Section 8(d)2. Petitioner's permanent partial disability rate is $502.96. Using this rate, the Arbitrator notes that the total wage differential award to which Petitioner would be entitled had he not opted out is the equivalent of approximately 23.38% loss of use of the body as a whole ($58,537.44 ÷ $502.96 = 116.39 weeks ÷ 500 = 23.28%). The Arbitrator places significant weight on this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner sustained a lumbar spine injury. He underwent conservative care for several months consisting of physical therapy, medication, injections, and restricted activity. He eventually underwent surgery on August 18, 2015, consisting of L4-5 anterior lumbar discectomy, epidural decompression, removal of annulus, and total disc

arthroplasty. Dr. Kovalsky recommended on several occasions that Petitioner undergo post-surgical right SI joint injections, which were not approved and apparently were not administered. Petitioner testified that he continues to have back pain that is constant but varies in intensity. It sometimes shoots down into his buttocks, legs, and calves. He is able to do only a little bending, and usually squats to pick things up. Twisting back and forth make his back pain worse. He is unable to perform certain activities with his daughter, such as playing basketball, wrestling on the floor, or teaching her how to defend herself. He testified that the longer he drives, the more his condition gets agitated. The Arbitrator notes, however, that he continues to ride his motorcycle, albeit for shorter periods of time. Petitioner testifies that he wears a brace when his back is bothering him and he continues to take prescription Tramadol and Tylenol on a daily basis.

Dr. Kovalsky noted in his final treatment record of February 9, 2017, that Petitioner had an excellent outcome status post total disc arthroplasty at L4-5. The note reflects that Petitioner denied having any increase in back pain, no referred pain into his legs, and no leg weakness. On examination, he had some pain with lumbar extension, negative straight leg raise, minor discomfort over the left SI joint, and normal strength and sensation. X-rays showed the disc replacement was well-positioned with no signs of subsidence. Petitioner was instructed to continue taking Tramadol, but there is no mention of him being instructed to wear a back brace.

The Arbitrator notes there is a bit of difference between Petitioner's testimony and what is recorded in the final treating medical records. However, overall, the Arbitrator finds Petitioner's current complaints to be credible and corroborated by the records. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 40% loss of use of the body as a whole (200 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $838.27. The Arbitrator finds his permanent partial disability rate is $502.96. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit against the permanency award in the amount of $6,369.875, that being the amount Respondent has paid Petitioner for advanced PPD payments. The Arbitrator further finds that, to the extent Respondent has made additional PPD advances since the time of arbitration, it is entitled to credit for same.

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

RICHARD OLMSTED,
Petitioner,

v.

NO: 08 WC 30368

18IWCC0531

FREEMAN UNITED COAL MINING CO.,
Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the First District Appellate Court, Workers' Compensation Division. The case originally proceeded to trial on February 13, 2014. In his March 24, 2014 decision, the Arbitrator found Petitioner proved he suffers from coal workers' pneumoconiosis ("CWP") causally related to his exposure to coal dust and other substances while working as a coal miner for approximately 30 years. The Arbitrator further found Petitioner's average weekly wage equal to $1,106.97. Regarding permanent disability, the Arbitrator denied wage differential benefits pursuant to §8(d)1 and instead awarded benefits pursuant to §8(d)2 of the Act.

Both parties filed Petitions for Review. On November 6, 2014, a prior iteration of Commission Panel B unanimously reversed the decision of the Arbitrator, found Petitioner failed to prove disablement or causal connection and denied all benefits.

Petitioner subsequently appealed to the circuit court and thereafter, the Appellate Court. On August 14, 2017, the Appellate Court entered an Order finding the Commission failed to make the requisite factual findings as to whether Petitioner suffers from CWP, chronic bronchitis, or obstructive ventilator defect, and remanded the matter to the Commission.

The matter is now before this panel to weigh the competing medical evidence and determine whether Petitioner established he is afflicted with the claimed conditions and if so, the

benefits due. The Commission, having considered the issues and being advised of the facts and law, reinstates and 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.

I. Exposure/Disease

Petitioner alleged he suffers from three occupational diseases: CWP, chronic bronchitis, and obstructive ventilator defect. We address each condition in turn.

Coal Workers' Pneumoconiosis

In finding Petitioner has CWP causally related to his exposure to coal dust and other substances while working in a coal mine for 30 years, the Arbitrator found the opinions of Drs. Cohen, Smith, and Alexander to be more persuasive than the opinions of Drs. Wiot and Rosenberg. We affirm the Arbitrator but provide further reasoning for our determination.

The Commission observes a focus of the conflicting medical opinion was whether Petitioner's x-rays are consistent with CWP given the B-readers indicated the nodules were located in the mid and lower lung zones. Dr. Wiot testified CWP "invariably" and "always" begins in the upper lung fields. RX1, p. 34. Dr. Cohen disagreed and testified recent research shows that notion to be false: "There are studies of large numbers of x-rays of coal miners showing that the opacities can be present in the mid and lower zones, not starting necessarily in the upper zones and that I think is a pretty old-fashioned and really not well evidence-based statement..." PX1, p. 32-33. The specific authority Dr. Cohen cited is a 2012 study by Laney and Petsonk which the doctor testified showed CWP was "pretty equally distributed" between the upper, mid, and lower zones. PX1, p. 34. The Commission observes Dr. Wiot's involvement in this case ended in 2010, and there is no evidence the doctor had an opportunity to review that research. Dr. Rosenberg, however, is familiar with the study and commented on it during his deposition. Dr. Rosenberg testified there is no information in that abstract of any meaningful scientific basis. RX2, p. 26-27. He then identified the authorities that address whether nodules first occur in the upper lung zones; significantly, though, when discussing these sources Dr. Rosenberg did not parrot Dr. Wiot's statement that nodules "invariably" or "always" appear in the upper zone; rather, Dr. Rosenberg testified these studies show the changes "are greatest in the upper lung zone" and demonstrate a "predominance of upper lobe micronodularity." RX2, p. 27-28. To be clear, "invariably" and "predominantly" are not synonyms. The Commission believes the distinction is significant. We further note Dr. Cohen's testimony of an evolution in the understanding of how CWP presents:

> We're kind of talking about the old - - and I must say that I actually published a review article, maybe five or eight years ago that also talked about coal workers' pneumoconiosis having round opacities beginning in the upper lobes. But when we went back, and Laney and Petsonk did a wonderful literature review of this and looked at what was the foundation for that assertion. It wasn't very strong and the information that supported that wasn't good. And when they rigorously looked at where opacities

> can occur in CWP, they realized that that is not the case in a significant percentage of miners. So Ramy and Jardin are authors of a prominent pulmony (sic) and chest radiology textbook, and other authors were sort of quoting the old mythologies. PX2, p. 7-8.

The Commission finds Dr. Cohen's testimony as to this development is highly persuasive.

Having analyzed the evidence, the Commission finds the following facts compelling: Petitioner has a 30-year underground coal mine dust exposure history and is a lifetime non-smoker; three certified B-readers identified CWP on Petitioner's chest x-rays; and Dr. Cohen credibly opined Petitioner's coal mine dust exposure caused his CWP. The Commission affirms the Arbitrator's finding that Petitioner has CWP. As the Appellate Court noted when remanding the matter, this finding obviates any causation or disablement analysis: "Once it has been determined that a claimant has CWP, the presence of CWP is outcome determinative both as to causation and disablement." *Olmsted v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160303WC-U, ¶25, citing *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Commission*, 2013 IL App (5th) 120564WC, ¶35, 999 N.E.2d 382.

Chronic bronchitis

The medical experts agree Petitioner has chronic bronchitis. The dispute is whether it was caused or aggravated by coal dust exposure.

In his report, Dr. Rosenberg opined since Petitioner's bronchitis persists despite Petitioner leaving the mine environment, this indicates the bronchitis was not related to the coal mine exposure:

> Finally, it should be appreciated that Mr. Olmsted has a long history of sinusitis and bronchitis. Undoubtedly, this is causing his cough and sputum production. One would not expect cough and sputum production developing in relationship to past coal mine dust exposure to persist three years after a coal miner has left his coal mine employment. RX2, DepXB.

During his deposition, Dr. Rosenberg explained when a person has chronic bronchitis, the inciting fact which causes the bronchitis causes the glandular portion of the lining of the airways to enlarge; this increased glandularity makes increased mucous which leads to increased cough and sputum production. RX2, p. 36. Dr. Rosenberg then testified those mucous production and glandular changes will revert after cessation of exposure occurs, so chronic bronchitis from coal mine exposure will resolve once coal mine exposure ends:

> ...when the inciting agents are stopped or removed, the chronic irritant effect goes down and the cough and sputum production should dissipate...Over time. What I'm talking about is the cough and sputum production that people have that define

clinically chronic bronchitis, you would expect most of that to resolve within the first year or so of the inciting agent being removed. RX2, p. 37-38.

Dr. Cohen, on the other hand, concluded Petitioner's chronic bronchitis was caused by his 30 years of coal mine dust exposure: "He didn't have any other occupational exposures, and he did not have any smoking history. So coal mine dust was really his only exposure." PX1, p. 29. Presented with the opinion Petitioner's chronic bronchitis could not be from coal mining because if it was, it would resolve within a few months of the exposure ending, Dr. Cohen stated that was ludicrous. PX1, p. 39. Noting NIOSH recently published an update to a criteria document reviewing all the medical information relating to the health effects of coal mine dust, Dr. Cohen testified as follows:

> ...both of those documents very clearly showed a review of the literature that indicated a beautiful dose-response relationship between the symptoms of cough, sputum production, shortness of breath and coal mine dust exposure such that the more coal mine dust exposure you had, the more cough and sputum production and, therefore, chronic bronchitis you have. There's no evidence that miners who are susceptible all leave the industry or that it all goes away. In fact, it's just very strongly related to your total dose of coal mine dust. PX1, p. 40.

When he was deposed the second time, Dr. Cohen reiterated his disagreement with Dr. Rosenberg's opinion that chronic bronchitis caused by coal mining resolves within a year or so after leaving the mine environment, and testified the literature is counter to that theory: "And, in fact, there's a lot of literature associated with respiratory symptoms of coughing, sputum production with total exposure to coal mine dust. And it doesn't support the notion that it goes away if it's only from mining." PX2, p. 9.

Having weighed the conflicting opinions, the Commission finds Dr. Cohen's conclusions and testimony as to the causation of Petitioner's chronic bronchitis are more persuasive than Dr. Rosenberg's. Therefore, the Commission finds Petitioner established he suffers from chronic bronchitis causally related to his coal dust exposure.

Obstructive ventilator defect

Petitioner's final claimed occupational disease is obstructive ventilator defect. Again, there are conflicting medical opinions from Dr. Cohen and Dr. Rosenberg.

As part of his June 1, 2010 evaluation, Dr. Cohen conducted pulmonary function testing. The results of Petitioner's Resting Pulmonary Function Test were as follows: "FVC is normal, with reduced FEV1 and FEV1/SVC ratio. There was no clear response to bronchodilators, however the FEV1 became low normal post bronchodilator." Dr. Cohen's impression was "Mild obstructive ventilatory defect, not reversible with use of bronchodilator. Normal lung volumes. Normal gas exchange." PX1, DepX2. During his deposition, Dr. Cohen detailed his findings. Dr. Cohen used

the NHANES III for his predictor. PX1, p. 30. Petitioner had a FEV1 of 78% and an FEV1 over SVC ratio of 66%, indicating a mild obstructive defect. PX1, p. 27-28. Dr. Cohen explained FEV1 over SVC has been recommended over the FEV1 over FVC ratio because it is more sensitive for the diagnosis of obstructive lung disease. Petitioner's SVC was 4.22 liters, and his FVC was only 3.77; the doctor testified that is because people with obstructive lung disease often compress the airways when they're breathing out forcibly, therefore underestimating the true size of vital capacity. PX1, p. 28. Dr. Cohen discussed Petitioner's exercise test and stated Petitioner had a normal work capacity, anaerobic threshold and cardiovascular response to exercise; Petitioner had some gas exchange abnormalities with an increased A-a gradient but that was a mild abnormality. PX1, p. 31. Dr. Cohen opined the obstructive impairment was caused by Petitioner's coal mine dust exposure. PX1, p. 29.

Dr. Rosenberg reviewed Petitioner's pulmonary function testing as part of his record review and documented his observations in his report:

> The predicted values of Dr. Cohen were based on the NHANES III-Stroger values. When the measured values were gauged against the Knudsen predicted values, Mr. Olmsted's pre-bronchodilator FEV1 was 81.9% predicted increasing to 88.7% predicted after bronchodilators. Also, he had no evidence of restriction, with his TLC being normal at 111% predicted. In addition, his diffusing capacity measurements were normal and he had normal gas exchange in association with exercise. Furthermore, he was able to achieve a normal oxygenation consumption…it should be appreciated that Mr. Olmsted has no restriction or even obstruction, when his spirometric measurements are gauged against the Knudsen predicated values. Additionally, even if one uses the NHANES III-Stroger predicted values, Mr. Olmsted's post-bronchodilator FEV1 is normal at 85% predicted. Thus, any recorded pre-bronchodilator obstruction based on the latter predicted values reverses to normal after bronchodilator administration. RX2, DepXB.

During his deposition, Dr. Rosenberg explained the 2005 American Thoracic Society and European Respiratory Society guidelines indicate that to look for the possibility of obstruction, compare the FEV1 to vital capacity; he noted there is more than one vital capacity: inspiratory vital capacity, forced vital capacity, and slow vital capacity. RX2, p. 23. Petitioner's FEV1/FVC ratio was 73% and that would be normal, and Petitioner's FEV1 was within the normal limits. RX2, p. 24. Dr. Rosenberg testified the 2005 guidelines indicate when an individual has one measure that is lower limit of normal, then further investigation should be done through giving bronchodilators, looking at the flow volume curves and doing diffusing capacity measurements. RX2, p. 24. He then stated Petitioner was administered a bronchodilator and his FEV1, FEV1/FVC and FEV1/SVC were all normal. RX2, p. 24. Dr. Rosenberg further explained the flow curve was normal for Petitioner, there was no evidence of any restriction or obstruction with Petitioner's lung volume test, Petitioner's diffusing capacity was normal, Petitioner's blood gasses were normal both at rest and with exercise, and Petitioner's exercising test was normal. RX2, p. 25-26. Dr.

Rosenberg testified, based on the totality of the tests that were performed, Petitioner does not suffer from any pulmonary impairment. RX2, p. 26.

The Commission is persuaded by Dr. Rosenberg's analysis and conclusions on this issue. The Commission finds Petitioner failed to prove he suffers from obstructive ventilator defect.

II. Average Weekly Wage

When, as here, a claimant has worked for the same employer continuously during the year next preceding the day of last exposure, Section 10(a) of the Occupational Diseases Act provides compensation "shall be computed on the basis of the annual earnings which the person with a disability received as salary, wages or earnings." *820 ILCS 310/10(a)*. Section 10(g) defines earnings: "Earnings, for the purpose of this section, shall be based on the earnings for the number of hours commonly regarded as a day's work for that employment, and shall include overtime earnings. The earnings shall not include any sum which the employer has been accustomed to pay the employee to cover any special expense entailed on him by the nature of his employment." *820 ILCS 310/10(g)*.

As the Arbitrator noted, the evidence regarding Petitioner's earnings was meager. Petitioner's W-2 forms for 2006 and 2007 were admitted as Petitioner's Exhibit 10. Additionally, Petitioner was questioned as to the earnings documented on the W-2s. Petitioner agreed he received a clothing allowance from Respondent and further agreed that would be included on his W-2. T. 33-34. Petitioner also testified Respondent provided money so he could purchase his own insurance, and that too would be reflected on his W-2. T. 34. In addition, Petitioner's vacation pay, graduated vacation days, and sick days would be included. T. 34.

The Arbitrator based his average weekly wage calculation on the amounts identified as Petitioner's "wages, tips, other compensation" rather than the higher amount identified as "Social Security wages." The Arbitrator reasoned the amounts Petitioner received for clothing allowance, to purchase insurance, and as sick and vacation pay accounted for the difference between Petitioner's Social Security wages and his "wages, tips, other compensation." The Commission views the evidence differently.

The Commission finds the amount Respondent provided for health insurance, $1,100.00, does not constitute earnings associated with a "day's work"; therefore, we exclude that amount from the wage calculation. The Commission observes the clothing allowance would qualify as a special expense necessitated by the nature of his employment and therefore be excluded from Petitioner's earnings pursuant to Section 10(g). However, the dollar amount of that allowance is not in the record, so the Commission is unable to quantify an amount to be deducted.

The W-2 for 2006 demonstrates Social Security wages of $57,580.16. Subtracting the 2006 insurance subsidy of $1,100.00, Petitioner's applicable earnings are $56,480.16. Dividing by 52 yields an average weekly wage for 2006 of $1,086.16. The period to be considered is September

1, 2006 through December 31, 2006, 17 3/7 weeks. Therefore, the applicable earnings for 2006 are $18,930.22 ($1,086.16 x 17 3/7 = $18,930.22).

The W-2 for 2007 evidences Social Security wages of $53,519.34. Subtracting the 2007 insurance payment of $1,100.00 yields earnings of $52,419.34. Those wages were earned from January 1, 2007 through August 30, 2007, a period of 34 4/7 weeks.

The Commission finds Petitioner earned $71,349.56 in the 52 weeks preceding the last day of exposure ($18,930.22 + $52,419.34 = $71,349.56). This yields an average weekly wage of $1,372.11 ($71,349.56 / 52 =$1,372.11).

III. Permanent Disability

Petitioner sought a wage differential award at arbitration. The Arbitrator concluded the evidence did not support §8(d)1 benefits: "While Petitioner cannot return to work as a coal miner, he is capable of performing heavy manual labor. While Petitioner's testimony as to his post-mining earnings was unrebutted, there was no evidence that regular full-time work was not available to him within his capability of performing heavy manual labor." The Arbitrator instead awarded 10% loss of use of the person as a whole. The Commission affirms the denial of a wage differential but writes separately to expand upon the analysis.

"The Diseases Act incorporates the recovery provisions of the Workers' Compensation Act (the Compensation Act)...820 ILCS 310/7 (West 1994)." *Freeman United Coal Mining Co. v. Industrial Commission*, 283 Ill. App. 3d 785, 790, 670 N.E.2d 1122 (1996). Under §8(d)1 of the Compensation Act, an impaired worker is entitled to wage differential benefits when (1) he is "partially incapacitated from pursuing his usual and customary line of employment" and (2) there is a "difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1*. Alternatively, §8(d)2 provides for an award based on a percentage loss of use of the person as a whole under three circumstances: when the claimant's injuries do not prevent him from pursuing the duties of his employment but he is disabled from pursuing other occupations or is otherwise physically impaired; when his "injuries partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earning capacity"; or when the claimant having suffered an "impairment of earning capacity...elects to waive his right to recover under [8(d)1]." *820 ILCS 305/8(d)2*.

Regarding the first element, Dr. Cohen concluded, due to the CWP and chronic bronchitis, any further exposure to coal mine dust would endanger Petitioner's health. The Commission further notes, although Dr. Rosenberg did not believe Petitioner suffered from CWP, he did agree there is no safe level of exposure for an individual diagnosed with CWP. Since Petitioner's occupational diseases preclude him from returning to work in a coal mine, he satisfied the first prong: his injuries partially incapacitate him from pursuing the duties of his usual and customary

line of employment. Therefore, as Petitioner has clearly not waived his right to a §8(d)1 award, "the linchpin factual issue in the present case is a determination of whether the claimant's work-related injuries have resulted in an 'impairment of earning capacity.' 820 ILCS 305/8(d)2." *Jackson Park Hospital v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 142431WC, ¶43, 47 N.E.3d 1167.

As to earning capacity, Petitioner argues the Commission must award a wage differential based on his road commissioner earnings. Petitioner's position can be summarized as follows: his burden of proof is preponderance of the evidence; he presented evidence of what he is able to earn whereas Respondent presented none; therefore, since some evidence preponderates no evidence, the Commission is compelled to adopt the Cahokia Township Road Commissioner earnings as the measure of what Petitioner is able to earn. The Commission disagrees. We do not believe the mere existence of some evidence in the record constrains us to finding it credible or controlling. Furthermore, the Supreme Court of Illinois has held that "[a]lthough wages are indicative of earning capacity, they are not necessarily dispositive." *Cassens Transportation Co. v. Industrial Commission*, 218 Ill. 2d 519, 531, 844 N.E.2d 414, 423, 300 Ill. Dec. 416 (2006). The test does not focus exclusively on the amount earned, but instead focuses on the capacity to earn. *Id.* "'[P]ost-injury earnings and earning capacity are not synonymous' because other evidence can show that 'the actual earnings do not fairly reflect claimant's capacity.' 4 A. Larson & L. Larson, Larson's Workers' Compensation Law § 81.03[1] (2005)." *Jackson Park Hospital*, 2016 IL App (1st) 142431WC, ¶44. As such, whether Petitioner has sustained an impairment of earning capacity cannot be determined by simply comparing pre- and post-injury income. Rather, the "analysis requires consideration of other factors, including the nature of the post-injury employment in comparison to wages the claimant can earn in a competitive job market." *Jackson Park Hospital*, 2016 IL App (1st) 142431WC, ¶45.

Section 8(d)1 of the Act requires Petitioner to present evidence of some type of "suitable employment or business" in which he may be employed following his accident. *820 ILCS 305/8(d)1* (West 2013). As the court noted in *Jackson Park Hospital v. Illinois Workers' Compensation Commission*, when §8(d)1 is construed in conjunction with §8(d)2, the focus turns to an impairment of earning capacity which is established by a claimant's wages earned in a "suitable" post-accident occupation. 2016 IL App (1st) 142431WC, ¶¶41, 42. This Commission acknowledges the court's holding in *Crittenden v. Illinois Workers' Compensation Commission*, which defines suitable employment as "employment in which the claimant is both able and qualified to perform." 2017 IL App (1st) 160002WC, ¶24. This definition, though, was not determined in the context of earning capacity as the parties in *Crittenden* stipulated that the claimant was entitled to a wage differential award due to the claimant's impairment of earnings. The issue addressed in *Crittenden* was whether the claimant was capable or qualified to perform a job identified by the vocational expert. The court noted the job identified must be one the claimant has the ability to perform. The court's holding appears to set a standard- at a minimum, a claimant must possess the requisite skills to perform a job for the job to be considered suitable at the onset. But merely requiring a claimant to establish he is able and qualified to perform any job would not meet the requirements of "suitable employment" in the context of impaired earning capacity. If

such is the standard, it runs directly afoul of the court's holding in *Jackson Park Hospital v. Illinois Workers' Compensation Commission* which requires the Commission to determine "whether the claimant has established an impairment of earning capacity [which] cannot be determined by simply comparing pre- and post-injury income. The analysis requires consideration of other factors, including the nature of the post-injury employment in comparison to wages the claimant can earn in a competitive job market." 2016 IL App (1st) 142431WC, ¶45.

We are cognizant it is Petitioner's belief the road commissioner position was the best job he could obtain given his lack of a high school diploma. T. 19. While we do not doubt the sincerity of Petitioner's belief, the Commission notes Petitioner's testimony does not rise to the level of vocational expert opinion. Moreover, we must consider the totality of the evidence. Functionally, although Petitioner was 59 years old as of the arbitration date, he has no significant health issues beyond his breathing problems, and both Dr. Cohen and Dr. Rosenberg concluded Petitioner remains capable of heavy manual labor. PX1, p. 72; RX2, p. 26. Vocationally, Petitioner has three decades of experience performing mechanical repair: in addition to the welding, electrical, and repair work he performed for Respondent, Petitioner has been self-employed as a general mechanic, repairing automobiles and lawnmowers, for 25 years. T. 15, 17-18, 29, 35. There is no evidence these skills are not transferable. The record is similarly devoid of any evidence to suggest there is no competitive job market for mechanical repair work or that the wages of such jobs are lower than Petitioner's wages with Respondent.

Considering Petitioner remains capable of heavy physical work and not only has extensive experience with machine repair but in fact continues to perform that work in his home-based repair business, the Commission finds Petitioner's testimony is insufficient to prove an impairment of earning capacity.

The Commission finds Petitioner's CWP and chronic bronchitis resulted in the 12.5% loss of use of the person as a whole under §8(d)2. Given our above determination Petitioner's average weekly wage is $1,372.11, Petitioner's PPD rate as calculated pursuant to §8(b)2.1 is $823.27 ($1,372.11 x 60% = $823.27); however, this exceeds the statutory maximum for Petitioner's last day of exposure which is $636.15. Therefore, the Commission finds Respondent shall pay to Petitioner $636.15 per week for a period of 62.5 weeks.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 24, 2014, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused 12.5% 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.

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 $32,000.00. 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 24 2018

L. Elizabeth Coppoletti

LEC/mck

D: 6/6/18

Charles J. DeVriendt

43

Joshua D. Luskin

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VIVIAN WIRES,

Petitioner,

vs.

NO: 14 WC 027207

ILLINOIS DEPARTMENT OF HUMAN SERVICES,

18IWCC0532

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and proper notice given, the Commission after considering the issues of accident, notice, medical expenses, causal connection, temporary total disability, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator and awards compensation as stated below.

Petitioner was a 25 year caseworker with the State of Illinois Department of Human Services. Petitioner testified that she worked 42.5 hours per week with a one hour lunch and two 15 minute breaks per day. Her responsibilities included assisting individuals with medical benefits, cash benefits, SNAP benefits / food stamps and assisting families with the Temporary Assistance to Needy Families program. The parties stipulated to Petitioner's average weekly wage was $1, 337.76.

Petitioner testified that 90% of her work day is comprised of computer and mouse work to complete and navigate forms. She stated that for 20 years her workstation was not comfortable and required that she "rest her hands on the desk". In late April 2014 Petitioner developed symptoms of carpal tunnel syndrome in her right hand. Around that time Petitioner testified that she was moved to a new desk and provided a keyboard that was easier on her upper extremities.

The Arbitrator denied accident based upon his analysis of Petitioner's testimony and the request of Respondent. The Commission finds that many of the opinions of Dr. Williams are not supported by the undisputed testimony of Petitioner regarding her working conditions and the amount of time spent daily typing and operating a mouse at her computer over many years. Additionally, Petitioner's description of sustained right hand and wrist activities is consistent with Respondent's Job Description which was entered into evidence. The CMS Demands of the Job requires use of hands for fine manipulation e.g. typing, for four to six hours per day. Petitioner notified her supervisor on May 19, 2014. Petitioner completed a Worker's Compensation Employee's Notice of Injury on June 2, 2014.

Petitioner testified that she was initially diagnosed with carpal tunnel syndrome in her right hand by Dr. Dedes about April 24, 2014, after noticing increasing symptoms of pain in her right elbow down to her wrist with tingling and numbness. An EMG and nerve conduction test was performed on May 16, 2014 which revealed right chronic moderate median nerve entrapment at the right wrist i.e. carpal tunnel syndrome.

Petitioner later obtained medical care from Dr. Anthony Biggs, an occupational medicine specialist at Quincy Medical Group, on referral from Dr. Dedes, on August 7, 2014. Dr. Biggs stated in his note that "... history, symptoms and exam consistent with carpal tunnel syndrome due to chronic median nerve compression neuropathy and likely secondary to occupational activity. Therefore this is a compensable cumulative work injury."

On February 13, 2015 Petitioner underwent a right open carpal tunnel release surgery performed by Dr. Crickard. Petitioner returned to work three days following surgery and did not miss any time from her employment as a caseworker. (In the Request for Hearing form, Petitioner did not claim any temporary total disability benefits).Dr. Crickard charted in his progress notes on June 30, 2015 that he felt Petitioner's work and repetitive typing as a caseworker could aggravate or exacerbate her symptoms. The Arbitrator discounted Dr. Crickard's opinion, questioning what Dr. Crickard understood about the exact nature of Petitioner's job duties. The Commission gives significant weight to the opinion of Petitioner's treating physician who performed her surgery.

Additionally, Petitioner underwent a Section 12 examination on November 10, 2015 with Dr. David Brown M.D., an orthopedic specialist who opined, based upon Petitioner's job description that her work activities were a "potential exacerbating factor to her diagnosed right carpal tunnel syndrome." The Commission finds that Petitioner met her burden of proof on the issues of accident and causal connection. Petitioner sustained a repetitive trauma injury which manifested on April 24, 2014.

Petitioner testified that all medical bills were paid by the State's insurance with the exception of $1, 947.88 in outstanding bills. Dr. David Brown's examination of Petitioner revealed that she was at maximum medical improvement and was able to continue work without

restrictions. Petitioner testified that she no longer experiences numbness or tingling and that her right upper extremity is painful "every now and then".

With regard to subsection (i) of Section 8.1(b) of the Act, the Commission notes that the record contains an impairment rating of 1% of the right hand as determined by Dr. David Brown, M.D., pursuant to the 6th Edition AMA Guides to the Evaluation of Permanent Impairment. The Commission notes that this level of impairment does not necessarily equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation.

Subsection (ii) of Section 8.1 (b) of the Act references the occupation of the employee. The Commission notes that Petitioner was employed as a case worker at the time of the accident and that she was able to return to her prior employment in her prior capacity and remains so employed at the time of hearing. Because Petitioner has been able to return to work full duty and did not testify to any significant pain, problems or limitations due to the accident, the Commission gives lesser weight to this factor.

With regard to subsection (iii) of Section 8.1(b) of the Act, the Commission notes that Petitioner was 49 years of age at the time of the accident. Petitioner testified that she does not have any limitations in her work because of this accident. She does have pain "every now and then" which she treats with Tylenol, and that she occasionally uses her brace when doing heavy work. The Commission gives greater weight to this factor.

Concerning subsection (iv) of Section 8.1(b) of the Act, the Commission notes that Petitioner sustained no difference in earning capacity. Because Petitioner has no difference in earning capacity, the Commission gives lesser weight to this factor.

The Commission notes with regard to subsection (v) of Section 8.1(b) of the Act, evidence of disability corroborated by the treating medical records, that Petitioner expressed no complaints of residual numbness, tingling or other than occasional mild pain following her recovery from the right carpal tunnel release. Because Petitioner has minimal ongoing complaints after treatment, the Commission gives lesser weight to this factor.

Based on the above factors, and the record taken as a whole, the Commission finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the right hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 18, 2018 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,947.88 in outstanding medical bills pursuant to Sections 8(a) and 8.2 of the Act,

subject to the prohibition against balance billing. Respondent is entitled to a credit for the medical bills the group health insurance carrier paid on Petitioner's behalf on account of said accidental injuries, provided to the extent Respondent claims credit under Section 8(j) of the Act, Respondent shall hold Petitioner harmless from any claims by the providers or the group health insurance carrier.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 802.66 per week for a period of 14.25 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 7.5% loss of use of Petitioner's right hand.

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

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

Pursuant to Section 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 27 2018
o-7/12/18
SM/msb
44

Stephen J. Mathis
Stephen Mathis

David S. Gore
David Gore

DISSENT

I respectfully dissent from the Decision of the majority. I would have affirmed and adopted the well-reasoned opinion of the Arbitrator who found that Petitioner did not sustain her burden of proving that her current condition of right-sided carpal tunnel syndrome was caused by her work activities.

Petitioner was a case worker for Respondent. She alleged repetitive keyboarding and using a computer mouse as the only bases for arguing her carpal tunnel syndrome is causally related to her work activities. As the Arbitrator pointed out, the maximum Petitioner could have been engaged in keyboarding and/or mousing was six hours a day. Respondent's Section 12 medical examiner, Dr. Williams, opined that the type of activities Petitioner performed in her work did not

involve the sufficient repetition, duration, or intensity to be a causative factor for developing carpal tunnel syndrome.

In addition, Dr. Williams had Petitioner demonstrate the manner in which she performed her keyboarding and mousing activities. He noted that her typing position did not put undue strain on, or cause extensive flexion of, her wrist. Dr. Williams had a better understanding of the exact nature of Petitioner's work activities than Petitioner's treating doctor and Section 12 medical examiner, neither of whom actually observed the manner in which she performed her work activities. Therefore, in my opinion, the Arbitrator was justified in finding the causation opinion of Dr. Williams persuasive and relying on it. In addition, also in my opinion, the Arbitrator was justified in relying on the Commission decision of *Rosich v State of Illinois, Department of Human Services*, 16 I.W.C.C. 779. There, the claimant had the same job, case worker, as the Petitioner here. In *Rosich*, the Commission found that the claimant's work activities were not a causal factor in her developing carpal tunnel syndrome. The Commission in *Rosich* based its decision on the causation opinion of the same Dr. Williams who testified here.

Based on the persuasive opinions of Dr. Williams, I would have affirmed the Decision of the Arbitrator who found that Petitioner did not sustain her burden of proving an accident or a causal connection between her work activities and her condition of ill-being of right-sided carpal tunnel syndrome and denied compensation. For these reasons, I respectfully dissent.

Deborah L. Simpson

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIRES, VIVIAN
Employee/Petitioner

Case# **14WC027207**

ILLINOIS DEPARTMENT OF HUMAN SERVICES
Employer/Respondent

18IWCC0532

On 1/18/2018, 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 1.60% 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:

0293 KATZ FRIEDMAN EAGLE & ET AL
PHILIP A BARECK
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

0502 STATE EMPLOYEES RETIREMENT
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PO BOX 19255
SPRINGFIELD, IL 62794-9255

4138 ASSISTANT ATTORNEY GENERAL
WARREN A WILKE
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SPRINGFIELD, IL 62704

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

JAN 18 2018

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

18IWCC0532

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

- [ ] 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

Vivian Wires
Employee/Petitioner

v.

Illinois Department of Human Services
Employer/Respondent

Case # **14** WC **027207**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Quincy**, on **December 6, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **April 24, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident **N/A** 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 **$69,564.00**; the average weekly wage was **$1337.76**.

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

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

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

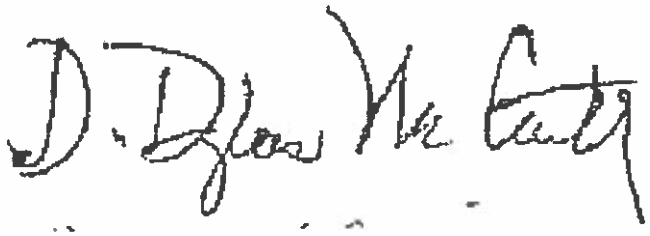
Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

ORDER

Based upon the attached findings of fact and conclusions of law, the Arbitrator finds that Petitioner has failed to prove an accident arising out of her employment which was causally related to her condition of ill being. Based upon these findings, Petitioner's claim for benefits is denied.

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

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



Signature of Arbitrator

1/12/2018
Date

JAN 18 2018

The Arbitrator hereby makes the following findings of fact and conclusions of law regarding the disputed issues of accident and causation:

In a claim involving repetitive trauma, the issues of accident and causally are closely intertwined. One must prove that their work was causally related to their injury. Medical testimony is critical to the Arbitrator in making the determinations.

Petitioner claims to have suffered carpal tunnel syndrome in her right hand because of her repetitive work duties.

In the instant matter, Petitioner has supplied the medical opinion of Dr. Anthony Biggs, the orthopedic surgeon to whom the Petitioner was referred for treatment of her condition. At his initial examination on August 7, 2014, Dr. Biggs was given a history from the Petitioner. He understood that her job involved primarily entering data and completing applications on a computer. This is consistent with the Petitioner's trial testimony. He also was told that she might have to type up to 50 minutes non-stop each hour of work. This history is not supported by the testimony at trial.

In an average day, Petitioner worked with four program screens. (T. 66). Each time Petitioner changed screens she had to use the mouse. (T. 65). Each program had various pages which she used the mouse to access. (T. 62). Each page had various boxes which she had to frequently navigate and interchangeably use the keyboard and mouse. (T. 61-62). Each box from each page will have sub-boxes which would have to be accessed by the mouse and keyboard interchangeably. (T. 80-81). On direct, Petitioner testified that the totality of her mouse work was between one and two hours per day. (T. 23). Petitioner worked eight hours and thirty minutes per day. However, Petitioner had a one hour lunch and two fifteen minute breaks; meaning, that Petitioner's job duties accounted for seven hours of her work day. Furthermore, although Petitioner worked seven hours a day, her medical records indicate that the absolute maximum time she spent using her computer was six hours per day. (PX 2).

In short, the above testimony refutes Dr. Biggs' belief that the Petitioner typed up to 50 minutes non-stop during each hour of work. In fact, the job involved intermittent typing and mouse use. As such, Dr. Biggs' opinions on causation are not persuasive.

The second medical opinion on the issue came from Dr. David Brown, an orthopedic surgeon to whom the Petitioner was referred by his attorney for an examination on November 10, 2015. (RX 2, P. Dep x 4) Before discussing Dr. Brown's conclusions, an issue was raised at arbitration which needs discussion. For some reason, the report from Dr. Brown was not offered as a separate exhibit at trial. The Petitioner did however offer it into evidence without objection during the deposition of Dr. James Williams. (RX 2 at 77) Respondent at trial objected to the use of the report on the issue of causation on the grounds of hearsay. It argued that the report was only used during the deposition so that Dr. Williams could give credibility to the AMA rating which Dr. Brown included in his report. Initially, at trial, the Arbitrator agreed with the Respondent. However, after now reading the deposition, the Arbitrator believes that the Respondent waived his right to object or limit the use of the report by not objecting during the deposition.

With that said, the Arbitrator does not find Dr. Brown's causation opinions persuasive for similar reasons to those addressed above concerning Dr. Biggs. Dr. Brown assumed that the Petitioner worked with "her hands on the keyboard five to six hours a day." (Id, P. Dep x 4) While it is possible that her hands could have been on or near the keyboard for that time period, the evidence does not support the conclusion that she was keyboarding during that time. Again, her job duties were varied and her keyboarding was not continuous.

Petitioner also cited the opinion of Dr. Crickard, the surgeon who performed the carpal tunnel release, in support of causation. In his office note of June 30, 2015, Dr. Crickard indicates that he discussed causation with the Petitioner. It appears that they discussed the Petitioner's job duties as well as the fact that medical data went both ways on the issue. Dr. Crickard then wrote that he felt her work and repetitive typing as a caseworker could aggravate or exacerbate her symptoms. (PX 2) The entire note from the doctor concerning causation consists of four lines. The Arbitrator is left to guess at what the doctor understood as to the exact nature of the Petitioner's job duties. As such, the opinion is given little weight.

Respondent has offered the opinion of Dr. James Williams who opined that Petitioner's job duties were of insufficient frequency, intensity, and duration such as to have caused Petitioner's condition of ill-being. Dr. Williams focused not solely on the activity of typing, but the position of her extremities while typing, which he found to not be causative in the development of carpal tunnel. Petitioner, as she did at trial, demonstrated her typing position for Dr. Williams. Moreover, Dr. Williams' opinion was not predicated solely on the angle at which Petitioner typed but whether Petitioner sustained that angle for a sufficient duration such as to be causative. Dr. Williams found Petitioner's work activities to be too intermittent, in that Petitioner was constantly switching between different work duties, such as the totality of her job duties were not causative.

First, Dr. Williams opined it was not the activities of mousing and typing per se that cause carpal tunnel syndrome, but the position of the extremities while performing those activities. Dr. Williams further opined that the improper position must occur for sufficient sustained periods of the day over the course of several years. (T. 77-79). Dr. Williams opined that typing at in a 45 degree flexed position for four to five sustained hours per day combined with one hour of sustained mouse work per day while resting one's wrist on the edge of the table over a period of 20 years would cause sufficient extrinsic pressure in the carpal tunnel over a sufficient duration that would potentially contribute to the development or aggravation of carpal tunnel syndrome. (RX 2 pg. 75-79, 81-85)(RX 2, RX4).

Petitioner's trial testimony does not indicate that her claim rises to Dr. Williams' causative standard. Petitioner demonstrated her typing position to Dr. Williams during her examination. He testified that her wrists were not particularly extended or flexed, and that her wrists were not resting on the edge of the table. (Id at 32) Petitioner demonstrated her typing at trial on two occasions. The Arbitrator observed that her demonstrations changed. Thus, said demonstrations are not particularly helpful to the Arbitrator in making his determinations.

More importantly, as Dr. Williams said several times, the typing needed to be of a continuous nature in order for it to be causative. He said that continuous typing for more than six hours, like that done by someone doing a transcription, would provide a risk. (Id at 31) If that person's wrists were in a poor position ergonomically, then the time require might decrease. (Id at 32) However, it was important to the doctor that the typing and wrist positions were sustained. (Id at 78-79)

Petitioner did neither typed nor moused in a sustained or constant manner. Petitioner specifically testified the typing with her right hand was constantly interrupted by the need to do mouse work, and that the totality of this interruptions amounted to between one and two hours of mouse work per day. (T. 23). Petitioner stated that each time she used the mouse, she spent between five and ten seconds using the mouse, meaning her mouse-work was intermittent and brief. While this does not account for all the other duties that would interrupt Petitioner's typing, the evidence and testimony clearly demonstrates that neither Petitioner's typing nor her mouse-work were sustained, constant, and uninterrupted.

Petitioner's wrists were not always on the edge of her desk. Dr. Williams found that whether a person rests their on the edge of a table or desk while typing to be a significant factor in assessing whether one's carpal tunnel syndrome could be attributed to their positioning while typing. (RX 2 pg. 32, 76, 83-84)(RX 2, RX 4). The trial record indicates that edge of Petitioner's keyboard was 5 inches from the edge of her desk. Petitioner's typing position never once showed Petitioner as having her wrists on the edge of her desk. The location of Petitioner's wrists while mousing, in relation to the edge of the desk, was never demonstrated with certainty at trial.

The Arbitrator finds Dr. Williams' opinions on causation to be persuasive. He demonstrated a thorough understanding of the Petitioner's actual job duties and he based his opinions on current scientific data. He also explained that the data is constantly evolving. (Id at 86) On cross-examination, Petitioner's attorney properly asked the doctor to explain how he could opine that typing could be causative now while testifying previously that it was not. Respondent has argued that the line of questioning was improper but the Arbitrator disagrees. The doctor was shown decisions of the Commission in which he gave different testimony concerning typing and carpal tunnel. Dr. Williams agreed that he gave such testimony. He then explained that his opinions had changed based upon ongoing medical studies. The line of questioning was proper and relevant on the issue of the doctor's credibility. However, the doctor was given a chance to explain his current opinions, and the Arbitrator believes his testimony to have been credible.

Finally, the Arbitrator finds persuasive the Commission decision in the case of Rosich v. State of Illinois, Department of Human Services, 16 IWCC 779 (2016). The petitioner in Rosich had the same job as the Petitioner herein. Her job duties were very similar. Her orthopedic surgeon testified that her carpal tunnel could have been work related, but the Commission felt his testimony was based upon facts not shown at trial. Specifically, they found that her keyboarding was not continuous in nature nor done to the extent per day that she had provided in her history. They gave greater weight to the opinions of the same Dr. Williams who testified in this case. He opined that the keyboarding and computer use was not of a continuous nature.

Based on the forgoing, and having considered the totality of the evidence submitted at trial, the Arbitrator finds that the Petitioner has failed to prove an accident arising out of her employment causally related to her right carpal tunnel. . Due to these findings all other disputes are rendered moot, and Petitioner's claim is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Ullrich,

Petitioner,

vs.

NO: 16 WC 23604

18IWCC0533

Staffing Network,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 13, 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 $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 27 2018
SJM/sj
o-7/26/2018
44

Stephen J. Mathis

David L. Gore

DISSENT

I respectfully dissent from the Decision of the majority. The Commission affirmed and adopted the Decision of the Arbitrator who found that Petitioner's current condition of ill-being of his left knee was causally related to a work accident and ordered Respondent to authorize and pay for prospective surgery recommended by Dr. Wolin. I would have found that Petitioner did not sustain his burden of proving the alleged work-accident caused the current condition of ill-being of his left knee.

Petitioner sustained a stipulated accident on July 19, 2016 when he tripped, fell, and landed on his hands and knees. He testified that for at least 10 years prior to the accident, he had problems with his left knee including "dislocations, car accidents, some just bumps and bruises" for which he saw doctors periodically. Petitioner also testified that after the instant accident, he informed his treating doctors and physical therapists about his prior left-knee problems and treatment. Specifically, Petitioner denied that on August 16, 2016, he told Dr. Wolin that he did not have any problems with his left knee for several years previously.

Respondent's witness, Michael Gacek, testified he supervised Respondent's workers who were on restricted duty, including Petitioner after his accident. He never observed Petitioner with an unusual gait or favoring his left knee in any way. He indicated that Petitioner was not complying with the doctor restrictions that Respondent was accommodating. Prior medical records show that Petitioner complained of the same symptoms both before and after the accident, including a buckling feeling in his knee, which Dr. Wolin cited as justification for his

recommended surgery. It is also important to note that surgery was recommended to Petitioner prior to the instant accident. In his deposition testimony, Dr. Wolin acknowledged that he did not review Petitioner's prior medical records.

In his decision, the arbitrator noted that "nowhere in the records with dates of service on or after July 19, 2016 is there a reference to left knee treatment in, specifically, 2013, 2014, and 2015. Yet, Petitioner testified that he informed Alexian Brothers physicians, and Dr. Tu of the 2015 treatment, but they did not document it. On August 16, 2016, Petitioner reported to Dr. Wolin that in 2005, he dislocated his left kneecap, received treatment, made a full recovery from this injury, and has had no problems with the knee for the past several years."

In addition, the Arbitrator noted that Petitioner "repeatedly denied any previous injuries or problems with respect to the left knee" to Respondent's Section 12 medical examiner, Dr. Gegenheimer. The Arbitrator concluded that "Petitioner's credibility has been called into question." He specifically found Petitioner's testimony that he informed his providers of his prior condition and their failure to record it, not credible. Nevertheless, the Arbitrator found causation based on the opinion of Dr. Wolin that the accident aggravated his pre-existing left-knee condition.

Dr. Gegenheimer examined Petitioner and, unlike Dr. Wolin, reviewed his medical records prior to the instant accident. He noted that MRIs taken prior and after the accident "essentially looked identical. The osteochondral injury to the medial femoral condyle" had not significantly changed and neither showed a "specific medial meniscus tear." He opined that the osteochondral condition was "definitely not caused by the injury sustained on July 19, 2016. It definitely existed prior to the injury and probably at least a few years prior to that." Dr. Gegenheimer had access to prior medical records that Dr. Wolin did not. Therefore, I find Dr. Gegenheimer's opinion more persuasive than Dr. Wolin's.

The record before us presents serious issues regarding Petitioner's credibility. He has not shown that his condition materially changed after the instant accident. In my opinion, Petitioner did not sustain his burden of proving his accident on July 19, 2016 caused his condition of ill-being of his left knee. Therefore, I respectfully dissent from the majority opinion.

Deborah L. Simpson

Deborah L. Simpson

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

ULRICH, DANIEL
Employee/Petitioner

Case# **16WC023604**

STAFFING NETWORK
Employer/Respondent

18IWCC0533

On 12/13/2017, 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 1.46% 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:

0391 HEALY SCANLON LAW FIRM
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1505 SLAVIN & SLAVIN LLC
DAVID VanOVERLOOP
100 N LASALLE ST 25TH FL
CHICAGO, IL 60602

18IWCC0533

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)

Daniel Ullrich
Employee/Petitioner

v.

Staffing Network
Employer/Respondent

Case # 16 WC 23604

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 27, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **July 19, 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned an average weekly wage of **$403.77**.

On the date of accident, Petitioner was **31** years of age, *single* with **0** dependent children.

Petitioner *has not* received all reasonable and necessary medical services.

Respondent is entitled to 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 Petitioner temporary total disability benefits of **$269.18**/week for **39-1/7** weeks, commencing on **8/3/2016** through **9/20/2016**, and from **12/15/2016** through **7/27/2017**, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective medical care in the form of the left knee surgery that Dr. Wolin has recommended, pursuant to Section 8(a) and subject to Section 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 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

12/14/2017
Date

DEC 13 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Ullrich v. Staffing Network
16 WC 23604

Findings of Fact

Petitioner, Daniel Ullrich, was employed by Respondent, Staffing Network, on July 19, 2016. Respondent is a temporary staffing agency, and Petitioner was placed for work at Florida Plastics as a forklift operator in his role as a temporary employee. Petitioner's job duties while working for Respondent at Florida Plastics included loading and unloading trucks, stocking shelves, and wrapping pallets.

On July 19, 2016, while at work for Respondent at Florida Plastics, Petitioner tripped over a shelving unit and fell. Petitioner testified he fell forward, landing on his hands and knees. Petitioner testified he had immediate swelling in his left knee, and as time progressed he had increased pain and was unable to put any weight on his left knee.

Petitioner provided notice and was directed to seek medical attention. He presented to Alexian Brothers Medical Center that day and provided a history of tripping and landing bilaterally on both knees with most of his weight coming down on the left knee. He rated his pain as 8/10. The records of Alexian Brothers indicate Petitioner further provided a history of "6 years ago he had a dislocated patella, but there is no known history of fracture in the knee." X-rays were taken, which were interpreted by the radiologist as revealing: "Age-indeterminate osteochondral fracture of the medial femoral condyle. MRI of the knee recommended for further evaluation." Petitioner was diagnosed with a fracture of the femoral condyle. He was provided work restrictions of sitting duty only, and was referred for orthopedic evaluation. (Px #1)

Petitioner testified that he returned to work for Respondent at Florida Plastics within his restrictions. He continued to work within those restrictions through August 2, 2016.

On July 21, 2016, Petitioner presented to Kevin Tu, M.D., of G&T Orthopedics and Sports Medicine. He provided a history of slipping and falling at work on July 19, 2016, landing on the anterior aspect of the left knee. He described pain localized to the anterior aspect of the knee and difficulty with prolonged ambulation. He further provided a history of left patellar dislocations, but denied any recent dislocation. Dr. Tu reviewed the x-rays previously performed and determined there was no evidence of patella fracture. There was abnormality over the medial

femoral condyle consistent with previous osteochondral lesion. Dr. Tu diagnosed Petitioner with a left knee contusion, recommended physical therapy, and provided restrictions of sitting work only. If Petitioner's symptoms were persistent after 3-4 weeks, an MRI would be considered. (Px #2)

Petitioner testified he began undergoing physical therapy as recommended by Dr. Tu. Petitioner was initially evaluated at Athletico Physical Therapy on July 26, 2016. The medical records of Dr. Tu include the summary of this initial evaluation wherein Petitioner provided a history of falling at work and landing on his left knee, with pain, swelling, and difficulty walking later in the day. He reported a left patellar dislocation ten years prior, but stated the current injury did not feel like that one. He had subjective complaints of left knee pain at rest that increased with prolonged standing and walking, and described his knee as feeling tight and feeling like "it might give away." (Px #2)

Petitioner never returned to Dr. Tu, and instead presented to Preston M. Wolin, M.D., on August 16, 2016. Petitioner testified he sought treatment with Dr. Wolin to obtain a second opinion. The records of Dr. Wolin indicate Petitioner provided a consistent history of falling at work and landing on his left knee. His left knee had swelled up very quickly, and he experienced increased pain. He also described a sensation of popping in the knee. The medical record of Dr. Wolin indicates Petitioner states "that in 2005 he dislocated his left knee cap … He states he made a full recovery from this injury and had no problems with his knee for the past several years." Dr. Wolin reviewed left knee x-rays and diagnosed Petitioner with a closed fracture of the left medial femoral condyle. He discontinued therapy and recommended the Petitioner be off work completely.

Petitioner underwent a left knee MRI on September 10, 2016. The impression of the radiologist was Stage III medial femoral condyle OCD (unstable) and free edge blunting medial meniscus body. There was intrinsic signal alteration involving the posterior horn and body with possible communication to the surface which may potentially represent degeneration/fraying versus a subtle tear, particularly of the posterior horn. There was also noted to be medial patellar retinacular edema.

On September 21, 2016, Petitioner returned to work for Respondent, where he performed sedentary work at Respondent's Oak Brook location. Petitioner continued in this capacity until December 14, 2016, after which time Respondent no longer offered him light-duty work.

Petitioner returned to Dr. Wolin on October 5, 2016. The medical record indicates Petitioner complained of continued giving way and mechanical symptoms medially. Dr. Wolin reviewed the MRI and diagnosed a medial meniscus tear and transchondral fracture of the medial femoral condyle. He recommended surgery with possible medial meniscectomy, and Petitioner's work status was unchanged.

On December 1, 2016, Petitioner underwent a Section 12 examination by Alan P. Gegenheimer, D.O. at Respondent's request. Dr. Gegenheimer, an osteopathic doctor, is a board-certified orthopedic surgeon who devotes one-third of the treatment and surgical care he renders to conditions of the knee. (Rx #1, Rx #1, Dep. Ex. 1)

Petitioner testified that prior to the accident of July 19, 2016, he was able to perform his work without limitation. On direct examination, he testified that he had dislocated his kneecap in 2005, and had no serious injury to his left knee other than "bumps and bruises" until July 19, 2016. Petitioner later testified to receiving treatment for his left knee in 2013, 2014, and 2015. Petitioner testified, however, that despite his prior treatment history, he believed the need for surgery was related to the July 19, 2016 work accident as he had never experienced buckling in his left knee prior to that specific accident.

Respondent offered into evidence medical records of Little Company of Mary Hospital and MidAmerica Orthopaedics. (Rx #6, Rx #7)

The records of Little Company of Mary Hospital include a visit of August 15, 2014 with a history of Petitioner being involved in a car accident in which his left knee hit the dashboard. Petitioner, at that time, gave a history of left knee problems, and stated he "was supposed to have surgery on this knee" prior to the car accident, but the pain had worsened due to the accident.

On August 15, 2014, Danilo J. Martinez, M.D., interpreted Petitioner's left knee x-rays as follows:

> "Left knee 4 views: 8/15/2014
> Indication: Trauma
> There is no joint effusion. Bony structures
> are intact. No fracture nor dislocation present.
> Small benign appearing bone density or a spur
> is seen in the medial patella.
> Impression: No acute fracture is seen. (Rx #6)

Following a review of Dr. Martinez's interpretation of the left knee x-rays, a medical professional diagnosed Petitioner with a left knee contusion. (Rx #6)

Petitioner returned to Little Company of Mary on August 27, 2014 and was documented to have "PAIN IN LT (+ BUCKLING; NO SWELLING; PAIN CONSTANT)." Petitioner was diagnosed with a left knee strain as well as low back and neck strains, and was discharged home in good condition. (Rx #6)

The records of MidAmerica Orthopedics indicate that on July 16, 2015, Petitioner presented for treatment to his left knee after a work-related injury occurring on July 6, 2015, at which time Petitioner tripped over a hose and fell onto the anterior aspect of his left knee. He was diagnosed with left knee pain, and an MRI was ordered. (Rx #7)

On July 20, 2015, routine multiplanar MRI sequences of Petitioner's left knee were taken. Radiologist Matthew Eisenstein interpreted the images and provided a detailed report. His impression is as follows:

(1) Osteochondral signal abnormality and deformity involving the medial femoral condyle adjacent to the intercondylar notch with adjacent subchondral cystic changes and osteitis. Findings could be related to an acute and chronic injury. Correlate clinically. There are no definitive free fragments related to the deformity. There is associated chondromalacia

(2) Sprain or tear of the anterior cruciate ligament. Sprain of the medial collateral ligament, and tendinopathy of the infrapatellar and distal quadriceps. Infrapatellar and distal quadriceps tendinopathy.

(3) Reactive type signal within the menisci. There is not a definitive medial or lateral meniscal tear.

(4) Joint effusion. There is nonspecific soft tissue edema. (Rx #7)

Petitioner returned to MidAmerica Orthopedics on July 23, 2015 and was diagnosed with left knee pain with bone bruise and ACL/MCL sprain. There is no indication he returned to MidAmerica Orthopedics.

On cross-examination, Petitioner testified that he had told the medical professionals at Alexian Brothers and Athletico Physical Therapy, as well as Drs. Tu and Wolin, about his treatment in 2015, but not about the left knee incidents in 2013 and 2014.

Prior to the arbitration hearing, Dr. Wolin testified at an evidence deposition. Dr. Wolin testified that he is an orthopedic surgeon who focuses on the knee, shoulder and elbow, and in the course of his 25-year career, has performed approximately 4,000-5,000 knee surgeries. At the time of the deposition, Dr. Wolin continued to perform surgery on a weekly basis.

Dr. Wolin testified that Petitioner had suffered a fracture to the cartilage and underlying bone in his left knee which would require surgery in the form of an osteochondral plug or graft. Dr. Wolin testified that with a diagnosis of ostechondral defect, the key to determining whether surgery is necessary is the absence or existence of mechanical symptoms, as those symptoms confirm the defect or fragment is loose. He acknowledged that some or a lot of the osteochondral defect condition in Petitioner's left knee pre-existed 2016. However, Dr. Wolin testified that the need for surgery was directly caused by the accident of July 19, 2016. Dr. Wolin supported his causal opinion by noting the mechanism of a direct impact to the anterior aspect of the knee was a competent mechanism for causing an osteochondral defect to break free and become loose, that the mechanical symptoms documented in his second visit with Petitioner confirmed the fragment was loose, and that there was no evidence of such mechanical symptoms prior to July 19, 2016.

Dr. Wolin testified that prior to the evidence deposition, the only history of treatment prior to 2016 that Petitioner reported to him was of the dislocation in 2005. On the day of the deposition, he reviewed records relating to left knee treatment in 2013, 2014, and 2015. At the evidence deposition, Dr. Wolin summarized the records of 2013, 2014 and 2015 and agreed that the mechanisms of injury in 2014 and 2015 were the same as the mechanism of injury in 2016, which he testified was a competent cause of the fragment breaking loose in the osteochondral defect. However, he testified there was no mention of mechanical symptoms prior to the 2016 accident. Therefore, until after July 19, 2016, there was no indication that the defect had become unstable such that surgery was required. Dr. Wolin testified that he did not document mechanical symptoms at his initial visit with Petitioner despite diagnosing Petitioner with the osteochondral lesion. He further testified that he had not previously reviewed the initial treating records of Alexian Brothers or Dr. Tu to ascertain whether mechanical symptoms were documented in those records, and had not reviewed any diagnostic test results prior to first seeing Petitioner other than the MRI report of July 20, 2015; Dr. Wolin did not review the films from that test.

With regard the September 10, 2016, MRI of Petitioner's left knee, Radiologist Akash Shah, M.D., reviewed non-enhanced, multiplanar, multisequence images and made, in pertinent part, the following findings:

> "Patellofemoral joint: Patella femoral cartilage is intact. Edema is present adjacent to the medical patellar retinaculum (series 6. Image 13).
> Medial compartment: Subtle blunting of the medial meniscus free edge is present (series 4, image 15). Intrinsic signal is seen within the medial meniscus body and approaching the undersurface of the horn body junction (series 4, image 17). Intrinsic signal is also noted within the posterior horn (series 3, image 9) approaching the superior surface. Medial femoral condyle osteochondral fragment is present measuring approximately 1.3 x 1.3 cm (transverse by AP; series 4, image 15 and series 3, image 10). T2 hyperintensity is seen deep to the fragment, at least 75% of the deep surface, with adjacent subcortical sclerosis, T2 hyperintensity and cystic change. ******
> IMPRESSION: Stage III medial femoral condyle OCD (unstable). Free edge Blunting medial meniscus body. Intrinsic signal alteration involving the posterior horn and body with possible communication to the surface. Finding may potentially represent degeneration/fraying versus a subtle tear, particularly of the posterior horn." (Px #3)

Dr. Gegenheimer testified at an evidence deposition prior to trial. Dr. Gegenheimer testified he had been hired by Respondent to perform an examination of Petitioner, and received payment from Respondent for the time he spent performing the evaluation and authoring the report following the evaluation.

Dr. Gegenheimer testified that Petitioner provided subjective complaints of pain and some instability. He provided a history of falling directly onto the anterior aspect of his left knee on July 19, 2016, and repeatedly denied any previous injuries or problems with respect to the left knee. Dr. Gegenheimer performed a physical examination of Petitioner which revealed some pain, but no mechanical symptoms. Dr. Gegenheimer further reviewed several records, including prior treatment in 2013, 2014, and 2015. In conjunction with his review of the records, Dr. Gegenheimer

also reviewed the films of the MRIs performed on July 20, 2015 and September 10, 2016, and found the studies to be identical with respect to both the osteochondral defect and meniscus. Dr. Gegenheimer specifically found that neither study identified loose fragments in terms of the osteochondral injury, and neither study showed a meniscus tear.

Dr. Gegenheimer diagnosed Petitioner with an osteochondral injury that had been existing for several years prior to July 19, 2016. According to Dr. Gegenheimer, the condition was not caused or contributed by the accident of July 19, 2016, as a comparison of the MRI films of July 20, 2015 and September 10, 2016 showed Petitioner's left knee condition to be unchanged. Specifically, Dr. Gegenheimer pointed to Dr. Shah's description of the defect as extending 75% of the deep surface as confirmation that there was not complete detachment of the fragment, which was similar to Dr. Eisenstein's interpretation of the earlier MRI that showed no evidence of any loose fragment. Dr. Gegenheimer agreed that Petitioner would benefit from surgery due to the diagnosed irregularity in his knee, but further stated such surgery would not be for a loose body since the diagnostic films and physical examination did not establish any indication that a loose body was present.

Furthermore, Dr. Gegenheimer found no meniscus injury to have occurred on July 19, 2016. Dr. Gegenheimer again noted the September 10, 2016 MRI to be almost identical to the previous MRI performed on July 20, 2015, and opined that neither MRI showed a tear and that his interpretations are consistent with the radiologists' respective reports.

At trial, Respondent called Michael Gacek to testify. Mr. Gacek testified he worked for Respondent as a Business Development Manager out of Respondent's Oak Brook location, and as part of his job duties, he supervised the light-duty assignment of Petitioner for the period of September 21, 2016 through December 14, 2016. Mr. Gacek testified that on the first day of Petitioner's assignment, Petitioner arrived late as he went to the wrong building and had had to walk two blocks. Mr. Gacek observed that Petitioner did not exhibit any signs of limping or difficulty with respect to his left knee. Mr. Gacek memorialized the incident through a contemporaneous email to the "higher-ups" at Respondent. (Rx #3) Mr. Gacek further testified that he would have to remind Petitioner to perform his work in a seated position as Petitioner would frequently be moving about. In those instances, Mr. Gacek did not notice any limping or favoring of Petitioner's left leg. Mr. Gacek testified specifically to one such incident when Petitioner was observed pacing the hallway for 15 minutes without difficulty. Mr. Gacek again

memorialized the situation with a contemporaneous email, as well as a formal written disciplinary action form. (Rx #4, Rx #5)

Conclusions of Law

F. In support of the Arbitrator's decision regarding whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator concludes as follows:

Respondent has stipulated to the issue of accident.

Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was *a* causative factor in the resulting condition. *Rock Road Construction v. Indus. Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967)

The Arbitrator finds that by a mere preponderance of the weight of the evidence, Petitioner has proven that his current condition of ill-being is causally related to the accident of July 19, 2016.

The Arbitrator notes that nowhere in the records with dates of service on or after July 19, 2016 is there a reference to left knee treatment in, specifically, 2013, 2014, and 2015. Yet, Petitioner testified that he informed the Alexian Brothers physicians and Dr. Tu of the 2015 treatment, but that they did not document it. On August 16, 2016, Petitioner reported to Dr. Wolin that in 2005, he dislocated his left kneecap, received treatment, made a full recovery from this injury, and has had no problems with his knee for the past several years. (Px #3)

To Dr. Gegenheimer, Petitioner provided a history of falling directly onto the anterior aspect of his left knee on July 19, 2016, and repeatedly denied any previous injuries or problems with respect to his left knee.

The Arbitrator finds that Petitioner's credibility has been called into question.

Dr. Gegenheimer testified that after comparing the MRI films of July 20, 2015 and September 10, 2016, he found that there was no loose fragment in the osteochondral lesion. Dr. Gegenheimer opined that the radiologist (Dr. Shah) identified a fragment that was at least 75% of the deep surface and not a complete rupture, which would confirm that there is no loose fragment.

Yet, Dr. Shah identified an osteochondral fragment that measures approximately 1.3 x 1.3 cm.

Dorland's Illustrated Medical Dictionary, 31st Edition, defines "fragment" as "one of the small pieces into which a larger entity has been broken."

Dr. Gegenheimer also testified that on physically examining Petitioner, he found that Petitioner did not exhibit left knee swelling or mechanical symptoms, which would indicate that there was a loose fragment of cartilage was irritating the knee. Dr. Gegenheimer did not observe an antalgic gait.

Mr. Gacek testified that he did not see Petitioner limping or favoring his left leg throughout the three months he performed light-duty work under Mr. Gacek's supervision.

In all of the treating records submitted into evidence, the Arbitrator finds no evidence that before or after the July 19, 2016 accident, Petitioner complained of "locking" of his left knee. Dr. Wolin, in his deposition, testified that he identified an onset of locking in Petitioner's left knee.

Petitioner testified that he has been experiencing "buckling" ever since the July 19, 2016 accident and that he had never experienced "buckling" prior to July 19, 2016, and he therefore knew that this accident was different than the previous "bumps and bruises" he had experienced in the years following the 2005 dislocation of the left knee.

Prior to the accident, there is mention of his left knee "buckling" in the August 27, 2014 record of Little Company of Mary Hospital. (Rx #6)

Since the accident, although there is no specific mention in any of the medical records of the word "buckling," there is mention in the July 26, 2016 Athletico record of Petitioner's knee feeling that "it might give away." (Px #2)

Moreover, since the accident, Petitioner complained to Dr. Wolin of "popping" in the left knee, which is a new complaint. (Px #3)

The MRI of Petitioner's left knee from July 20, 2015 was interpreted as showing "no definitive free fragments related to the deformity" and "[t]here is not a definitive medial or lateral meniscal tear." (Rx #7) Dr. Eisenstein's impression, in part, is as follows: "Osteochondral signal abnormality and deformity involving the medial femoral condyle adjacent to the intercondylar notch with adjacent subchondral cystic changes and osteitis." (Rx #7)

The new injury is evident from the interpretation of Petitioner's left knee MRI following his July 19, 2016 accident. Specifically, Dr. Shah finds that the September 10, 2016 MRI indicates: "Medial femoral condyle osteochondral fragment is present measuring approximately 1.3 x 1.3 cm." (Px #3) Furthermore, Dr. Shah's impression of these images is: "Stage III medial femoral condyle OCD (unstable)." (Px #3)

The Arbitrator notes that Dr. Eisenstein, when interpreting the July 20, 2015 MR images, did *not* find that Petitioner's osteochondral defect was unstable.

Prior to the accident of July 19, 2016, Petitioner last treated for his left knee on July 23, 2015.

Moreover, Petitioner was able to perform labor-intensive duties for Respondent for seven months prior to his accepted work injury, which demonstrates his ability to work full duty until the date of accident.

Following a review of Petitioner's September 10, 2016 MRI, Dr. Wolin, in his October 5, 2016 record, wrote: "I personally reviewed the MRI. There is a medial meniscus tear as well as a transchondral fracture of the medial femoral condyle *** The medial meniscus tear is definitely related to the work injury. The transchondral defect, while possibly present previously, has now become loose and is symptomatic. At a minimum it was aggravated by the work injury." (Px #3)

The Arbitrator notes that it was not until Petitioner's second visit to Dr. Wolin - - after the doctor had reviewed the results of the September 10, 2016 MRI - - that this Dr. Wolin wrote: "He continues to have giving way and mechanical symptoms medially." The Arbitrator finds that this inconsistency is not fatal, given 1) the history of accident that he provided to the two prior physicians and a physical therapist, 2) his complaint to the physical therapist on July 26, 2016 that his knee feels like it might give away, 3) his complaint to Dr. Wolin on August 16, 2016 of "popping" in the left knee, which is a new symptom, 4) the acceptance by Respondent of a work-related injury to Petitioner's left knee, 5) Dr. Shah's interpretation of the September 10, 2016, MR images, and 6) the objective change in the MRIs, as Dr. Wolin opined.

L. In support of the Arbitrator's decision regarding whether Petitioner is owed temporary benefits, the Arbitrator concludes as follows:

The Arbitrator finds Petitioner is entitled to temporary total disability (TTD) payments from August 3, 2016 through September 20, 2016, and from the time modified-duty work was no longer provided, December 15, 2016 through the date of hearing, July 27, 2017, a period of 39-1/7 weeks. On July 21, 2016, Dr. Tu allowed Petitioner to continue his work activities with restrictions, sitting work only. Petitioner testified that he continued to work within those restrictions through August 2, 2016. Dr. Wolin took Petitioner completely off work on August 16, 2016, and then again on October 5, 2016. Per Mr. Gacek's testimony, Respondent provided

modified-duty work from September 21, 2016 through December 14, 2016. Although Petitioner has not yet reached MMI, Petitioner provided evidence of a job search. (Px #6) The parties have stipulated that Petitioner's average weekly wage was $403.77, which results in a TTD rate of $269.18. As such, the Arbitrator finds Petitioner is entitled to TTD benefits from August 3, 2016 through September 20, 2016, and from December 15, 2016 through July 27, 2017.

Respondent earned occasional wages operating a snow plow for Ball Park Four, Ltd. The certified records of Ball Park Four, Ltd. indicate that Petitioner earned a total of $585.00 for work performed, intermittently, between December 11, 2016 and January 13, 2017. (Rx #8)

Evidence that the employee has earned occasional wages does not preclude him from entitlement to temporary total disability benefits. *Zenith v. Indus. Comm'n*, 437 N.E.2d 628, 62 Ill. Dec. 940 (1982)

Respondent is entitled to a credit in the amount of $585.00 for the monies earned by Petitioner at Ball Park Four, Ltd., during a period of temporary total disability.

K. In support of the Arbitrator's decision regarding whether Petitioner is entitled to prospective medical care, the Arbitrator concludes as follows:

The Arbitrator finds that Petitioner is entitled to the prospective surgery that Dr. Wolin has recommended. Dr. Wolin stated that Petitioner will not improve without surgical intervention. (Px #3, p. 6) Dr. Wolin testified that Petitioner had a pre-existing injury to the left knee, but no evidence of loose cartilage. (Px #4, p. 11) In 2016, Petitioner sustained a new injury and this fragment now came loose and caused mechanical symptoms in Petitioner's left knee. Dr. Wolin testified that to a reasonable degree of medical certainty, Petitioner's 2016 injury caused the looseness in his knee. Dr. Wolin based his opinion on Petitioner's history, the physical examination, and the MRI.

Dr. Wolin testified that Petitioner should have an osteochondral plug, and osteochondral graft. (Px #4, pp. 11-12) Such procedure would consist of taking the cartilage and the bone from a donor and placing it into the area of the left knee in which Petitioner has the fracture. (Px #4, p. 12) Dr. Wolin testified that the need for this surgery is related to his 2016 injury.

Recognizing that Petitioner has a long-standing, pre-existing problem with his left knee, Dr. Wolin related the need for surgery now to the existence of an unstable osteochondral fragment from the 2016 fall. (Px #4, p. 12) In addition to any prior pain Petitioner had, Dr. Wolin noted an

onset of locking in the knee that he related to his 2016 fall. As a result of the fall, Petitioner sustained a direct impact to his left medial femoral condyle. Dr. Wolin testified that an injury to this area can cause loosening of a fragment, locking, and therefore, the need for surgery. (Px #4, pp. 12-13)

Based on the foregoing, the Arbitrator finds that the left knee surgery Dr. Wolin has prescribed is necessary, reasonable, and related to the July 19, 2016 accident.

Therefore, the Arbitrator directs Respondent to authorize and pay for such surgery, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Brian T. Cronin
Arbitrator

12-14-2017
Date

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

Chris Fields,

Petitioner,

vs. NO. 16 WC 20120

White County Coal,

Respondent.

18IWCC0534

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, 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 August 16, 2017 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.

18IWCC0534

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $38,500.00. 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 27 2018
SJM/sj
o-7/26/2018
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FIELDS, CHRIS
Employee/Petitioner

Case# **16WC020120**

WHITE COUNTY COAL
Employer/Respondent

18IWCC0534

On 8/16/2017, 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 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0693 FEIRICH MAGER GREEN & RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

18IWCC0534

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chris Fields
Employee/Petitioner

v.

White County Coal
Employer/Respondent

Case # **16** WC **20120**

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

FINDINGS

On **May 31, 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* 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 stipulation of the parties, Petitioner earned **$60,325.25**; the average weekly wage was **$1,244.33.**

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$1,903.66** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$1,903.66.**

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

Respondent shall pay for medical services **as set forth in Petitioner's Exhibit 7** 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 **as set forth in Petitioner's Exhibit 7** 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 bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$829.55**/week for **14 3/7** weeks, **for the timeframe of June 1, 2016 through September 10, 2016,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$1,903.66** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$1,903.66.**

Respondent shall pay Petitioner the sum of **$746.60/week** for a period of **37.95 weeks,** as provided in **Section 8(e)** of the Act, because the injuries sustained caused **15% loss of use of the left arm.**

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. Rose Sullivan
Signature of Arbitrator

8/15/17
Date

ICArbDec p. 2

AUG 16 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chris Fields
Employee/Petitioner

Case # **16** WC **20120**

v.

Consolidated cases: **N/A**

White County Coal
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he started working for Respondent as an underground coal miner on the belt crew in October of 2009. He testified that he is right hand dominant. He testified that his job duties required frequent lifting up to 70 pounds.

Petitioner testified that he started a shift at 10:00 p.m. on Monday, May 30, 2016. He testified that at approximately 1:00 a.m. on May 31, 2016, he was lifting a 60-70 pound belt structure. He described grabbing the belt with both hands and tossing it right to left into a tray when he felt a pop in his left arm. He testified that he felt immediate burning pain in the area of the left bicep. He testified that he felt like he engaged all of the muscles in his arm when he threw the belt. He testified that he completed his shift performing light lifting and reported the accident. He testified that he also told his co-workers about the accident.

Petitioner admitted that he had problems with the left upper arm prior to May 31, 2016. Specifically, he described treatment to the lateral portion of the left elbow and the left tricep. He denied having missed any time from work for his left elbow prior to the accident at issue. He admitted that he lifted weights prior to the work accident, including bench presses and bicep curls.

Petitioner testified that he still experiences some weakness in the left bicep but that the pain has completely resolved. He testified that he is more hesitant performing activities at and away from work because of the weakness.

The Pattiki Mine Accident Investigation Report was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The report referenced a date of accident of May 31, 2016 and indicated that Petitioner lifted a top belt structure, tossed it into a tray and felt pain in the left bicep muscle. The report further identified witnesses of Joe Milligan and Frank Gray. The investigator was noted to have been that of Jay Kittinger and the classification of injury was noted to be that of handling materials. (PX1).

The transcript of the deposition of Dr. James Goris was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Goris testified that he is a board-certified orthopedic surgeon who has a subspecialty in arthroscopy and sports medicine. (PX2).

Dr. Goris testified that he first saw Petitioner on May 31, 2016, at which time he was complaining of pain in his left elbow and noted bruising. It was noted that Petitioner reported that he was having some numbness and tingling, that he was lifting a belt in the coal mine which weighed 70-80 pounds and that

when he lifted it, he felt a pop in his arm with immediate pain. He testified that the pop was in the distal upper arm near the elbow and that Petitioner noted pain in that area. He testified that the physical examination findings were consistent with a distal biceps rupture on the left and that the diagnosis was also that of a distal biceps rupture. He testified that the treatment for an acute distal biceps rupture was surgical repair and that you wanted to get to surgery within the first 7-10 days. He testified that he performed surgery the next day. He testified that it was reasonable to say that at a minimum, Petitioner was on work restrictions following the surgery. He agreed that if his notes reflected that he either had Petitioner off work or on light duty until releasing him full duty on September 11, 2016, it seemed the right timeframe for this type of surgery. (PX2).

Dr. Goris testified that he believed that Petitioner did very well with the surgery and that when he last saw him, he had a little bit of weakness but that his motion was back. He testified that Petitioner was functioning and doing quite well and was ready to return to work. He testified that he last saw Petitioner on August 24, 2016. He testified that the bicep looked like it was adequately repaired and in place and that Petitioner's forearms and biceps were quite muscular so he was still not quite equal to the other side but that it was not surprising having had surgery to repair a detached muscle. He testified that he believed that Petitioner was at maximum medical improvement on that date and that he would not expect him to have any further treatment. (PX2).

Dr. Goris testified that he was given pre-accident medical records for the Raymond Wells Clinic and Petitioner's primary care physician, Dr. Boren, and that Petitioner had some treatment to his left upper arm predating the work accident. He testified that lateral epicondylitis and a distal biceps injury were two completely different injuries. He testified that epicondylitis was not uncommon in people who did weight lifting, especially because of the forceful grip with heavier weights. He testified that the triceps area as referenced in the December 2015 notes was different than the biceps area and that they were two separate and opposing muscle groups. He testified that other than the fact that they both moved the arm, injury to one would not necessarily and would probably exclude injury to the other. (PX2).

Dr. Goris testified that the deltoid area was more of a shoulder rather than elbow muscle. He testified that if someone had a shoulder pad the deltoid would be in that area whereas the bicep was the "Popeye" muscle. He testified that in the pre-accident medical records, there was never a formal diagnosis of a distal bicep tear on the left. (PX2).

When asked whether he had an opinion whether the May 31, 2016 work accident caused, aggravated or contributed in any way to the need for the surgery he performed, Dr. Goris responded that it appeared that prior to the accident there was injury to the upper arm which was diagnosed not as a biceps injury by the treating physician and that when Petitioner came to his office and presented with his history and examination, he had classic findings of a distal biceps rupture. He testified that when he did Petitioner's surgery there were some findings, specifically some scarring along the biceps, which would usually not be consistent with an injury that had just occurred, so he believed that Petitioner had some degree of biceps injury prior to his May 31st injury. He testified that from the information he had, Petitioner was able to perform his job as a coal miner and that the arm functioned, so he thought that Petitioner had at least a partial injury to his distal biceps. He testified that when Petitioner had surgery, he had symptoms consistent with an acute injury to at least some of his distal biceps which underwent repair and that with the bruising, Petitioner had an aggravation of any partial or distal biceps rupture that he had previously had, if he had had one. He testified that he believed that the work accident at least contributed to the need for surgery. (PX2).

On cross examination, Dr. Goris agreed that in his June 29, 2016 note he indicated that he could not with 100% certainty say that Petitioner did not have some pre-existing partial tendon tearing that was not symptomatic prior to his claimed work injury. He agreed that it was his understanding that Petitioner

was asymptomatic prior to his claimed work accident. He further agreed that he based his causation opinion on his understanding that Petitioner was asymptomatic prior to the work accident and that it was fair to say that if Petitioner were, in fact, symptomatic prior to May 31, 2016, it would cause his causation opinion to be called into question. (PX2).

On cross examination, Dr. Goris agreed that he performed surgery the day after Petitioner's alleged work accident. He agreed that in the Operative Report he described an old hematoma around the biceps. He agreed that Petitioner was diagnosed with a left upper hematoma in December of 2015 which was aspirated in January of 2016. He agreed that he noted scarring in the biceps tendon and that he further noted that the biceps tendon did not have normal mobility in the area of scarring. He agreed that it was his opinion that the operative findings including the scarring and the lack of mobility made it unlikely that the majority of the biceps tendon rupture was acute and that he characterized the findings as showing a more subacute-type injury. (PX2).

On cross examination, Dr. Goris testified that he believed that a significant portion of the biceps injury had not happened the day prior to the surgery because of the scarring and hematoma that was there. He testified that at least a substantial portion of the biceps was abnormal, consistent with something that had happened several weeks to several months prior. He testified that it was almost impossible to parcel out which portions were acute and which portions were subacute. He agreed that the history that he had on May 31, 2016 and that the history as he had it on the day of the deposition contained inconsistencies. (PX2).

On cross examination, Dr. Goris testified that he did not know whether he directly questioned Petitioner if there had been any previous injury, but that typically he would. He testified that he was not aware that Petitioner had any history prior to the May 31, 2016 injury when he saw him in the office, diagnosed the biceps tendon rupture and recommended repair. He agreed that there was no mention of Petitioner lifting weights for recreation anywhere in his records, but that from looking at Petitioner he was fairly certain that he did. He testified that a ruptured distal biceps tendon was the kind of injury that could result from something less controlled like something falling or grabbing/jerking on something quickly where the tensile strength of the tendon was exceeded by a force that was beyond normal. (PX2).

On redirect, Dr. Goris testified that the history that Petitioner was lifting 70-80 pounds and felt a pop in his elbow was consistent with there being a biceps tear and that that was one of the factors that made him think it was an acute tear. (PX2).

The physical therapy records from Wabash Christian Therapy & Medical Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent physical therapy for the timeframe of June 29, 2016 through August 22, 2016. The Occupational Therapy Plan of Care dated June 30, 2016 noted that Petitioner underwent distal biceps repair on June 2, 2016 and reported complaints of decreased range of motion, strength and pain, as well as impaired ability to perform work-required duties. It was noted that Petitioner cancelled the appointment on July 6, 2016. At the time of the July 14, 2016 visit, it was noted that Petitioner reported soreness in his elbow after driving his 4-wheeler the day before. At the time of the July 18, 2016 visit, it was noted that Petitioner reported minimal discomfort during active assistance range of motion of the left elbow and that the main concern was weakness. It was noted that Petitioner tolerated the treatment well but muscular fatigue was noted at the end of the session. At the time of the July 25, 2016 visit, it was noted that Petitioner reported no pain. At the time of the August 18, 2016 visit, it was noted that Petitioner rated his pain level at 0-1/10 and reported that he had been lifting 10# free weights at home. The Reassessment noted that due to financial concerns, Petitioner reported the need to return to work, that his range of motion was within normal limits and that his strength was improving. It was noted that Petitioner's elbow pain increased with forced extension. It was noted that it was felt that Petitioner would benefit from work conditioning, but due to

insurance/financial concerns he would be agreeable to pursuing an independent "gradual" work conditioning at a local fitness center. (PX3).

The medical records of Dr. Raymond Wells were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. At the time of the January 20, 2015 visit, it was noted that Petitioner had epicondylitis of the left elbow and recurrent left shoulder pain both from heavy repetitive weight lifting. Petitioner was given an injection into the left deltoid on that date. At the time of the February 4, 2015 visit, it was noted that Petitioner continued to have left elbow pain. Petitioner was given Meloxicam. At the time of the October 6, 2015 visit, it was noted that Petitioner indicated that his elbow tendonitis was relieved with Meloxicam and that he requested a refill. It was noted that Petitioner stated that it was the outer side of his left elbow, that he did not have a brace and that lifting exacerbated the pain. Petitioner was given medications and instructed to ice before and after lifting to reduce inflammation and that he was also instructed to use an elbow brace to the left elbow below the joint. (PX4).

The records of Dr. Wells reflect that Petitioner was seen on December 16, 2015, at which time it was noted that he reported an injury while "lifting." It was noted that Petitioner had a large purple bruise to the medial side of his left arm and that he reported that while bench pressing he mis-racked the bar causing it to drop on his left side. It was noted that Petitioner was able to catch the bar but felt a sharp pain in the tricep area. It was noted that Petitioner's upper arm was swollen but had receded and was now in the elbow and forearm. Petitioner was advised to take Ibuprofen for pain and inflammation and instructed not to lift heavy weights for one week. At the time of the January 7, 2016 visit, 15 cc of fluid was removed from Petitioner's left elbow. At the time of the January 11, 2016 visit, Petitioner was given a Kenalog injection into the left deltoid for complaints of elbow bursitis. At the time of the May 13, 2016 visit, it was noted that Petitioner complained of pain in his left elbow from lifting weights, which was recurring. It was noted that Petitioner requested a steroid shot and that his last injection was in January of 2016. It was noted that Petitioner's pain was lateral on the left elbow. It was also noted that Petitioner was tender above the epicondyle process. Petitioner was given a Kenalog injection and was instructed that use of daily NSAIDs would keep the inflammation down and he could avoid steroid injections. At the time of the May 31, 2016 visit, it was noted that Petitioner stated that he needed a brace for his left elbow. It was noted that Petitioner stated that he hurt it around 1:00 a.m. that morning lifting about 60# while moving a structure at work. It was noted that Petitioner stated that it was painful now but worse when it happened and that he mentioned that he heard a pop during the lifting. It was noted that Petitioner stated that it was the same elbow he had tendonitis in in the past. It was noted that Petitioner had a bruise above and below the left elbow that was dark purple in color and that he was painful to palpation below the elbow medially with some tissue swelling. The assessment was noted to be that of possible ruptured elbow tendon. (PX4).

The medical records of Dr. Phillip Boren were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on December 28, 2015, at which time it was noted that he was weight lifting three weeks prior and had sudden discomfort in the area of the left triceps that was followed by a lot of ecchymosis which had largely subsided. It was noted that Petitioner still had some puffiness above the left elbow. The assessment was that of muscle strain left triceps with residual hematoma. At the time of the January 5, 2016 visit, it was noted that Petitioner's hematoma was unresolved in the distal left upper arm. Petitioner was instructed to return in 48 hours for aspiration. At the time of the January 7, 2016 visit, Petitioner was seen for aspiration of his hematoma just slightly superior to the left elbow. It was noted that Petitioner was very anxious. It was noted that there remained a fluctuant mass in the distal left upper arm. The records reflect that 15 cc of serosanginous fluid was aspirated at that time. (PX5).

The medical records of Gholson Chiropractic were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Arbitrator notes that the vast majority of the records appeared to have been referring to treatment to the lumbar spine. (PX6).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Photograph of Petitioner's Left Arm was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The transcript of the deposition of Dr. Michael Moskal was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Moskal testified that he is an orthopedic surgeon and that the overwhelming majority of the work that he does is shoulder and elbow. He testified that he is board-certified by the American Academy of Orthopedic Surgeons. (RX1).

Dr. Moskal testified that he performed a records review on or about April 5, 2017. He testified that he had opportunity to review several of Petitioner's medical records from prior to his alleged date of accident. He testified that as to the January 20, 2015 note that he reviewed, the noted referenced left elbow epicondylitis and recurrent left shoulder pain as well as heavy, repetitive weight lifting. He testified that the February 4, 2015 note referenced that the elbow pain was persistent and that the October 16, 2015 note referenced pain on the other side of the elbow, which was the of medial epicondylitis, and that a brace was recommended as well as an anti-inflammatory. He testified that as to the December 28, 2015 note, there was documented a purple bruise on the medial side of the arm as well as pain, that the triceps was swollen, that Petitioner had pain in the elbow and forearm and that he had strength of 4/5. He testified that there was also noted a lot of ecchymosis, puffiness above the elbow and a fluctuant area. (RX1).

Dr. Moskal testified that on January 5, 2016, it was documented that Petitioner had a hematoma in the left distal area and that Petitioner returned to Dr. Boren on January 7, 2016 and underwent aspiration of the hematoma. He testified that the records reflected that on January 11, 2016, the assessment was that of bursitis at the elbow. He testified that at the time of the May 13, 2016 visit, elbow pain at the lateral aspect of the elbow was noted and was referenced from lifting weights. He testified that the records revealed that at the May 31, 2016 visit with Dr. Goris, Petitioner reported numbness and tingling occasionally down in the fingers and that he lifted a belt structure, felt a pop in his elbow and had immediate pain. (RX1).

Dr. Moskal testified that given the mechanism of injury documented by Dr. Goris on May 31st, this sort of bruising would not be consistent with a torn biceps tendon occurring the same day given that that dark and purple was not "new blood" which would be present on the day of tearing. He testified that it takes time for blood to get to places and that blood changes color. He testified that purple bruising would be consistent with an incident or injury occurring a couple of weeks prior. He testified that he did not believe that it was reasonable and necessary to perform an emergent surgery for this type of condition. (RX1).

Dr. Moskal testified that in the operative report, the reference to a little bit of old hematoma would not be describing a hematoma occurring hours earlier. He testified that Dr. Goris' note and operative findings were not consistent with a very small, less than 5%, band of tendon which did not appear to be completely ruptured. He testified that the significance of the tendon being somewhat scarred in the area that he was describing and not having normal mobility was that of timing. He testified that if the bicep tendon was in part attached to the bicipital tuberosity, then there was no myostatic contracture, there was no obliteration of the tunnel and it was not visually apparent that the biceps tendon was completely ruptured. (RX1).

Dr. Moskal testified that he did not causally relate Petitioner's condition as described in the operative report to the claimed work accident of May 31, 2016. He testified that it would not be an old hematoma within 24 hours, that the color of dark purple was listed as visualized in the skin which meant there needed to be time to spread and that the attachment site was small compared to the swath of property described above and below the elbow. He also testified that there was scar tissue, which meant that there had to be time for blood to convert to a different tissue and that the myostatic contracture suggested that it was a complete distal biceps rupture and had existed long prior to May 31st. (RX1).

Dr. Moskal testified that the findings as noted in the records of May 13, 2016 when Petitioner was seen with complaints of left elbow pain secondary to lifting weights were consistent with a left elbow injury. He testified that assuming Petitioner's biceps tendon tear occurred on or around May 13, 2016, Petitioner would have been able to continue to work despite a biceps tendon tear. When asked to assume that the May 31, 2016 event actually occurred and whether that event might or could have aggravated any bicep tendon issue in Petitioner's left elbow, Dr. Moskal responded that the overwhelming majority of the data was such that the tendon was completely torn and that one could not tear something more than 100%. He testified that the data was that the biceps tendon and the subsequent changes were not changed by the event. He further testified that he did not relate the need for the surgery performed by Dr. Goris to Petitioner's claimed work accident of May 31, 2016. (RX1).

On cross examination, Dr. Moskal testified that it was possible to have a partial tear of a distal biceps tendon. He testified that it was possible that in a patient with a partial tear of a distal biceps tendon, they could have an event that could cause additional tearing of the same tendon. He testified that it was possible that a patient could have a distal bicep tendon tear that had not yet been treated surgically to not be painful. (RX1).

On cross examination, Dr. Moskal testified that a pop or snap sound was a symptom consistent with a distal biceps tendon tear. He testified that he has patients that say they hear a pop or snap and nothing is torn and that he also has patients that say they hear a pop and snap and have a torn tendon. He testified that he also has patients who do not hear any sounds and have a torn tendon, and that it could be the joint popping or it could be another muscle in the area. (RX1).

On cross examination, Dr. Moskal agreed that the examining individual in both the May 13th and May 31st notes was LKD, ATM. He agreed that in the May 13th note, the examining individual never used any language in the assessment that indicated ruptured or torn biceps or elbow tendon. He agreed that on both occasions in the note of May 13th, the pain was described as on the left lateral elbow. He testified that this was not a different area than the left distal bicep. He further testified that the medical professional did not describe any soft tissue swelling. As to the swelling described on May 31st and whether soft tissue swelling would be consistent with a lifting injury described by Petitioner, Dr. Moskal responded that in the span of a number of hours there would be no swelling in that timeframe. When asked if one believed that the doctor correctly documented findings, he agreed that the soft tissue swelling medially was not present on May 13, 2016 but was present on May 31, 2016. (RX1).

On cross examination, Dr. Moskal agreed that Petitioner acknowledged to Dr. Wells that he had had some tendonitis in the elbow in the past. As to the injections previously performed in the deltoid, Dr. Moskal testified that the deltoid was not the same as the distal bicep. He further testified that the tricep area was not the same as the distal bicep area. (RX1).

On cross examination, Dr. Moskal testified that he did not see a diagnosis of a bicep tendon tear in Petitioner's left arm prior to May 31, 2016. He testified that he did not know either way whether Petitioner had ever received physical therapy for his left upper extremity prior to May 31, 2016. (RX1).

On redirect, Dr. Moskal testified that individuals who have acute distal biceps tendon tears in his experience were exquisitely painful when they tried to do "palm up" or supination, and that "LDK" noted that Petitioner had no pain. (RX1).

The report of Dr. Michael Moskal dated April 5, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The medical records of Dr. Raymond Wells were entered into evidence at the time of arbitration as Respondent's Exhibit 3. While primarily duplicative of those as contained in Petitioner's Exhibit 4, the

records additionally reflect that Petitioner underwent a post-accident urine drug screening test on June 6, 2016. (RX3; PX4).

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on May 31, 2016.

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. Industrial 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. Industrial 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 finds that Petitioner was performing a task incidental to his employment when his injury occurred. The Arbitrator notes that the detail that Petitioner was lifting a 60-70 pound belt structure and was tossing it into a tray when he felt a pop in his left arm is in nearly every history of injury contained in the medical records. The Arbitrator notes that Petitioner reported the accident the same shift and sought treatment the same date. As the Arbitrator finds Petitioner to have been a credible witness at the time of arbitration and notes that he appeared to testify in a forthright manner, 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 May 31, 2016.

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 the undisputed facts demonstrate that Petitioner was working full duty prior to this accidental injury, and that Petitioner's testimony was unrefuted as to his job duties requiring him to perform frequent lifting up to 70 pounds. Petitioner testified that although he had some left elbow complaints prior to the accident, the medical evidence reflects that at no time prior to the date of accident had Petitioner sought any treatment for a distal bicep tendon tear prior to May 31, 2016. It is evident to the Arbitrator that, while Petitioner did suffer from a pre-existing condition with respect to his left upper extremity, the work accident of May 31, 2016 aggravated and/or accelerated his condition of ill-being.

While Dr. Goris' Operative Report suggests that a substantial portion of the distal biceps appears to have been ruptured prior to May 31, 2016, the evidence reflects that it only became clearly apparent and sufficiently symptomatic to require a surgical referral as a result of the May 31, 2016 accident. (PX2). Furthermore, Petitioner's testimony that his problems prior to May 31, 2016 were for the lateral left elbow and left triceps is supported by the medical records. Dr. Boren only diagnosed a triceps injury. Nurse Russell only diagnosed elbow tendonitis and a triceps injury. (PX5). While it is certainly possible that some of Petitioner's pre-accident pain was coming from the distal biceps, the evidence reflects that it apparently did not impact his ability to work, lift weights. The evidence also reflects that Petitioner was never given notice by any medical provider of a biceps tear. Furthermore, there is no evidence that any left arm issues prior to May 31, 2016, prevented Petitioner from working a job that required frequent heavy lifting, nor did the left arm significantly impede his weightlifting outside of work. That said, the Arbitrator finds that Petitioner proved the May 31, 2016 work accident was a contributing factor in the need for the biceps tendon surgery.

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 May 31, 2016.

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 May 31, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 7, 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 June 1, 2016 through September 10, 2016. (AX1).

The Arbitrator notes that the evidence reflects that Dr. Goris either had Petitioner off work or on light duty until releasing him full duty on September 11, 2016 and no evidence was offered by Respondent at the time of arbitration suggesting otherwise. As a result thereof, the Arbitrator finds that Petitioner was temporarily and totally disabled for the timeframe of June 1, 2016 through September 10, 2016, a total of 14 3/7 weeks.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 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. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was admitted into evidence. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that the record reveals that Petitioner worked as an underground coal miner prior to his injury and that he was released to return to work without restrictions following the completion of his treatment. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 41 years old on his date of accident. Given the relatively younger age of Petitioner and the fact that his treating physician, Dr. Goris, gave him a full duty/no restriction release, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes there was no direct evidence of reduced earning capacity contained in the record. As such, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he still experiences some weakness in the left bicep but that the pain has completely resolved. He testified that he is more hesitant performing activities at and away from work because of the weakness. Dr. Goris testified that he believed that Petitioner did very well with the surgery and that when he last saw him, he had a little bit of weakness but his motion was back. He testified that Petitioner was functioning and doing quite well and was ready to return to work. He testified that he last saw Petitioner on August 24, 2016. He testified that the bicep looked like it was adequately repaired and in place and that Petitioner's forearms and biceps were quite muscular so he was still not quite equal to the other side but that it was not surprising having had surgery to repair a detached muscle. (PX2). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were corroborated by the testimony of his treating physician, Dr. Goris. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and 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** 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

Shannon Schneider,

Petitioner,

vs.

No. 16 WC 27080

18IWCC0535

Universal Protection Service,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, benefit rates and temporary disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner's application for adjustment of claim alleges that on July 30, 2016, Petitioner sustained accidental injuries to the left knee and leg when she tripped over an area rug. The ensuing section 19(b) hearing focused on Petitioner's lumbar spine condition. The Arbitrator found Petitioner's lumbar spine condition to be causally connected to the accident. For the reasons that follow, the Commission disagrees that Petitioner proved her lumbar spine condition is causally connected to the accident.

Petitioner, a security officer, testified that she began working for Respondent in May of 2016. Prior to working for Respondent, Petitioner worked as an emergency medical technician

for 25 years. Regarding her earnings from Respondent, Petitioner testified the first two weeks was paid training, during which she worked less than full-time hours. After two weeks of training, Petitioner worked 40 hours a week, plus non-mandatory overtime.

On July 30, 2016, while working the night shift, Petitioner sustained a work accident, which is not in dispute. Petitioner described the accident as follows: "I was sitting at a desk. I had to go outside. I pushed the desk chair back and got up out of the chair, walked outside. When I came back in, I tripped over an area rug. I'm assuming I rolled it with the chair, I'm not sure, but I tripped over the area rug and fell into a chair." Petitioner stated she "caught" herself on the chair and did not fall to the floor.

Petitioner reported the accident and was sent for treatment to St. Louis Urgent Care, where she complained of pain in the left leg from just above her knee to just below the knee. Petitioner treated at St. Louis Urgent Care for some time and underwent some physical therapy, which she stated did not help. Petitioner's attorney referred her to Multicare Specialists, whose staff in turn referred her to Dr. George Paletta. Dr. Paletta obtained imaging studies, which did not reveal any pathology in the left knee or leg. Petitioner testified that she continued to have problems with her left leg and eventually developed low back pain. The staff at Multicare Specialists referred Petitioner to Dr. Matthew Gornet, who initially prescribed conservative treatment and subsequently recommended surgery. Petitioner would like to proceed with the surgery, describing her current condition as follows: "Constant low back pain, still having a lot of pain in my left leg, can't sit for a long time, can't stand for a long time, can't lift anything. I don't drive just because quick reactions hurt me, cause me pain." Petitioner stated she needs help with housekeeping and caring for her three-year-old grandson, who lives with her. Petitioner denied prior problems with her back or left leg.

The medical records in evidence show that on July 31, 2016, a triage nurse at St. Louis Urgent Care noted the following history and complaints: "Patient indicates to have tripped over an area rug at work, twisted (L) leg, swelling, numbness, tingling, *** feels like a knot on back of leg, and pain level 7/10." Family Nurse Practitioner Angela Jones noted the following history: "I was at work and I tripped over an area rug, I lost my balance and twisted my left leg, *** and since then I have had increasing pain and swelling in my left knee." FNP Jones noted a previous injury to the left leg: "3 years ago she was in a motorcycle accident, she was sitting on the bike and it fell over and she rolled down a hill and fractured her lower leg." On physical examination, Petitioner had pain in the left knee with varus and valgus stress, and tenderness to palpation. X-ray of the left leg showed no abnormalities. FNP Jones wrapped the knee in an Ace bandage, prescribed medication, and released Petitioner to return to work on light duty. Petitioner testified that Respondent did not have any light duty work for her.

The medical records further show that on August 3, 2016, Petitioner followed up at St. Louis Urgent Care, complaining of persistent pain and swelling. FNP Kayla Krueger noted: "[P]ain is now extending down to mid-calf; pt states 'It feels like a charlie-horse.' She states this is a new symptom." Petitioner also reported numbness in her left foot when it is not elevated.

She also reported buying and wearing a knee brace. On physical examination, Petitioner complained of tenderness to palpation of the left knee and calf. FNP Krueger prescribed physical therapy and kept Petitioner on light duty.

On August 8, 2016, Petitioner complained she was "having restless nights and left leg goes to sleep sometimes." She localized the pain to the posterior and lateral knee. She also complained of tenderness and soreness in the lateral thigh. FNP Rachael Myers noted: "Pt. states her symptoms are slightly worse. Pt. states she is feeling more pain on the lateral aspect of her left leg that goes up a bit above her knee. Pt. states she is feeling more aching/pulling behind her left knee. Pt. states every once in a while from the knee down to her left foot goes to sleep. Pt. states she occasionally also has muscle spasms of her left lateral knee/lateral thigh area that comes and goes throughout the day, about 3-4 times, lasting a few seconds." Petitioner's restrictions were modified.

On August 15, 2016, Petitioner followed up, complaining of stiffness behind the left knee and a "squeezing pain" in the lateral knee and thigh. FNP Myers noted: "Pt. states her symptoms are slightly better. Pt. states the radiation of pain that was going up her left lateral leg has diminished and now the pain only radiates to the left knee area and no longer goes up her left thigh area." Petitioner reported the spasms went away. However, she still had the falling asleep sensation from the left knee down to the ankle "mostly when she is in a sitting position, pt. states this goes away once she stands up."

On August 22, 2016, Petitioner followed up, complaining of popping and throbbing pain in the knee, with the pain radiating up and down the leg and difficulty walking. She complained she was not getting any better. Petitioner was referred to physical therapy at Athletico and kept on restricted duty.

Physical therapy records from ProRehab/Athletico show that on August 22, 2016, Petitioner attended an initial physical therapy evaluation for left knee pain. The physical therapist noted the following history: "[The pain] started on July 30th when she was at work and tripped over an area rug. She lost her balance, stumbled but did not fall. She felt a sharp twinge in the knee but was able to weight bear. It began to swell over the next few hours." Petitioner complained of "constant pain in her Left lateral and posterior lateral knee. Reports her knee has 'pain with giving way.' Swelling still occurs when on her feet a lot. Reports popping/grinding in the knee. Denies groin or foot pain. States her back has been sore but she associates this to her limping." After the initial evaluation, Petitioner cancelled her physical therapy appointments.

On August 24, 2016, Petitioner followed up at St. Louis Urgent Care, complaining of worsening symptoms since the physical therapy two days earlier, describing the pain as "almost debilitating." She complained of symptoms from the knee down and radiating slightly up the thigh area. FNP Jones put physical therapy on hold and requested authorization for an MRI. Petitioner was kept on restricted duty.

On August 29, 2016, Petitioner complained of throbbing pain and feeling "like the side of her knee is going to pop out" when she stands up. FNP Myers further noted: "Pt. states her symptoms are a little better. Pt. states 'I don't know what to do anymore it's been like a month now. The only thing I can say is that staying off of it completely seems to help a little bit.' Pt. states she is unable to work at all because now she is on crutches." FNP Myers noted that Petitioner underwent an MRI earlier that day and they were awaiting the results. Petitioner's restrictions were modified to no weightbearing on the left leg and to use crutches.

An MRI of the left knee with and without contrast performed August 29, 2016, showed a small joint effusion and mild chondromalacia, and no other pathology.

On August 30, 2016, Petitioner consulted Chiropractor Mark Eavenson at Multicare Specialists, who noted the following history: "The patient reports that on July 30, 2016 she tripped over an area rug and tweaked/twisted her left knee. She did not fall to the ground." Petitioner complained of significant pain in the knee. Dr. M. Eavenson noted: "She is on crutches and in a left knee brace, why I do not know." Physical examination was notable for "[t]he distal one-third of the IT band [being] very sensitive to palpation, even superficial palpation." Petitioner also complained of sharp pain with flexion of the knee. Dr. M. Eavenson reviewed the MRI report and diagnosed a "[l]eft knee sprain/strain with left IT band strain." He discontinued the crutches and the brace, prescribed physical therapy, referred Petitioner to Dr. Paletta, and took her off work.

The medical records from Dr. Paletta at the Orthopedic Center of St. Louis show that on August 31, 2016, Petitioner presented with a chief complaint of left distal thigh pain, reporting catching her left foot on an area rug and twisting the left knee, feeling a pulling sensation behind the knee. Petitioner also gave a history of tibial fracture three years earlier, but stated she had recovered well from the fracture. Petitioner complained of pain "mainly along the lateral aspect of the distal thigh in the region of the iliotibial band about 6 to 8 inches above the joint line." She also complained of pain in the posterior aspect of the knee and a little pain in the posterior aspect of the calf. "She denies any radiating pain or associated numbness, tingling or paresthesias." Physical examination of the left knee was unremarkable, with the exception of subjective complaints of pain and tenderness, as well as pain limiting the range of motion. "However she is able to walk down the hall normally with no limp and achieves a full knee extension during the single leg stance of gait." X-rays performed in the office were unremarkable. Dr. Paletta reviewed the MRI, agreeing with the radiologist's reading. Because the MRI did not include the area of maximum tenderness in the distal thigh, Dr. Paletta ordered an MRI of the distal thigh. An MRI of the left femur performed September 12, 2016, was interpreted as negative by the radiologist. On September 14, 2016, Dr. Paletta reviewed the MRI of the left femur, finding it entirely normal. In sum, Dr. Paletta found the MRIs showed "no structural abnormality and offer no explanation for the patient's complaints of pain. Based on these findings there does not appear to be an orthopedic explanation for her complaints of ongoing pain. As such, there is nothing else to offer her." Dr. Paletta referred Petitioner back to

Multicare Specialists, opining that Petitioner "requires no restrictions or limitations on activities."

On September 19, 2016, Petitioner followed up at Multicare Specialists, continuing to complain of left knee pain. "She states that the majority of the pain is along the lateral portion of her knee." On physical examination, there was "[m]oderate palpable tenderness along the distal IT band as well as the lateral joint line of the knee." Chiropractor Jonathon Brooks instructed Petitioner to continue physical therapy and released her to return to work on sedentary duty. During the next several follow-up visits, Petitioner continued to complain of significant pain along the lateral knee into the IT band, followed by reports of gradual improvement. On October 4, 2016, Chiropractor Ashley Eavenson noted complaints of pain "in the outside of [the] thigh/IT band." However, Petitioner also reported "she felt better than she had in months." On October 6, 2016, Petitioner reported to Chiropractor Brooks her pain was "primarily along the lateral portion of her knee."

On October 10, 2016, Petitioner reported to Dr. A. Eavenson that she "noticed an increase of pain over the weekend that went distal to her knee. She describes paresthesia-type symptoms." On physical examination, Petitioner had "sensory loss in the left lower extremity compared to the right. Mild weakness in the left lower extremity compared to the right. Positive straight leg raise on the left. Negative on the right. Left knee exam is unremarkable, although still tenderness at the distal IT band. Weakness with hip abduction is also noted." Chiropractor A. Eavenson thought Petitioner's symptoms could be coming from the lumbar spine and ordered lumbar x-rays and an MRI, stating: "This also seems causally related to her initial injury."

A lumbar MRI performed October 12, 2016, was interpreted by the radiologist as showing: "1. Right sided rotational anterolisthesis at L4-5 measuring up to 4-4.5 mm with right sided erosive facet arthropathy, bilateral ligamentum flavum hypertrophy and a right lateral recess epicenter annular tear and protrusion resulting in mild right greater than left foraminal stenoses, but no central canal stenosis. 2. L2-3 disc and foraminal height loss with annular disc bulge resulting in mild bilateral foraminal stenoses, but no central canal stenosis."

On October 13, 2016, Chiropractor A. Eavenson noted: "[The patient] states that she had to have help getting out of the MRI yesterday because she felt a numbness sensation from her waist down to the left lower extremity." Dr. A. Eavenson reviewed the MRI report and diagnosed a lumbar disc protrusion with left lower extremity radiculitis. Petitioner's physical therapy/chiropractic treatment was changed to address her lumbar disc herniation. Dr. A. Eavenson also referred Petitioner to Dr. Gornet.

Petitioner testified that on October 19, 2016, she returned to her job with Respondent full duty.

On October 20, 2016, Petitioner reported to Dr. A. Eavenson that "her lower back is sore, however, she no longer has pain distal to her knee." Similarly, on October 25, 2016, Petitioner

"reports only tiny bit of soreness over the IT band today. She states it is sensitive to touch. She states that prior to today she had five days of relief in her leg pain. She was very pleased, however, she has had an increase of her lower back pain. She states doctor actually 'my back is killing me.' " The same day, the physical therapist noted: "Patient states her low back has been really sore these past few days at work with increase[d] pain down both legs. Pt. states she remains very concerned there is more wrong with her." On October 26, 2016, Petitioner reported to Dr. A. Eavenson "she no longer has pain in her leg. She states her lower back is very sore." On October 27, 2016, Petitioner complained to Dr. A. Eavenson of "a lot of soreness over the thoracolumbar junction." On October 31, 2016, Petitioner reported to Dr. A. Eavenson she was doing much better and "[s]he no longer has had pain in her leg for now almost two weeks." On November 3, 2016, Petitioner reported to Dr. A. Eavenson "her lower back is doing much better. She denies any pain into her left lower extremity today." Dr. Eavenson charted Petitioner "is doing great."

On November 7, 2016, Petitioner reported to Dr. Brooks "[s]he has some tightness throughout the upper lumbar spine over the weekend and into today, however, she did not have any radicular symptoms." On November 8, 2016, Petitioner reported to Dr. Brooks "[s]he had an increase in her back pain and states that today it is a 5/10." On November 14, 2016, Petitioner reported to Dr. M. Eavenson "she is having increased pain in the lower back as well as the left ankle." The same day, the physical therapist noted: "Patient states over the weekend her left [leg] 'gave out on her' causing her to twist her left ankle falling to the ground. Pt. states she is unsure why her leg did this. Pt. states she has had increased low back, left ankle and left knee pain since this time." On November 15, 2016, Dr. A. Eavenson noted: "She still having some pain into her ankle. Her lower back is better overall." On November 17, 2016, Dr. A. Eavenson noted: "She reports her lower back is much better. She denies any pain in her left leg today." The same day, the physical therapist noted: "Patient states her left ankle cont. to hurt and her lower back has been really bothering her. Pt. states she has pain still in her lower back that does not seem to be improving."

On November 19, 2016, Petitioner consulted Dr. Gornet at the Orthopedic Center of St. Louis. Dr. Gornet noted: "Her main complaint is low back pain to both sides, radiating up to just below her shoulder blades and then left buttock and hip pain with pain down her left lateral thigh to her knee." Petitioner attributed her back pain to the work accident on July 30, 2016. "She states that her left leg was really the main pain throughout. Her low back pain developed slowly over the next several months, but was not present immediately." Petitioner reported she was receiving physical therapy for her low back and working full duty. "She does not recall any previous problems of significance with her leg or low back." X-rays performed in the office showed possible facet arthropathy on the right at L4-L5. Dr. Gornet interpreted the MRI from October 12, 2016, as follows: "[The study] reveals an obvious central disc herniation slightly more to the left at L4-5 with an annular tear present there. This correlates best with her symptoms. She also has some lateral recess stenosis at L4-5 on the left and facet arthropathy at L4-5 on the right." Dr. Gornet opined Petitioner "may have aggravated her underlying condition of stenosis as well as producing a new disc injury. I have discussed with her that lateral thigh

pain in our world is generally associated with the L5 nerve root and certainly her subjective complaints correlate with her objective abnormalities on MRI scan as well as her physical examination." Dr. Gornet further stated: "Based on the information I have, I do believe the patient's current symptoms in her left leg are causally connected to her work injury and I believe her initial injury was probably to her low back with referred pain in her left lateral thigh. This is especially true given the fact that she had these symptoms with a completely negative workup of her thigh and knee." Dr. Gornet referred Petitioner to Dr. Helen Blake for steroid injections and facet rhizotomies. He kept Petitioner on full duty.

On January 30, 2017, Petitioner followed up with Dr. Gornet after undergoing steroid injections and radiofrequency ablations in December of 2016 and January of 2017. She complained of "increasing pain in her low back, both sides, particularly the left buttock, left hip and lateral thigh." Dr. Gornet revised his diagnosis to "a disc injury at L4-5" and recommended a discogram at L4-L5 and L5-S1, as well as an MRI spectroscopy from L2 to S1. Regarding Petitioner's work status, Dr. Gornet stated: "I have directly asked her whether her symptoms are tolerable if I place permanent restrictions, but at this point, she has failed conservative measures and she still feels her pain is intolerable for a reasonable quality of life." Nonetheless, Dr. Gornet kept Petitioner on full duty.

On February 21, 2017, Dr. Gornet performed a discogram, x-rays and a CT scan. Dr. Gornet assessed: "Non-provocative discs at L5-S1. Provocative disc at L4-5 with concordant pain and posterior annular tear." The x-ray report notes "[a]bnormal disc pathology at L4-5 with posterior annular tear." Post-discogram CT scan was interpreted by the radiologist as showing: "1. Right sided annular tear with broad-based herniation at L4-5 on the right side with associated right facet arthropathy, resulting in advanced right foraminal stenosis. 2. Intact annulus at L5-S1."

On March 2, 2017, Petitioner followed up. "She continues to have low back pain to both sides, particularly the left side and left buttock and thigh." MRI spectroscopy revealed "no significant painful chemicals at L4-5. She has increased chemicals at L5-S1 of 6.28." Dr. Gornet charted that a discogram revealed "an obvious central posterior annular tear with 8 on a scale of 10 pain" at L4-L5. Post-discogram CT scan showed "fairly significant facet arthropathy, right greater than left at L4-5. Again, there is an obvious central annular tear present there. L5-S1 appears to be fairly normal." Dr. Gornet recommended a spinal fusion at L4-L5 with a right laminotomy at L5-S1, and kept Petitioner on full duty.

On March 16, 2017, Petitioner followed up, reporting the pain increased after the discogram, but was now returning to baseline. Dr. Gornet took Petitioner off work because "[s]he continues to have pain, which affects her significantly."

On May 18, 2017, Petitioner continued to complain of pain mainly in her left buttock, left hip and left lateral thigh. In anticipation of an upcoming section 12 examination by Dr. Andrew Zelby, Dr. Gornet stated: "It is important to note again that she does not recall any previous

problems of significance with her low back or leg and again while we believe that she may have had some level of facet arthropathy in the past, there is no indication that she was symptomatic and therefore, her underlying condition was fairly good. We have discussed how a fall like this could easily aggravate this underlying condition as well as cause a disc injury." Dr. Gornet kept Petitioner off work.

On September 5, 2017, Petitioner was concerned about the difference between Dr. Gornet's and Dr. Zelby's opinions. Dr. Gornet "explained to her that the iliotibial thigh pain that she described and was well-presented in all of the notes including Dr. Zelby's IME is actually referred pain from her spine. The L4-5 level generally refers into the hip and the lateral thigh and I believe that [the patient] was probably misdiagnosed initially. This became clear over time, as any symptoms in her knee resolved and her lateral thigh pain continued to the point that the chiropractor as well as Dr. Paletta's notes clearly indicate more of a radicular pattern. *** I explained to [the patient] that this type of pain easily is related to nerve root irritation. I discussed with her that in my opinion Dr. Zelby essentially misrepresents my note. I explained to her that her tear in her disc is central and I showed her image #67 of 98 on series 6 essentially showing that while it does propagate slightly to the right, there is also strong suggestion that it is directly central." Petitioner "seemed reassured and felt that a lot of the things that were placed in Dr. Zelby's report were inaccurate." Dr. Gornet also reassured Petitioner that he never detected any Waddell signs. Dr. Gornet continued to recommend surgery and kept Petitioner off work.

Dr. Gornet, a spine surgeon, testified by evidence deposition on August 3, 2017. Dr. Gornet provided the following causation opinion: "It's my opinion that [the patient's] subjective complaints early on, a portion of those subjective complaints *** particularly radiating into what they describe the IT band was associated with a spinal injury. That's why their treatment in that particular area was not successful because it wasn't really coming from the IT band." In response to Dr. Zelby's statement that Petitioner should have had an immediate onset of back pain, Dr. Gornet stated: "[L]ow back pain presents and low back injury presents in many different fashions. That's why we have what's called referred pain, referred pain into the buttocks, the hips, the legs. Oftentimes patients have very little low back pain after an injury. Back pain increases over time because it is an inflammatory response. *** [S]he had some documented subjective complaints into her leg that are consistent with a spinal problem independent of low back pain, and that spinal problem, I believe, is clearly documented in the initial physical therapy notes early on, and I agree that the mention of low back pain did not come until later on, but the subjective complaints in her leg are consistent with a spinal problem from the very beginning."

Dr. Gornet was asked to comment on Petitioner's right-sided MRI pathology vs. her left-sided symptoms. Dr. Gornet stated: "[F]irst, her pathology—she has two sets of pathology or three actually we discussed and so Dr. Zelby is, I believe, trying to take one aspect of that pathology and say it's not consistent. The reality is this is a woman who has some facet arthropathy. It is more on the right side and that is preexisting. She has stenosis which is bilateral in nature which we also believe was aggravated and that could easily cause her left-sided

pathology. Finally, she has an annular tear that approaches from the left side and moves directly central. It is not on the right side and that is well illustrated in the CT-discogram Image Number 25 of 40 where the tear approaches from left side to center and never crosses over, so I believe her left-sided symptoms are actually coming from her disc injury where her initial right-sided symptoms were coming more from her facet irritation."

Dr. Gornet summarized his causation opinion as follows: "[The patient] had preexisting facet arthropathy, mild stenosis and disc degeneration. I believe that the accident caused a new disc injury. It's clearly seen on the MRI. It's identified by the CT-discogram as a tear coming from the left side to the center. I believe it aggravated her underlying facet condition and stenosis."

On cross-examination, Dr. Gornet maintained that Petitioner was initially misdiagnosed. When questioned about the pathology at L4-L5, Dr. Gornet characterized it as: "[C]entral disc herniation, annular tear;" "more a tear in the disc and less of nerve compression. There's not a lot of nerve compression from the herniation, so I think it's more an inflammatory change from the tear itself;" and "[t]he herniation is directly central and I believe slightly more to the right side." Dr. Gornet explained the leg symptoms as "a combination of some stenosis. * * * [I]t is a combination of her disc injury and the inflammatory response. We know that there are acidic chemicals in the disc itself that when they leak out through the annular tear cause structural pain, they cause referred pain often in the hip and lateral thigh area, and so in that particular situation I think that is probably the main source."

Dr. Gornet was asked to comment on the radiologist's interpretation of the MRI from October 12, 2016, as showing pathology on the right side. Dr. Gornet responded: "I believe that there is a central herniation that goes to both sides. The radiologist even mentions some left foraminal stenosis present, but I believe the herniation portion is slightly more to the right side, yes." The exchange continued:

> "Q. So we're really looking, in terms of left side pathologies or abnormalities, explaining left side complaints, at more of the facet involvement?
>
> A. Well, I think she's got some stenosis there with some facet changes on the left, but again if you saw the CT-discogram and the tear going from left to right, you can clearly see the left-sided pathology moving to the center, so the tear actually goes completely from the left side all the way to the center. It doesn't come from the right side. *** [F]or whatever reason it's how her disc tore and that's where she feels it more, but it's clearly more on the left side objectively even though the MRI shows—again doesn't show the tear as well, but it shows the herniation central, both sides, more to the right."

Lastly, Dr. Gornet testified that he took Petitioner off work completely after multiple phone calls from Petitioner that she was getting worse.

Respondent's section 12 examiner, Dr. Zelby, testified by evidence deposition on October 25, 2017. Dr. Zelby, a neurosurgeon, testified that he examined Petitioner on June 7, 2017. Dr. Zelby noted the following mechanism of injury: "[The claimant] was walking without carrying anything, and tripped on an area rug. She went forward and twisted, catching herself on a desk chair, without falling to the ground. She said that she felt pain along the outside of the left knee from a little above the knee joint to a little below the knee joint; she did not have any low back pain." Petitioner reported the pain in the knee progressively worsened, and "about two to three weeks after her injury, she felt the pain starting to go up the outside of the left thigh to the hip, and that's when her low back pain started." Petitioner complained to Dr. Zelby of constant low back pain, as well as "pain in the left lower extremity that was circumferential in the entire left lower extremity." Petitioner stated the pain made her leg feel like the entire leg was being squeezed. She also complained of intermittent, daily numbness in the entire leg. "[The claimant] felt that she was so restricted by her pain that she did not know what activities might make her symptoms worse, because she said she could not do anything. She had found nothing that gave her relief; she was able to drive a car, she was able to put on her shoes and socks, reported no prior episodes of those or any similar type of symptoms."

Dr. Zelby's physical examination findings were as follows: "Her lumbar spine appeared normal. [The claimant] reported tenderness to palpation in the lower lumbar and left upper gluteal regions, even with nonphysiologic light touch. Range of motion in the lumbar spine showed little decreased movement in every plane; squatting was done a little over halfway down. Lying straight leg raise was positive on the left in the back only, but sitting straight leg raise was negative. There was no sciatic notch tenderness. Toe walking was normal; heel walking was not tested, because [the claimant] said she was not able to heel walk and did not try. Patrick's test was normal, Faber's test was normal, gait was normal, tandem [gait] was normal; posture was normal for her body habitus, there was no paraspinal muscle spasm. Strength in the lower extremities was normal with some encouragement for testing the lower extremity muscle groups; sensation to pin in the lower extremities was diminished in the entire left lower extremity, but otherwise preserved. ¶ Vibratory sensation in the lower extremities was diminished in the entire left lower extremity, but otherwise preserved. Reflexes in the lower extremities were diminished but symmetric laterally; the toes were downgoing bilaterally, clonus was absent. Inconsistent behavioral responses were positive for pain on superficial light touch, pain on simulation, diminished pain on distraction, and nonanatomic sensory changes. Measurement to the extremities demonstrated that they were symmetric and without atrophy ***. The distal pulses were normal and symmetric bilaterally."

Dr. Zelby stated the amount of pressure he applied with palpation testing was minimal, just a light touch. Dr. Zelby thought Petitioner's apparent decreased range of motion was "completely volitional," and not related to any pathology in the spine. Likewise, Dr. Zelby did not think Petitioner's decreased squatting was related to any spinal pathology. The disparity between the lying and the sitting straight leg raise test was an inconsistent finding. There was no physiologic explanation for Petitioner's inability to heel walk. Likewise, "[d]iminished

sensation in an entire limb is typically not neurologic in nature, but certainly having diminished sensation in an entire limb to both pain and vibration is inconsistent with any problem in the nervous system or spine." Dr. Zelby stated the findings on physical examination were all inconsistent.

Dr. Zelby interpreted the MRI from October 12, 2016, as showing the following at L4-L5 and L5-S1: "At L4-5, there was a broad based central and right disc protrusion, and posterior element hypertrophy. There was very mild left and moderate right lateral recess stenosis, and very mild bilateral foraminal stenosis. At L5-S1, there was a broad based bulging disc without stenosis." Dr. Zelby interpreted the post-discogram CT scan as showing: "At L4-5, there were degenerative changes with the paracentral right protrusion and annular tear with extravasation of contrast into the right lateral recess and right foramen. The left lateral recess and foramen were patent. At L5-S1, there were very modest degenerative changes with a generally well maintained nucleus." Dr. Zelby disagreed with Dr. Gornet's interpretation of the MRI that the disc herniation at L4-L5 was slightly more to the left, pointing out the post-discogram CT scan showed a disc herniation to the right and an annular tear with extravasation of contrast also to the right. Dr. Zelby further noted the radiologist's report also indicated the pathology was to the right. On the left at L4-L5 and L5-S1, Dr. Zelby opined "[t]here were very mild degenerative changes, certainly nothing beyond what you would expect for the regular aging of the spine."

Dr. Zelby disagreed that spinal fusion was appropriate, irrespective of the cause, explaining: "With mild degeneration such as [the claimant's], and symptoms that did not correlate with the findings, and by that I mean narrowing to the right side with complaints of left leg pain, there is no reasonable expectation that surgery would provide [the claimant] with any meaningful or sustained relief of her symptoms." Regarding the MRI spectroscopy that Dr. Gornet performed, Dr. Zelby stated: "There is no clinical applicability to the spine that would be anything more than experimental at this point." Regarding the injections and radiofrequency ablations, Dr. Zelby opined: "I think there was no medical basis to pursue any of that treatment because of the disparity between the findings on MRI *** and [the claimant's] symptoms. It's clear that in the absence of right leg pain that the disc abnormality to L4-5, number 1, was not acute; number 2, had nothing to do with her symptoms, and so there is no reason to pursue that treatment."

Dr. Zelby diagnosed degenerative spondylosis without radiculopathy. Dr. Zelby summarized: "[The claimant] had an essentially normal spine exam and neurologic exam, other than the report of diminished sensation that was inconsistent with any spinal condition. She also had four to five positive Waddell signs, with obvious symptom magnification. I felt that her reported persistence and reported severity of symptoms were inconsistent with the objective medical findings and inconsistent with the natural history of her objective medical condition. ¶ Based on the obvious disparity between her subjective complaints and her objective findings, the subjective complaints appeared related to symptom amplification and not to the presence of any infirmity in her spine." Regarding causation, Dr. Zelby opined "there is no identifiable

abnormality related to her spine that could be related to her reported injury." Dr. Zelby concluded that Petitioner could return to work full duty.

On cross-examination, Dr. Zelby testified that he did not document Petitioner crying during his examination. Had Petitioner cried, he would have documented it. Dr. Zelby disagreed with Dr. Gornet's opinion that Petitioner reported referred pain from the spine when she reported left lateral leg pain to Multicare Specialists. Regarding causation, Dr. Zelby noted that Petitioner did not complain of back pain for some time after the accident and stated: "[I]f you want to opine that somebody injured their spine and had an acute annular tear, for example, they would have at least complaints of back pain within 24 to 48 hours, so the absence of those complaints is pretty clear evidence that no injury occurred to the spine at that time."

Petitioner testified that by the time Dr. Zelby's exam was done, she was in tears from the pain. Petitioner stated: "Several of the exams that he did, one of which was squatting, which is a very hard thing for me to do, he literally put his hands on my shoulders and pushed me down. The other one was the standing and bending forward. He literally put his hand in the middle of my back and pushed me forward. Those are things I can't do."

Having carefully considered the evidence before us, the Commission finds that Petitioner failed to prove her lumbar spine condition is causally connected to the work accident. The Commission does not find credible Petitioner's escalating left knee/leg complaints and subsequent escalating back complaints. Petitioner's complaints are also inconsistent from provider to provider. The Commission underscores the history of prior motorcycle accident causing a left leg fracture, noted by the staff at St. Louis Urgent Care and by Dr. Paletta. However, Petitioner denied prior significant injuries during her testimony and to Dr. Gornet. There is also evidence of a subsequent fall the weekend before November 14, 2016, which Petitioner did not disclose to Dr. Gornet. The Commission gives greater weight to the diagnostic and causation opinions of Dr. Zelby, which are consistent with the radiologists' interpretations of the imaging studies. The Commission finds that Petitioner was at maximum medical improvement by September 14, 2016, the date Dr. Paletta found no explanation for her complaints of knee/leg pain. The Commission denies all medical benefits after that date.

Regarding the issues of benefit rates and temporary total disability, the Commission notes the wage statement in evidence shows Petitioner began working for Respondent on May 26, 2016. During the nine weeks preceding the date of accident, Petitioner earned $3,932.02 in regular, non-overtime wages. Petitioner worked 16 hours during her first week and 18 hours during her second week of training. After that, Petitioner worked 40 or more hours a week. Petitioner testified that overtime was not mandatory. Accordingly, the Commission only includes the non-overtime wages in the average weekly wage calculation. Pursuant to section 10 of the Act and *Sylvester v. Industrial Comm'n*, 197 Ill. 2d 225 (2001), the Commission excludes from the calculation the days Petitioner did not work during her training. This method yields an average weekly wage of $491.50 ($3,932.02 / 8). In the request for hearing form, the parties stipulated that Respondent paid $1,757.65 in temporary total disability benefits. The

Commission finds that Respondent is not liable for any further temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is limited to the sum Respondent has paid. No further temporary total disability benefits are awarded.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits after September 14, 2016, including prospective medical care, is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

AUG 27 2018

DATED:
o-08/02/2018
SM/sk
44

Stephen Mathis

Deborah Simpson

David L. Gore

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

SCHNEIDER, SHANNON
Employee/Petitioner

Case# **16WC027080**

UNIVERSAL PROTECTION SERVICES LLC
Employer/Respondent

18IWCC0535

On 3/6/2018, 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 1.83% 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 PC
LESLIE N COLLINS
PO BOX 99
E ALTON, IL 62024

1872 SPIEGEL & CAHILL PC
PHILLIP JOHNSON
15 SPINING WHEEL RD SUITE 107
HINSDALE, IL 60521

☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Shannon Schneider
Employee/Petitioner

v.

Universal Protection Services, LLC
Employer/Respondent

Case # **16** WC **27080**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **January 5, 2018**. 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?

FINDINGS

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

On this date, an employee-employer relationship *did* exist between 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 $4,378.44; the average weekly wage was $523.84.

On the date of accident, Petitioner was 45 years of age, married with 1 children under 18.

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

Respondent shall be given a credit of $1,757.65 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1.757.65.
Respondent shall be given credit for all payments previously made for medical surgical and hospital services.

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

ORDER

SEE ATTACHED

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

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

Edward Lee
Signature of Arbitrator

3/2/18
Date

ICArbDec19(b)

MAR 6 - 2018

The Arbitrator finds the following Facts:

Petitioner, Shannon Schneider, testified she was working for Respondent, Universal Protection Services, on July 30, 2016. Petitioner testified she was working as a security officer. Petitioner testified she began working for Respondent in May of 2016.

Petitioner testified her job duties included signing visitors in and out, and directing them to the correct department. Petitioner testified she has to check vehicles that are coming in and out making sure they are not bringing anything into the plant, and not taking anything out of the plant. Petitioner testified on the evening of July 30, 2016, she was working in the position that was considered to be a dispatcher. Petitioner testified alarms from different areas come into her office and she has to dispatch security officers to the required area. Petitioner testified that on July 30, 2016 she had been outside. Petitioner testified whenever she came back into the office, she tripped over an area rug. Petitioner testified she fell into a chair. She testified she tripped and caught herself on the chair, however, she did not fall completely to the floor. Petitioner testified there were no witnesses to the accident.

Petitioner reported the accident immediately to her supervisor, Russ Meiters. Petitioner testified she received medical treatment at an urgent care facility, she believed to be St. Louis Urgent Care. Petitioner testified on that date, she had left leg pain from just above her knee to just below her knee. Petitioner's leg was wrapped and she was told to stay off of it for a couple of days. Petitioner was told to return to the urgent care facility 3 days later. She received x-rays and was provided with crutches. Petitioner testified she was not able to return to work because she is not allowed to have any medical devices in the plant. Petitioner testified she was referred for physical therapy at ProRehab. Petitioner testified the physical therapy was not helping her.

Petitioner testified she was referred to Multicare Specialists by her attorney. Petitioner was referred to Dr. Paletta to have him look at her knee.

Petitioner saw Dr. Paletta on August 31, 2016. Dr. Paletta noted the history of the accident as provided by Petitioner. He noted she had complaints of left distal thigh pain. She reported the incident as catching her left foot on an area rug and twisting her left knee. Petitioner told Dr. Paletta she felt a pulling sensation behind the knee. When Petitioner saw Dr. Paletta, she complained of pain around the lateral aspect of the distal thigh in the region of the iliotibial band about 6 to 8 inches above the joint line. He also noted complaints in the posterior aspects of the knee. Dr. Paletta examined Petitioner. He noted a normal gate. He noted examination of the left knee revealed no obvious asymmetry, no muscle apathy or deformity. He did not note any soft tissue swelling, and did not note any effusion. He noted tenderness around the iliotibial band about 4 finger widths above the knee joint. He noted some tenderness in the popliteal fossa but did not note a mass. Petitioner complained of pain when trying to fully extend the knee. Dr. Paletta looked at x-rays performed at the Orthopedic Center of St. Louis. The x-rays appeared to be normal. He did note the previous tibial plateau fracture. Dr. Paletta also reviewed the MRI dated August 29, 2016. He noted everything appeared to be intact and normal. He did note the MRI did not include the area of maximum tenderness of the distal thigh as complained by Petitioner. Dr. Paletta recommended that Petitioner undergo an additional MRI of the thigh. He

noted if the MRI was entirely normal, then Petitioner likely did not present with an orthopedic problem. He would then refer her back to Dr. Eavenson for therapy and symptomatic treatment. Petitioner had an MRI performed at BrightWay Imaging on September 12, 2016. Dr. Paletta reviewed the MRI. Dr. Paletta noted the MRI scan was entirely normal. Dr. Paletta referred Petitioner back to Dr. Eavenson for physical therapy and symptomatic treatment.

Petitioner returned to Multicare Specialists to continue therapy. Petitioner was treated for iliotbial band syndrome of the left leg and a sprain of unspecified collateral ligament of the left knee. Petitioner continued to do physical therapy at Multicare Specialists. During the physical therapy treatments, it was noted that Petitioner began experiencing an increased soreness around her lateral IT band. When Petitioner presented for treatment on October 10, 2016 at Multicare Specialists, she complained of left knee pain and left posterior hip pain. The physical examination on that date revealed a sensory loss in the left lower extremity compared to the right. Mild weakness in the left lower extremity was noted compared to the right. There was a positive straight leg raise on the left and a negative on the right. Tenderness along the distal IT band on the left leg was still noted. X-rays were performed on this date that revealed narrowing at L5-S1. An MRI of the lumbar spine was ordered on this date. Dr. Ashley Eavenson noted Petitioner's symptoms could be coming from the lumbar spine, especially symptoms distal to the knee. Dr. Eavenson noted this would be causally related to her injury. She continued the work restrictions. Petitioner returned to Multicare Specialists on October 13, 2016 and she continued to note the left lateral thigh pain. Dr. Eavenson referred Petitioner to Dr. Gornet on this date.

Dr. Gornet first saw Petitioner on November 9, 2016. Petitioner complained of low back pain to both sides radiating just below her left shoulder blade and left buttock, and hip pain with pain down her left lateral thigh to her knee. Dr. Gornet took an accurate history from Petitioner. Petitioner reported to Dr. Gornet that she did not have any history of leg or low back problems. Dr. Gornet reviewed the MRI scan of October 12, 2016. The MRI revealed a central disc herniation slightly more to the left at L4-5 with an annular tear. Dr. Gornet noted that it correlated with Petitioner's symptoms. Dr. Gornet also noted the MRI revealed some lateral recess stenosis at L4-5 on the left, and facet arthropathy at L4-5 on the right. At said visit, Dr. Gornet advised Petitioner that she may have aggravated underlying stenosis, as well as a new disc injury. He discussed that the lateral thigh pain is associated with an L5- nerve route injury and her subjective complaints correlated results on the MRI scan. Dr. Gornet recommended steroid injections at L4-5 and referred her to Dr. Blake for those injections. He also recommended facet rhizotomies at L4-5 and L5-S1. He gave her a prescription for Meloxican. Dr. Gornet was of the opinion that the initial injury was probably to her low back with referred pain into the left lateral thigh. He noted that given the fact she had these symptoms with a completely negative workup of her thigh and knee it was likely related to her back.

Petitioner underwent a steroid injection on the left at L4-5 on December 6, 2016. She then had RFA's on the right on January 10, 2017, and on the left January 17, 2017.

Petitioner returned to see Dr. Gornet on January 30, 2017. He noted increasing pain in the low back. Both sides particularly the left buttock, left hip, and lateral thigh. Upon examination, she had decreased EHL and ankle dorsiflexion at 4-5 on the left. Dr. Gornet again noted the MRI scan revealed what he believed was a central herniation slightly more to the left at L4-5 with an

annular tear present. He also noted he believed there were some facet arthropathy at L4-5 on the left, as well as the right. On that date, Dr. Gornet's working diagnosis was a disc injury at L4-5. Dr. Gornet recommended a discogram at 4-5 and 5-1. He also noted he would like to do an MRI spectroscopy L2-S1. He noted that between the CT scan looking at the facet joints, discogram and MRI spectroscopy, he will be able to see if there is reasonable treatment plan to help the Petitioner. Dr. Gornet noted that Petitioner has failed conservative measures and she still feels the pain was intolerable for a reasonable quality of life. He noted there was an obvious central annular tear. Dr. Gornet noted the best option for Petitioner would be a spinal fusion at L4-5. He noted she was working full duty. He noted that an alternative to surgery would be permanent restrictions. He noted the best option would be a posterior spinal fusion with instrumentation at L4-5 with laminectomy at L5-S1 right. He discussed the issues with Petitioner and noted she would continue to work as before and they would seek approval for surgery.

Petitioner returned to see Dr. Gornet on March 16, 2017. Dr. Gornet noted Petitioner had increased pain after the discogram. Dr. Gornet took x-rays to make sure Petitioner was not developing a loss of disc height. His recommendation on March 16, 2017 was an AP fusion at L4-5. Dr. Gornet noted that if the pain did not die down he would consider a new MRI scan. He noted they continued to seek approval for treatment. Dr. Gornet recommended that Petitioner be taken off work completely at this point. He recommended that Petitioner focus on her weight. He noted her next follow up would be in approximately 2 months or sooner if treatment was approved. Dr. Gornet noted he would consider a CT myleogram once treatment was approved.

Dr. Gornet followed up with Petitioner on May 18, 2017. He noted Petitioner was continuing to slowly lose weight. He continued to hold Petitioner off work on this date. Petitioner followed up with Dr. Gornet on September 5, 2017. Petitioner brought a copy of the Independent Medical Exam performed by Dr. Zelby. He continued to recommend surgical intervention. He continued to hold Petitioner off work.

Petitioner testified she saw Dr. Gornet on December 21, 2017 and he continued to hold her off work and recommended the surgery. Petitioner testified at trial that she is desirous of having the recommended surgery performed by Dr. Gornet.

Petitioner testified that she had an Independent Medical Examination with Dr. Zelby on June 7, 2017. She testified that during the examination she became emotional and started crying due to pain as a result of the examination. Petitioner testified that she recalls the appointment with Dr. Zelby lasting less than 1/2 hour. Dr. Zelby noted a consistent history of the accident as reported by Petitioner. Petitioner advised Dr. Zelby there was no immediate back pain. Petitioner told Dr. Zelby she was experiencing constant low back pain at the time he saw her. Petitioner had complaints of numbness in the left lower extremity which was intermittent but occurred on a daily basis.

Dr. Zelby physically examined Petitioner. He noted tenderness of the lumbar spine and left upper gluteal region. He noted the lying straight leg raise was positive but the sitting straight leg raise was negative. He noted normal strength in the lower extremities. It was Dr. Zelby's opinion that there was symptom amplification during this examination.

Dr. Zelby noted he reviewed the MRI scan of October 12, 2016. In his opinion, there was a mild left and right lateral recess stenosis and very mild bilateral foraminal stenosis. He noted that he reviewed the January 21, 2017 CT scan. Dr. Zelby was of the opinion that there were some degenerative changes at L4-5 with paracentral right disc protrusion and annular tear to the disc of the right lateral recess and right foraminal. Dr. Zelby also noted the study demonstrated modest to degenerative changes at the level of L5-S1. It was Dr. Zelby's opinion that the MRI of October 12, 2016 and CT scan revealed no pathology to justify a spinal fusion irrespective of cause. It was also Dr. Zelby's opinion that Petitioner did not need any sort of back surgery.

Dr. Gornet's evidence deposition was taken on August 3, 2017. Dr. Gornet is a Board Certified Orthopedic Spine Surgeon. Dr. Gornet testified that it was his opinion that Petitioner's initial complaints as set forth in the Multicare Specialists and the Athletico records were all in fact related to her back and not her IT band. Dr. Gornet testified the IT band is the lateral thigh. He testified, "The lateral thigh is often seen in a distribution from the hip to the lateral thigh and even sometimes lower in the leg and usually we see that with L4-5 pathology and so those objective complaints early on are consistent with the pathology we see." (PX 5 at 8) Dr. Gornet testified it was his opinion that Petitioner's subjective complaints early on particularly radiating into what they described the IT band was associated with a spinal injury.

He testified that was a common misconception from physical therapists and again he noted the subjective complaints were consistent with an underlying spinal problem. Dr. Gornet was of the opinion that Petitioner was initially presenting with what is referred to as referred pain. Referred pain into the buttocks, hips and legs. Dr. Gornet testified that often times patients have very little low back pain after an injury. He testified back pain increases over time because it is an inflammatory response.

Dr. Gornet testified Petitioner's subjective complaints into her leg were consistent with a spinal problem independent of low back pain, and that the spinal problem is clearly documented in the initial physical therapy notes early on. He agrees that the mention of low back pain did not come until later on, but the subjective complaints into her leg are consistent with a spinal problem from the very beginning.

Dr. Gornet was asked about Petitioner's symptoms being on the left side but the pathology on the MRI being right sided. Dr. Gornet was asked to explain if there is right sided pathology why are there left sided symptoms? (PX 5 at 13) Dr. Gornet's response was, "Well, first....the reality is this is a woman who has some facet arthropathy. It is more on the right side and that is preexisting. She has stenosis which is bilateral in nature which we also believe was aggravated and that could easily cause her left sided pathology. Finally, she has an annular tear that approaches from the left side and moves directly central. It is not on the right side and that is well illustrated in the CT discogram Image number 25 of 40 where the tear approaches from left side to center and never crosses over, so I believe her left sided symptoms are coming from her disc injury where her initial right sided symptoms were coming more from her facet irritation." (PX 5 at 13,14) (See Dr. Gornet's deposition Petitioner's Exhibit 3)

During Dr. Gornet's deposition, he marked Petitioner's Exhibit 3 left and right and further testified that the tear comes from the center of the disc and angels directly central from

the left side to the center. He noted the tear comes from the left side and believes that is what is responsible for the left side symptoms because the tear originates on the left side. (PX 5 at 14) Dr. Gornet testified that it is a definite tear and explains her objective complaints.

Dr. Gornet testified the result of the MRI spectroscopy which was performed on February 21, 2017 was consistent with Petitioner's symptoms. Dr. Gornet testified the purpose of an MRI spectroscopy is to evaluate the internal chemistry of the disc. He noted it gives a different look at the disc and health than a regular MRI. He testified it helps a doctor understand the adjacent level discs in particular. He testified if a fusion is going to be planned, the health of the adjacent disc is relevant and helps better diagnose and treat a patient. Dr. Gornet testified he decided to take Petitioner off work completely on March 16, 2017 because Petitioner was suffering from significant pain. He noted her pain subjectively was consistent with the studies he reviewed. Dr. Gornet testified he believes patients should not be on narcotics for treatment of structural back pain. He testified keeping her off work was the best option for her from a medical stand point.

Dr. Gornet testified in his opinion, Petitioner had preexisting facet arthropathy, mild stenosis, and disc degeneration. Dr. Gornet testified he believes the accident caused a new disc injury as seen on the MRI. Dr. Gornet further testified it is identified by the CT discogram that a tear is coming from the left side to the center. He testified he believes the accident aggravated the underlying facet conditions and stenosis. Dr. Gornet testified the basis of this opinion is the subjective studies, treating like and similar patients, and Petitioner's objective physical examination. Dr. Gornet testified Petitioner's subjective complaints early on of IT band is consistent with those findings. Dr. Gornet testified the MRI findings together with the other findings all line up to support his opinion. (PX 5 at 20)

Dr. Zelby gave his evidence deposition on October 25, 2017. Dr. Zelby is a board certified neurosurgeon. Dr. Zelby testified there is nothing when you take Petitioner's symptoms, findings on exams, and findings on diagnostic studies, all together for someone to put this information together in a cogent medical way and come up to the conclusion the person needs any kind of back surgery. (RX 1 at 24) Dr. Zelby testified that was his opinion irrespective of causation. It was Dr. Zelby's opinion that there was not reasonable expectation that surgery would provide Petitioner with any meaningful or sustained relief from her symptoms. Dr. Zelby was of the opinion that the disc protrusion on the MRI that was performed on October 12, 2016 revealed a disc protrusion at L4-5 to the right. His opinion differs from Dr. Gornet with regard to where the protrusion actually originates. On page 33 of Dr. Zelby's deposition, he testified that Dr. Gornet's statement there was an obvious central disc herniation slightly more to the left was inconsistent with the MRI. Dr. Zelby testified there was no medical basis to pursue any of the treatment because of the disparity of findings on the MRI and Petitioner's symptoms. He testified it is clear that the absence of right leg pain that the disc abnormality to L4-5 was not acute and had nothing to do with her symptoms so there is no reason to pursue the treatment. Dr. Zelby testified there was mild degenerative changes at L4-5 and L5-S1. Dr. Zelby testified it was his opinion that Petitioner suffered from degenerative spondylosis without radiculpathy. Dr. Zelby testified he believed Petitioner could return to her job without restrictions.

On cross examination, Dr. Zelby testified he could not recall whether Petitioner was crying during the examination. He testified he would have noted this within his report. Dr. Zelby

testified he could not recall whether or not anyone accompanied Petitioner to her examination. Dr. Zelby testified he reviewed the actual CT discogram film and he did not see a tear going from left to right.

Petitioner has the following outstanding bills relating to treatment for her injuries:

Creve Coeur Urgent Care: $2,425.00
CT Partners of Chesterfield: $2,240.00
Premier Anesthesia: $770.00
Dr. Gornet: $12,972.41
St. Louis Spine & Orthopedic Surgery Center: $6,612.00
Orthopedic Ambulatory Surgery Center of Chesterfield: $7,675.03
Pain & Rehab Specialists: $9,627.00
Dr. Paletta: $435.66
Multicare Specialists: $4,175.00

Base on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner's current condition of ill-being is casually related to her work accident of July 30, 2016. Petitioner testified at trial she had no history of back pain prior to this work accident. Dr. Gornet testified it is clearly set forth in the CT discogram that Petitioner sustained an annular tear that begins on the left and goes central to the right. Thus, explaining her left sided buttock, hip, low back and left leg pain. Dr. Gornet's opinion is more credible than that of Dr. Zelby. Dr. Gornet gives a clear explanation of where Petitioner's symptoms are coming from and why.
2. Petitioner's average weekly wage is $523.84 based on the evidence submitted at trial. Petitioner trained for the first two weeks and was paid 34 hours. Her pay for these two weeks total $426.84. Logically, since the total of the two weeks is only 34 hours, they shall be combined to one week, using weeks or parts thereof. Pay periods ending June 16, 2016, June 23, 2016, June 30, 2016, July 7, 2016, and July 14, 2016, her average weekly wage was $528.44 (overtime calculated at straight time), pay period ending July 21, 2016, average weekly wage was $480.40, pay period July 28, 2016, average weekly wage was $631.84. Petitioner's total wages for the time period was $4,378.44. Her average weekly wage, when calculating over time at straight time and counting the first two week's training as one week's wages is $523.84.
3. Respondent is responsible for, and shall pay, the outstanding medical bills relating to Petitioner's work injury pursuant to the fee schedule. Said bills are set forth in Petitioner's Exhibit 10. Respondent shall be given credit for any bills already paid. Said outstanding bills are as follows:

   Creve Coeur Urgent Care: $2,425.00
   CT Partners of Chesterfield: $2,240.00
   Premier Anesthesia: $770.00
   Dr. Gornet: $12,972.41
   St. Louis Spine & Orthopedic Surgery Center: $6,612.00

18IWCC0535

Orthopedic Ambulatory Surgery Center of Chesterfield: $7,675.03
Pain & Rehab Specialists: $9,627.00
Dr. Paletta: $435.66
Multicare Specialists: $4,175.00

4. Respondent shall pay Petitioner TTD benefits for the following periods:

   July 31, 2016 through October 18, 2016 and March 16, 2017 through January 5, 2018, representing 53 3/7 weeks at the rate of $349.23. Respondent shall be given credit for TTD benefits paid in the amount of $1,757.65 representing August 27, 2016 through October 16, 2016, at the rate of $246.17.

5. The treatment recommended by Dr. Gornet is both reasonable and necessary. Respondent shall authorize the treatment as recommended by Dr. Gornet and shall pay the same pursuant to the Fee Schedule.

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

Rodolfo Salas,
Petitioner,
vs.

NO: 12WC 31206

18IWCC0536

Olympic Steel ,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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 October 24, 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 $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 3 1 2018

Charles J DeVriendt

CJD/rlc
o082918
049

Joshua D. Luskin

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SALAS, RODOLFO
Employee/Petitioner

Case# **12WC031206**

OLYMPIC STEEL
Employer/Respondent

18IWCC0536

On 10/24/2016, 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:

0787 MEYERS & FLOWERS LLC
JOHN N HARP III
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT HARRINGTON JR
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rodolfo Salas,
Employee/Petitioner

Case # **12 WC 31206**

V.

Olympic Steel,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 18, 2016 and August 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

FINDINGS

On **August 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 $77,345.32; the average weekly wage was $1,487.41.

On the date of accident, Petitioner was 35 years of age, *married* with 2 dependent children.

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

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

Respondent shall be given a credit of $89,103.09 for TTD, $0 for TPD, $0 for maintenance, and $7,125.52 **PPD advance** for other benefits, for a total credit of $96,228.61.

Respondent is entitled to a credit of $96,228.61 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$283.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$991.61**/week for **89 1/7th** weeks, commencing **August 21, 2012** through **November11, 2012**, and **October 9, 2013** through **May 20, 2014** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **August 21, 2012** through **May 20, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$89,103.09** for TTD and **$7,125.52** for a PPD advance for a total credit of **$96,228.61**.

Respondent shall pay Petitioner permanent partial disability benefits of **$712.55**/week for **100** weeks, because the injuries sustained caused the **20%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Milton Black

Signature of Arbitrator

October 24, 2016

Date

OCT 24 2016

FACTS

It was stipulated that on August 20, 2012, Petitioner was a 35-year-old operations manager for Respondent, Olympic Steel, and that on that date he sustained a back injury in the course of his employment.

Petitioner testified that following the injury, he received treatment the same day at Northwest Community Hospital. X-rays of lumbar spine were negative for fracture and demonstrated mild degenerative disc disease at L4-L5 and L5-S2 (PX 1, p 25). He was diagnosed with lumbosacral strain and contusion. He requested that he follow up with his primary care physician, Carmen Fotso, M.D., at Fox Valley Immediate Care (PX 1, P. 1 and 2).

Petitioner was seen by Dr. Fotso on August 21, 2012 and an MRI of lumbar spine was ordered (PX 2, p4).

On August 22, 2012 Petitioner was seen by Dr. Tom Stanley at Midwest Bone and Joint Institute. Dr. Stanley ordered an MRI of the lumbar spine. On September 21, 2012 Dr. Stanley reviewed the MRI and diagnosed recurrent herniated disc at L4-L5. Dr. Stanley recommended epidural steroid injections (PX 3, p. 3).

On November 2, 2012, Petitioner was examined at the request of Respondent, Dr. Babak Lami, for purposes of a Section 12 independent medical examination. Dr. Lami diagnosed recurrent disc herniation and agreed with the recommendation for epidural steroid injections. Dr. Lami imposed restrictions of lifting 10 to 15 pounds, reviewed Petitioner's job description and found that he could return to work as a manager at that time (Res. Ex. Group 3, p. 6; T55).

Petitioner testified that Respondent accommodated these restrictions and provided modified duty work beginning on November 12, 2012 (T55). He testified that the light duty work involved working at a desk inside his office (T55, 56). He identified Respondent's Exhibit 7A, B, C and D as photographs of his office and desk where he worked from the day he started to work at Olympic Steel (T57). He testified that the office depicted in Respondent's Exhibit 7A, B, C and D was the same office he used for both his regular duty work before the accident date of August 20, 2012, and also when he returned to modified work (T59). On January 22, 2013 Dr. Stanley administered another

injection. On February 8, 2013 Dr. Stanley recommended lumbar fusion at L4-L5. He did not indicate Petitioner could not continue to work modified duty pending the surgery (PX 3, p. 37). Petitioner continued to work in the modified duty position until March 7, 2013. Petitioner left the premises that day and never returned to the modified duty position that was provided by Olympic Steel (T 60, 61).

On June 9, 2013, Petitioner was seen by Dr. Lami for an updated IME to address the prescribed surgery. Dr. Lami found that the recommended L4-L5 decompression and fusion was a reasonable option. On September 16, 2013, Dr. Lami issued an addendum report after reviewing additional medical records pertaining to Petitioner's pre-accident 2011 L5-S1 microdiscectomy. Dr. Lami concluded that his review of these additional records did not change his previous opinions. Dr. Lami found that the recurrent herniation was due to injury of August 20, 2012, and the need for treatment was also related to the August 20, 2012, accident (Res. Group Ex. 3, p. 17). Thereafter Respondent authorized the lumbar fusion, and the procedure was performed by Dr. Stanley on October 9, 2013. Temporary total disability benefits resumed on October 9, 2013 (Arb. Ex. 1).

On January 20, 2014, Petitioner was examined by Dr. Lami at Respondent's request for purposes of updated IME. Dr. Lami recommended one more month of physical therapy and concluded that after that Petitioner could return to his previous job as manager.

Petitioner began physical therapy at Accelerated Rehabilitation Center on March 27, 2014. Respondent disputed the job description that Petitioner provided to AthletiCo Rehabilitation Center and provided the company's job description and physical demand analysis to Petitioner's attorney, with directions to provide same to AthletiCo Rehabilitation Center (Res. Ex. 6, p. 106). Petitioner was discharged from physical therapy on April 15, 2014. Following that discharge from physical therapy, Petitioner did not report to modified work at Olympic Steel. As a result, benefits were not paid after May 20, 2014 (Arb. Ex. 1).

On August 15, 2014, Petitioner underwent a functional capacity evaluation at AthletiCo Rehabilitation Center on a referral from Dr. Stanley. The functional capacity evaluation report states that a functional job description was asked for but not provided by Petitioner's attorney at the time of the evaluation. The report indicates that as such, the job description was based solely on the Dictionary of Occupational Titles and an interview with Petitioner (Pet. Ex. 5, p. 7). The FCE found that Petitioner's pre-injury job was classified as medium physical demand level with carrying, pushing, and pulling requirements of up to 75 pounds occasionally. It found he did not demonstrate this function tolerance. The subpoenaed records for AthletiCo offered by Petitioner do not indicate that AthletiCo was provided the job description or physical demands analysis, which had been provided by Respondent to Petitioner's attorney (PX 5).

On August 22, 2014 Dr. Stanley reviewed the functional capacity evaluation and found that Petitioner was deemed to be qualified for medium duty work which involves occasionally lifting up to 50 pounds for a third of the day, between 10 and 25 pounds for up to two thirds of the day and less than 10 pounds for more than two thirds of the day. Dr. Stanley found Petitioner could do occasional standing for up to one third of the day, walking constantly for greater than two third of the day and sitting for up to one third of the day (PX 3, p. 085). Dr. Stanley's subpoenaed records offered by

Petitioner do not indicate that the doctor was ever provided the formal job description or physical demands analysis provided by Respondent to Petitioner's attorney (PX 3).

On October 6, 2014, Petitioner was examined by Dr. Lami again. The doctor was provided the physical demands analysis (RX 2) for his review. Dr. Lami found Petitioner had reached maximum medical improvement and that he could return to work with permanent restrictions of no lifting more than 20 pounds and no prolonged walking for more than 10 minutes (Res. Group Ex. 3, p. 27). On October 16, 2014, Dr. Lami issued an addendum report stating "assuming that the physical demands analysis for this job was accurate in the FCE report, then in my opinion this was a valid FCE." (Res. Group Ex. 3, p. 28).

On December 22, 2014, Petitioner was examined by Dr. Jeffrey Coe at Respondent's request for purposes of an AMA impairment rating. Dr. Coe concluded that Petitioner had reached maximum medical improvement and that he was no longer regularly followed by a specialist physician for his lower back. Dr. Coe assigned a final impairment rating of 14% loss of use of a person as a whole (Res. Ex. 4, p. 8).

At trial, Petitioner identified a one-page document summarizing a self-directed job search (Pet. Ex. 10). According to this document, the first date that Petitioner applied for any job was October 13, 2014. That was for a position as a Walmart greeter. Petitioner testified that this job would not require him to be on his feet (T65). The next time he applied for any job was October 17, 2014, as a Gander Mountain greeter. He testified that this job did not require him to be on his feet.

Mr. Edward Pagella testified for Petitioner that he was a Vocational Rehabilitation Consultant and that he generated an October 6, 2015, "Employability Study" report at the request of Petitioner's attorney. He testified that he was not provided with any job description in the materials provided to him by Petitioner's attorney. He testified that after reviewing the materials that were provided to him by Petitioner's attorney, he did not himself request a written job description. He testified he did not know what, if any, job description was provided to Dr. Stanley. He testified that it was his understanding that Petitioner had not returned to any work for Respondent since the date of accident. He had no understanding of any modified duty work that was accommodated to the Petitioner by the Respondent (Pet. Ex. 6, p. 20-23).

Petitioner's Exhibit 10 indicates the Petitioner started work as a Durham School Bus Driver driving a 40 foot, 70 passenger, school bus on November 4, 2015 (Pet. Ex. 10 and T. 48). The subpoenaed records from Durham School Services, LP, include an October 13, 2015, medical examination report. Part of that report includes a physical examination conducted by a medical examiner. Section 7, question 11, reads, "Spine, other musculoskeletal." The report documents that there was no limitation of motion and no tenderness at the October 13, 2015 medical examination. (Pet. Ex. 8, p. 25). Petitioner testified that as a school bus driver, he has to drive over bumps and potholes in the road (T 81).

Petitioner testified that his regular duty job as operations manager at Olympic Steel required him to carry customer samples and also help employees load PVC rolls (T67). Petitioner testified that he spent six out of eight hours a day on the floor of the plant (T62).

Sean Heenan was called as a witness by the Respondent. Mr. Heenan testified that he has been employed by Olympic Steel for just over nine years and that for a little over a year he has been the general manager of the Winder, Georgia Olympic Steel location. He testified that prior to that, he was the general manager of the Schaumburg, Illinois, Olympic Steel location and that Petitioner reported directly to him in that capacity (T95). He testified that he oversaw Petitioner in his regular duty position at Olympic Steel before the August 20, 2012, accident and that he was also his supervisor during the modified work period that followed the accident (T139).

Mr. Heenan testified that in August of 2012, Petitioner's job title was operations manager and that he was familiar with the job description for operations manager at Olympic Steel, Schaumburg facility, as it existed in August of 2012. He identified Respondent's Exhibit No. 1 as a true and accurate copy of the job description for an Operations Manager at the Schaumburg facility as it existed in 2012 and also as it existed on the date of trial (T96-98).

Mr. Heenan testified that in his capacity as general manager at the Schaumburg facility, he was familiar with the physical demands of the position of Operations Manager (T98). He identified Respondent's Exhibit No. 2 as a physical demands analysis of operations manager of Olympic Steel. He testified that it says under II, weight restrictions, lifting weight between one and ten pounds "only if he takes a laptop home with him." He testified that the laptop weighed five pounds (T112). He testified that Respondent's Exhibit No. 2 accurately depicts the physical demands analysis for Petitioner's regular duty position (T101).

Mr. Heenan testified that he was present at trial for Petitioner's testimony and that he did not agree with Petitioner's testimony regarding alleged travel time on the floor of the plant. He testified that of an eight-hour work day, Petitioner's job as operations manager had him in his office for seven plus hours and on the floor for only a half hour or so (T102-103). He testified that Petitioner's desktop computer accessed 16 different camera views of the plant and there was no need for him to leave the office to tour the plant (T106-107). Mr. Heenan testified that as an operations manager, Petitioner would not go on sales calls by himself but with an outside sales representative. He testified that the outside sales representative would have the samples with them (T109). Mr. Heenan testified that the only difference between the modified duty work that was made available to Petitioner and his regular duty work was essentially that he did not have to walk out into the plant for about half hour a day (T110).

Mr. Heenan testified that on March 7, 2013, Petitioner was advised that he could soon begin to go back on the floor. He testified that after being told this, Petitioner left the building without telling anyone. Mr. Heenan testified that Petitioner did not return to modified work the next day and, never again returned.

Petitioner offered as Exhibit A medical bills from Dr. Stanley for May 7, 2015, totaling $283.00. Respondent objected to the bill on the basis of liability.

CAUSATION

The Arbitrator finds that the Petitioner established that he sustained a recurrent herniated disc at L4-L5 that was causally related to the August 20, 2012 work-related accident. This injury resulted in lumbar surgery performed by Dr. Stanley on October 9, 2013 for L4-L5 decompression, discectomy and fusion. The Arbitrator further finds that Petitioner reached maximum medical improvement for this condition and relies upon the medical opinions of Dr. Jeffrey Coe and Dr. Babak Lami.

MEDICAL

Petitioner offered only one medical bill into evidence, a bill from Midwest Bone and Joint Institute for a May 7, 2015 follow-up orthopedic evaluation by Dr. Stanley. The Arbitrator notes that this office visit is documented in the subpoenaed records of Dr. Stanley and finds the treatment to be reasonable and necessary.

TEMPORARY TOTAL DISABILITY

Petitioner established that he was temporarily totally disabled from August 21, 2012 through November 11, 2012 and from October 9, 2013 through May 20, 2014 for a total of 89-1/7 weeks.

In support of this finding the Arbitrator relies on the testimony of Petitioner's supervisor Sean Heenan, the Respondent's job description (Respondent's Exhibit 1) and the physical demands analysis (Respondent's Exhibit No. 2) for the position of operations manager. The Arbitrator notes that Mr. Heenan's testimony regarding the job duties and physical demands of operations manager was credible and consistent with the descriptions obtained (Respondent's Exhibit No. 1 and Respondent's Exhibit No. 2), and are based on his years of familiarity with the operations at the Schaumburg location and his direct supervision of Petitioner.

The Arbitrator finds that the testimony of Petitioner regarding his regular duty job description to be less than credible. The Arbitrator further finds that the August 15, 2014 functional capacity evaluation is not reliable in that it is based upon an inaccurate job description and physical demands analysis provided to that facility by the Petitioner. Of note, the Athletico report states that a functional job description was asked for but not provided.

The Arbitrator also relies upon the persuasive opinion of Dr. Lami, who reviewed the job description and physical demands analysis.

The Arbitrator finds that the job description and physical demand analysis provided by Petitioner to AthletiCo was inaccurate and that AthletiCo's classification of Petitioner's job as having a medium level physical requirement is unreliable.

The Arbitrator further finds that on March 7, 2013 Petitioner abandoned the modified duty that was being provided by Respondent and therefore failed to establish that he was entitled to temporary total disability benefits between March 7, 2013 and October 8, 2013, the day before his fusion surgery. The Arbitrator finds that Petitioner did establish that he was temporarily totally disabled from the date of his October 9, 2013 surgery through April 15, 2014, the date of discharge from physical therapy. The Arbitrator relies on the persuasive opinion of Dr. Lami that the Petitioner could return to work as a manager after completion of physical therapy.

The Arbitrator notes that benefits were continued through May 20, 2014 by Respondent and that Respondent stipulated to the period ending May 20, 2014. Accordingly, the Arbitrator awards a total of 89-1/7 TTD for the periods from August 21, 2012 through November 11, 2012 and October 9, 2013 through May 20, 2014.

MAINTENANCE

The Arbitrator finds that Petitioner's has not proved an entitlement to maintenance

Petitioner had reached pre-injury physical demand ability according to Dr. Lami's final report, which the Arbitrator finds persuasive.

The Arbitrator finds that based on the job description and physical demands analysis (Respondent's Exhibit 1) and (Respondent's Exhibit 2) Petitioner was physically capable of returning to his pre-injury regular duty job following the last day of physical therapy on April 15, 2014 and as such that he failed to establish entitlement to any maintenance benefits.

The Arbitrator finds the opinion of Edward Pagella to be unpersuasive and notes that Mr. Pagella was provided no job description or physical demands analysis from Petitioner's attorney although same had been provided to Petitioner's attorney. The Arbitrator finds the purported self-directed job search of Petitioner to be limited in scope, duration and description. The Arbitrator further finds that the job Petitioner voluntarily chose to take as a part-time bus driver working only five hours a day is not supported by any credible restrictions.

NATURE AND EXTENT

In determining permanent partial disability, Section 8.1(b) provides that permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

Regarding (i) or the reported level of impairment, Dr. Coe found the August 20, 2012 work accident resulted in an AMA impairment rating of 14% of the whole person.

Regarding (ii), Petitioner's occupation was operations manager and is now school bus driver. The Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that his permanent restrictions exceeded that of his regular duty job as an operations manager and that this change of occupation is a non-factor.

Regarding (iii), Petitioner's age at the time of the injury was 35 years. The Arbitrator finds that given Petitioner's permanent restrictions in line with his pre-injury job description and physical demands analysis, this factor increases Petitioner's level of permanent partial disability.

Regarding (iii), the employee's future earning capacity, Petitioner was released to return to permanent restrictions which exceeded his pre-injury regular job description based on the credible evidence presented at trial. As such, future earning capacity is a not a factor.

Regarding (v) or evidence of disability corroborated by the treating medical records, the Arbitrator weighs this factor in favor of Respondent. The FCE and the opinions of Dr. Stanley and Mr. Pagella were based upon an inaccurate job description provided by Petitioner. The Arbitrator finds the job description and physical demand analysis (RX 1 and RX 2) along with the testimony of Sean Heenan to be more credible and reliable on the issue of disability and in contradiction to the job description and physical demand analysis Petitioner provided the treating physician.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained the loss of 20% of the person as a whole.

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

Tameka Mingo,
Petitioner,

vs. No: 11 WC 28199

18IWCC0537

Chicago Transit Authority,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 11, 2017, is hereby affirmed and adopted.

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

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

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 31 2018

o-08/29/18
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MINGO, TAMEKA
Employee/Petitioner

Case# **11WC028199**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

18IWCC0537

On 4/11/2017, 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 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
JASON CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
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

Tameka Mingo
Employee/Petitioner
v.
Chicago Transit Authority
Employer/Respondent

Case # 11 WC 28199

18IWCC0537

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 Commission, in the city of **Chicago**, on **August 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 _____

FINDINGS

On **July 19, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$61,672.00**; the average weekly wage was $1,186.00.

On the date of accident, Petitioner was 38 years of age, ***single*** with 4 dependent children.

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

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

Respondent shall be given a credit of $66,415.44 for TTD, $ for TPD, $ for maintenance, and $5,720.00 for other benefits, for a total credit of $72,135.44.

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

ORDER

Respondent shall pay Petitioner temporary total disability at the rate of $790.67per week, from July 20, 2011 through February 27, 2013, representing 84 1/7 weeks, totaling $66,529.22.

Respondent shall be given a credit of $66,415.44 for total disability benefits previously paid to Petitioner and a credit of $5,720.00 for other benefits paid, for a total credit of $72,135.44.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78 for 37.5 weeks as the injury sustained caused 7.5% loss of a 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.

David A. Kane
Signature of Arbitrator

April 10, 2017
Date

APR 11 2017

BEFORE THE ILLINOIS WORKER'S COMPENSATION COMMISSION

Tamika Mingo,	)	
Petitioner	)	
vs.	)	11 WC 28199
Chicago Transit Authority,	)	
Respondent	)	18IWCC0537

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard in its entirely by Arbitrator Robert Williams, but was subsequently re-assigned to Arbitrator David Kane for issuance of Decision based on the transcript and the evidence submitted at trial.

The parties agree that on July 19, 2011, the Petitioner and the Respondent were operating Under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. They agree that on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute. They further agree that in the year preceding the injuries, the Petitioner earned $61,672.00 and that her average weekly wage was $1,186.00.

Respondent stipulated that any bills offered into evidence by the Petitioner reflecting outstanding charges for services rendered up through

the date of February 27, 2013 will be satisfied by the Respondent in accordance to the fee schedule as identified in the Act.

Petitioner waived her right to a wage differential award and seeks a permanency award for loss of occupation, if the evidence so proves.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to the injury alleged; (2) Were the medical services provided to the Petitioner ***after*** February 27, 2013 reasonable and necessary; [1](3) Is Petitioner entitled to TTD ***after*** February 27, 2013; (4) What is the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner's testimony:

Petitioner, who was 2.5 weeks shy of her 44th birthday as of the hearing, testified that she was hired by Respondent (CTA) as of May, 2002 in the capacity of a Bus Operator and always worked as such until her accident on 7-19-11. Petitioner testified that after 7-19-11 she never returned to employment with CTA in any capacity.

On 7-19-11 Petitioner worked out of the Kedzie Garage and was assigned to the bus line # 7/Harrison route. (T pg. 36) Petitioner testified that she would drive to and from work every day as she lived on the south side and worked on the west side-she did not avail herself to use of CTA transit system. (T pg. 76) At approximately 8:10 p.m. a male passenger boarded the bus and shoved his fare card in front of petitioner; he proceeded to sit down for a second and then got up acting erratic while walking towards the front of bus; he was standing up when a vehicle on the left side of the bus tried to make a right turn causing petitioner to break in

[1] The outstanding bill in the amount of $3,970.00 is for service dates from 9-6-13 through 2-10-14.

order to avoid a collision. Petitioner testified as the bus was stopped she got up from her seat to make sure the passengers were okay and while standing by her seat picking up the phone to call CTA's control center the male passenger punched petitioner –striking her in the head, knocking "part of" her a tooth out and punching her in the abdomen.[2] (T pgs. 10-14, 37-39, 43 RX 1) Petitioner testified that once she was struck in the head ("temporal lobe") she "blanked out, sort of" and could not defend herself. (T pg. 73)

Petitioner claimed that as a result of the assault she sustained physical injuries to her head, face, neck and psychological injuries. Petitioner testified that she was transported by the paramedics to Rush –Pres Hospital where she gave a history that her tooth was knocked out; she testified that she gave the same history when she went to Concentra on 7-21-11. (T pgs. 14-15, 46) In the E.R. the only MRI taken was limited to her face and head. (T pg. 48)

After petitioner was released from the E.R. she went back to the CTA garage work location where she completed a form titled "EMPLOYEE'S REPORT OF INJURY ON DUTY" (T pg. 88; RX1)[3]

After the initial E.R. visit petitioner was evaluated at Concentra on 7-21-11 at the direction of CTA. She also went to Advanced Physical Medicine ("Advanced") the same day and treated at that facility until August, 2012. (T pgs. 15-16, 61) While treating at Advanced she was referred for a cervical spine MRI that was completed on 8-26-11; she received physical therapy from August, 2011 through at least December, 2011 with no noted

[2] Petitioner testified on cross-examination that she did not recall giving a history any of the health care professionals who treated and/or examined her that she was sitting in her driver's seat secure by seat belt when initially struck by the passenger, so she could not do anything other than put her hands up in order to protect her face. (T pg. 40)

[3] RX1 identified as authored by petitioner stated *"I was in a defensive stance when he started hitting me."*

improvement; she was referred to Dr. Ronald Michael at Illinois Neuro Spine whom she first saw on 5-8-12. (T pgs. 19, 21-22)

Upon treating with Dr. Michael for right sided neck pain, petitioner received a series of 4 cervical epidural steroid injections between 5-22-12 through 7-17-12, after which she realized no relief other than possibly 1 hour after the injection (T pgs. 22-24) Petitioner testified on 7-31-12 she followed up with Dr. Michael and chose not to proceed with any further treatment recommendations made as she did not trust him. (T pg. 25-26)

Petitioner was also treated by Dr. Saleh Issam, DDS for the tooth that was knocked out (partially). (T pgs. 17-18) Petitioner eventually had a root canal performed on 2-28-12 although Petitioner's testimony was unclear whether the procedure was done on the affected tooth. (T pgs. 18, 45)

Shortly thereafter petitioner sought treatment with Dr. Daniel Kelley, psychologist, with the initial evaluation on 10-12-12. (T pg. 27) Petitioner testified that prior to the 7-19-11 assault at work she had never treated for psychological issues. (T pg. 55) Petitioner testified that when she saw Dr. Kelley the sessions lasted 30-60 minutes; that she was always open and honest with him; that she told Dr. Kelley "everything" about all other circumstances and family issues going on in her life during the time she treated with him; there was never any exposure therapy done, where Dr. Kelley would take her to a bus stop or board a bus with here, because petitioner was "too scared".(T pgs. 28,67, 78) However even though petitioner did not have exposure therapy she did ride CTA bus/rail system when she had to and usually while accompanied by family or friend. (T pgs. 30, 34-35)[4]

[4] RX2 identified: 150 days that petitioner used her employee ID badge for transit services between the period of 8/13/13 to 7/30/14 out of which 131 days used bus services versus 19 days used rail service exclusively.

Petitioner testified that prior to 7-19-11she did have a psychological evaluation on 6-23-11particular to pre-operative work up for a bariatric gastric sleeve procedure she underwent in November, 2011.(T pgs. 17,21)

Other operative/diagnostic procedures Petitioner had after the 7-19-11 work injury was: on 7-24-11 for abdominal pain; on 9-1-11 had surgery related to her gall bladder; on 11-30-11 gastric sleeve surgery; in October, 2012 inpatient tummy tuck and liposuction procedures related to her weight loss; and in February, 2013 revision of abdominal scar and breast augmentation in order to improve her appearance. (T pgs. 16, 52-54, 86)[5]

Petitioner testified that other circumstances or family issues that occurred immediately before, as well as after the work injury, did not affect her psychological well-being in anyway. The events testified to were:

immediately before Petitioner's accident her daughter was abducted and raped (T pg.66)(referenced in RX6 pgs. 68-69);

in September, 2012 Petitioner's son was arrested for unlawful possession of a firearm and charged with 3 felony counts (Id at 67-68)(referenced in RX3);

on or about the end of December, 2012 Petitioner witnessed a murder her building (Id at 68-69)(referenced in RX10);

in January, 2013 Petitioner's half-sister passed away (Id at 80) (referenced in RX9 pg.143);

in June, 2013 Petitioner's sister had her involuntarily committed to University of Chicago for psychological evaluation (Id at 57) (referenced in PX22, pg. 18; PX14, pgs. 114-116);

[5] 10-3-12 abdominoplasty liposuction and 2-4-13 breast augmentation and scar revision procedures done at University of Illinois (RX8, RX,9pgs, 103-108)

in November, 2013 Petitioner was assaulted in an attempted rape where she was struck about the face and right eye necessitating treatment at University of Chicago and her PCP, Dr. Alter (Id at 54-55) (referenced in PX9, pgs. 76-78).

Petitioner testified that after the July, 2011 assault on the bus she never returned to work at CTA in any capacity. (T pgs. 28, 80-81) She was administratively separated in July, 2014 as per the collective bargaining agreement for inactive employees. (T pg. 64) Petitioner testified that in the summer, 2015 she became employed doing home health care work for a woman residing in her same building. (T pgs. 29-31) She has worked 7 hours one day a week earning $13.00 an hour as there is someone else who assists the woman on other days.

Petitioner testified that at present she continues to see her PCP, Dr. Alter for all her medical conditions, injuries and conditions unrelated to work accident, and is prescribed medications accordingly. (T pgs.51, 72) Petitioner testified that she continues to have right sided neck pain, described as throbbing, as well as her whole body aching. (T Pg. 33-34) She takes Paroxetine and Mirtazapine for anxiety, Clonazepam to calm her, and Hydrocodone for pain which has been prescribed continually after her gastric sleeve procedure. (T pgs.71, 82, 84)

Rush Medical Center

Petitioner Exhibit 1 contains the CFD ambulance report and E.R. records for the date of injury, 7-19-11. In relevant part the ambulance report states that Petitioner was struck on her face and head, by passenger with his fists, with no loss of consciousness ("LOC") but with facial and jaw pain and dizziness. In the E.R. Petitioner gave a history of being struck on the right side of temporal lobe by a passenger, approximately 8 blows to the

head. She denied LOC but had dizziness, edema but no lacerations or abrasions. A CT scan of the brain was within normal limits and the CT scan of the face showed possible swelling of the right temporalis muscle, otherwise normal. It is further noted there was no tooth laxity; she was noted to have normal mood and affect with normal behavior. The diagnosis was facial contusion, dizziness and giddiness. Petitioner was discharged with 15 tablets (no refills) of hydrocodone-acetaminophen (Norco).

Concentra

On 7-21-11Petitioner presented with complaints of being hit repeatedly on the right side of her face, which had diffuse swelling and tenderness, trouble opening her jaw, a cracked tooth along the right mid molar, and diffuse soreness of her neck. (PX2) Petitioner also reported having constant crying spells since the attack and being nervous about getting back on a bus, although she was able to do so that day as a passenger to get to the clinic. Petitioner was diagnosed with major stress grief reaction, concussion, facial contusion, a cracked tooth and a cervical stain. Petitioner was taken off work activities, prescribed medication, recommended to seek psychological counseling and see a dentist.

University of Chicago Hospital

Petitioner Exhibit 3 offered into evidence records the hospitalization from 7-24-11 to 7-29-11 for what was diagnosed as acute pancreatitis. When Petitioner presented on 7-24-11 the stated history is … "*abdominal pain, nausea, vomiting, headaches. Pt was assaulted at work (on a bus) about 5 days ago* ***with fist punches to side of head;*** [6]*was diagnosed by company physician with concussion. Since then she has been nauseated*

[6] Emphasis added in bold as to actual physical assault contact. There are no medical opinions contained within the record that the acute pancreatitis is causally related to the work injury.

and vomiting continuously, "keeping very little food down.... Then yesterday developed sharp cramping abdominal pain diffusely... + HA over side and front of head (area of trauma). ***Abdomen not hit in trauma....***" (PX3 pgs. 11-12) A differential diagnosis was made of dehydration due to vomiting related to concussion vs gastroenteritis. (Id at 13) Petitioner admitted to a history of gallstone on interview by general surgeon resident. A CT scan of the upper abdomen/ pelvis taken showed no evidence of trauma. (Id at 16)

Good Samaritan Hospital

Petitioner Exhibit 4 offered into evidence records hospitalization from 9-1 to 9-4-11 for abdominal pain that necessitated laparoscopic cholecystectomy and intraoperative cholangiogram, adhesiolysis of adhesions, common bile duct exploration. (PX4 pgs. 290-291, 368-370, 430-433, 712-726)[7]Post-operative findings included gallbladder with signs of acute on chronic cholecystitis with evidence of hydrops with stones in the gallbladder wall as well. (Id at 723-724) On 11-30-11 Petitioner was hospitalized for her gastric sleeve procedure that was previously worked up and authorized before the work injury. (PX4 pgs. 271-274)

Rush Occupational and LifeWeigh Bariatrics

Petitioner's Exhibits5 and 6 relate to the pre and post 7-19-11 work injury work up attributable to the gastric sleeve procedure. On **6-23-11** Petitioner was referred for a psychological evaluation to ... "*rule out the presence of an eating disorder or psychological disturbance that would impact negatively on her decision to have laparoscopic vertical sleeve gastrectomy or her ability to adhere to post-operative lifestyle changes.*"

[7] There are no medical opinions contained within the record that the September, 2011 hospitalization and procedure is causally related to the work injury. The records record a prior medical history of diabetes, hip pain and knee pain. (PX4, pg. 431)

The evaluation notes ... *"Psych. History I Trauma" .... "Summary: Ms. Mingo appears to have an adequate social support network and has a basic understanding of the sleeve ...surgery..... no absolute contraindications to .....surgery... at this time."* (PX5, pgs. 11-13)

LifeWeigh Bariatrics records show that on 9-14-11 Petitioner complained of continual cervical pain after trauma and scared to get back on bus and go to work (PX6, pg. 34); 10-1-11 Petitioner quit smoking (Id at 19); on 12-8-11 follow –up it was noted that Petitioner had neck pain and mental state of panic attack prevented her from working (Id at 31).

Advanced Physical Medicine-Dr. Goldvekht; Illinois Neuro Spine Institute/ Dr. Michael and Instant Care Medical Group/Dr Mehta

On 7-21-11 Petitioner sought treatment at Advanced Physical Medicine ("Advanced") and was initially examined by James Kopsian, D.C. (PX8) The history of the assault given was that she was repeatedly hit in her face and head and that she put up her arms and hands trying to protect her head and face.(Id at 30) She was diagnosed with head/facial/jaw contusion and a cervical sprain/strain. Petitioner received physical therapy with chiropractor Kopsian from 8-11-12 through 12-13-11. When Petitioner started her therapy on 8-11-12 her complaints were headaches with a pain rating of 7/10, neck pain 6/10, jaw pain 8/10 and facial pain 7/10. (Id at 34) As of 12-13-11 Petitioner rated her complaints as: headache symptoms were no longer present, neck pain was 4/10, jaw pain was 0 and facial pain 2/10. (Id at 65) Physical therapy regiment switched from passive to active starting on 12-14-11 to 8-1-12. (Id at 7-26) During this time period Petitioner complained of neck pain, right shoulder pain and arm weakness, but no radicular symptoms, as well as abdominal pain.

While receiving chiropractic care at Advanced, Petitioner was also evaluated by Dr. Aleksandr Goldvekht on 8-25-11. (PX8, pg. 4) Petitioner was diagnosed with a cervical sprain/strain and multiple contusions and referred for an MRI. (Id at 4) Petitioner had a cervical MRI completed on 8-26-11. (PX18) The findings included straightening of the normal cervical lordosis which may have been positional in nature; no posterior soft tissue injury identified; congenital narrowing of the cervical spinal canal; spinal cord signal normal throughout; minimal bulging without central canal or neural foraminal stenosis at C4-5 through C6-7.

On 9-29-11, in follow up with Dr. Goldvekht, after the MRI, the diagnosis remained cervical sprain/strain and multiple contusions; a referral was made to Matthew Gallow, clinical counselor.[8]

It is unclear from the record as to how Petitioner came to treat with Dr. Ronald Michael, as there is no referral noted in the records from Advanced nor her PCP, Dr. Robert Alter. (RX6) Dr. Michael examined Petitioner on 5-8-12 and noted that as a result of the passenger punching Petitioner on the right side of her head she was caused to jerk her head to the left abruptly causing neck pain. At that time Dr. Michael found her general physical exam unremarkable, with no obvious motor, sensory or reflex abnormalities; the MRI… "*demonstrated C3-4 and C4-5 bulging discs.*"(Id at 8) and was diagnosed with disc protrusions at those levels accordingly. Dr. Michael recommended a series of epidural steroid injections.

Petitioner was referred to Dr. Amit Mehta, Board Certified Pain Management/ Anesthesiologist to perform a series of epidural steroid injections. (PX7) Petitioner filled out a questioner/pain chart identifying her

[8] Petitioner was seen by Matthew Gallo, MA LPC on 10-24-11, 10-31-11 and 11-4-11 although those chart notes are no longer available. (RX7)

symptoms as aching in the right neck area and right base of the neck with stabbing pain constantly around the right facial area when attempts to smile. (Id at 59-60) Dr. Mehta initially evaluated Petitioner on 5-22-12 and noted that her MRI imaging did show disc bulges from C3 through the C6-7 levels.[9] (Id at 39) Petitioner underwent cervical epidural steroid injections as follows: on 5-22-12 at the C6-7 level; on 6-12-12 at the C6-7 level; on 7-3-12 at the C5-6 level; on 7-17-12 at the C5-6 level. It was noted in Dr. Mehta's report of 7-10-12 that Petitioner had realized approximately 50% relief from the first 3 injections and her complaints of headache had also dissipated. In follow-up with Dr. Mehta on 7-24-12 Petitioner was noted to show signs and symptoms of cervicalgia, myofascial pain, headaches as well as cervical radiculitis. (Id at 52)

After the series of injections Petitioner returned to Dr. Michael on 7-31-12. (PX 11, pg. 4) where she continued to complain of neck pain and right upper extremity weakness with no arm pain per se. No other course of treatment was offered other than considering surgery. However Dr. Michael made it clear that prior to making a surgical decision a re-review of her August, 2011 MRI would be required and possibly other diagnostic tests. That was never pursued as Petitioner outright did not want to have surgery if that was an option. (Id)

Petitioner was last seen by Dr. Goldvekht on 8-2-12 where it was noted that she felt 50% better after receiving the abovementioned injections, although she still complained of neck pain and tenderness. (PX8, pg. 6) She also complained of sitting for any length of time and driving bothered

[9] The inclusion of the C3-4 level is not depicted on the MRI imaging.

her as she still had pain around the incisions and surgical scars.[10] Her diagnosis remained cervical sprain/strain and multiple contusions. She was deemed to have reached MMI for her physical injuries. (Id at 6)

Dr. Benjamin Goldberg IME Evaluations

Petitioner testified that she was seen by Dr. Goldberg at the request of CTA for IME evaluation(s). Dr. Goldberg evaluated Petitioner on two occasions, 9-16-11 and 8-27-12. (RX 4 and 5)

On 9-6-11 Petitioner complained of stomach pain, having recently had gallbladder surgery, pain on the right side of her neck and back of the neck, pain over her scalp and having a chipped tooth. The history given was she was attacked by a male passenger who punched her all over while she was in her seat. (RX4) On physical examination Petitioner had full range of motion of the neck with tenderness over the right side of her neck as well as head. Dr. Goldberg diagnosed Petitioner with contusion and ecchymosis to the right side of her face, a chipped tooth undermined if related to event, complaints of head, neck and upper back pain, and some symptoms of post-traumatic stress, depression and a concussion by report. Dr. Goldberg opined that the neck and head injuries should resolve in three months and if not a cervical MRI would be warranted. He opined that physically the Petitioner was capable of working an 8 hour day; he was concerned about the psychological effects of the assault on Petitioner as she cried while recounting the history of the event and deferred to a practitioner within that discipline.

[10] The surgical scars and incisions would refer to her gallstone and /or gastric sleeve procedure and unrelated to her work injury.

On 8-27-12 Dr. Goldberg re-evaluated Petitioner and recorded complaints of right-sided neck and scalp pain, headaches and dizziness. (RX5) Petitioner reported that she was on Imitrex for migraines, Wellbutrin for depression and seeing a psychiatrist. It was noted that Petitioner no longer cried while recounting the history of the assault but did appear depressed.[11] On examination she had full range of motion of her neck, normal strength and sensation in her upper extremities and tenderness over the right side of her neck and right posterior side of her head. Dr. Goldberg diagnosed that Petitioner had suffered a contusion and ecchymosis to the right side of her face with complaints of pain in her neck/upper back and head although her examination was grossly normal and neurologically intact; a concussion by report; she had some evidence of disc protrusions likely not post-traumatic; there was no evidence of dental trauma per the records reviewed related to the incident; she had some symptoms of posttraumatic stress disorder. Dr. Goldberg opined that the Petitioner had reached MMI of her physical injuries as of July, 2012 and did not sustain any objective permanent partial disability related to conditions in regards to her musculoskeletal system; no surgery for the cervical spine was reasonable or necessary; he deferred any restrictions and opinions as Petitioner ability to return to work only as it related to her psychiatric condition and any essential post-concussive symptoms.

Advocate Medical Group

Petitioner testified that she was seen by her PCP, Dr. Robert Alter, Advocate Medical Group, as a result of her work injury. (RX6). Those records, in relevant part, state the following for service dates **prior** to the 7-

[11] Petitioner's son had been arrested the day prior to this re-evaluation, although no information of this arrest was given by Petitioner. (RX3)

19-11work incident: on 11-1-10 Petitioner presented with complaints of SOB and light headness for over a month and getting worse.... *"She is very stressed now related to daughter's sexual assault... Psychiatric Exam: tearful at times."* (Id at 68-69); on 3-2-11 complained of sinus pain/pressure and headache (Id at 64); in April-June, 2011 complaints of right knee pain and swelling (Id at 56-63); on 7-6-11 noted only slept 4-6 hours a night (Id at 52); musculoskeletal back pain (Id at 23).

The first time Petitioner saw Dr. Alter after the assault at work was on 8-10-11. (RX6, pg. 50-51) On that date Petitioner complained of aching pain in her neck, had lumps on head and had headaches; history of having gallbladder attack with pancreatitis several days after the assault (with known history of gall stones in the past). Dr. Alter noted some spasm in the neck with good range of motion and tearful in describing assault. He recommended she take the medication prescribed by Concentra and to seek a psychological evaluation.

The Advocate records also include complaints of injuries and/or conditions **after** the July, 2011 assault, relevant in that they correlate to complaints recorded in PX8 (although unrelated to the work injury) as well as relevant to Petitioner's claim for psychological injuries. (RX6 and PX9) They include the following: on 2-5-12 complaint of left shoulder pain after picking up boxes resulting in radiating pain/tingling and diagnosed as left shoulder strain and possible nerve impingement syndrome (RX6, pgs.45-46, 103); constant abdominal pain in right lower quadrant in April, 2012 with imaging noting a probable ovarian cyst (Id at 15-39, 91-92); on 9-4-12

concern of opioid overuse (Id at 28)[12]; in October , 2012 noted use of Hydrocodone for various pains in addition to use for neck pain but clearly overusing narcotics (PX9, pg. 62-63); noticeable uptake of erratic behavior and concern of amount of medications taken recorded between October, 2012 through March, 2013 (PX9, pgs. 65-71)[13] ; on 11-29-13 presented with history of being assaulted by an unknown male two days prior (*the attempted rape per Petitioner's testimony)* where she was struck in the face and complained of right eye pain with noted ecchymosis around the orbit, upper lid swollen, abrasion to right cheek (PX9, pgs. 76-78); follow up for continual effects of attempted rape still noting right side facial numbness (PX9, pgs. 82-84).

Dr. Daniel Kelley's medical records and deposition testimony

Petitioner sought psychological treatment with Dr. Daniel Kelley, Licensed Clinical Psychologist, from 10-12-12 to 2-10-14, each session lasting 30 minutes. (PX 13and 21; PX 14, pg. 117) During this entire period of time the diagnosis maintained attributable to the work injury was Adjustment Disorder with Mixed Anxiety and Depressed Mood.[14] But as of the 3-13-13 progress report authored by Dr. Kelley the diagnosis of Personality Disorder, NOS (Histrionic and Narcissistic Traits) was added; it was opined to have been pre-existing and chronic in nature and likely exacerbated (flare-up and not on a permanent basis) by the work injury as well as subsequent events in Petitioner's life. (PX21, pg13; PX14, pgs. 50-52,53; PX16, pgs. 26-27)

[12] Petitioner testified that he son was arrested and charged with three felony counts within this time period, information she did not disclose to her PCP—the arrest was made on 8-26-12 for aggravated unlawful use of weapon. (RX 3)

[13] Petitioner testified as to witnessing a murder in her building at the end on 2012 which was not disclosed to PCP.

[14] Petitioner never met the criteria for a diagnosis of PTSD. (PX 14, pg. 81, 120)

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When Petitioner first presented herself on 10-12-12 she was vague in her report of psychosocial history. (PX 13, Pg. 6) She reported a dispute with a male passenger upon his boarding and after reminding him that he needed to use his permit card in the future. He in turn approached her and began punching her face and body repeatedly and she didn't fight back. (Id at 7) After the aforementioned diagnosis was made the treatment plan was to engage in cognitive-behavioral therapy and a referral for a psychiatric consultation with Dr. Beck for medication management. (Id at 9-11) In follow up sessions Dr. Kelley noted erratic attention, frequent crying spells and escalating emotions as Petitioner started to disclose various life stressors to include caring for her autistic son, feeling guilt regarding her son's house arrest and witnessing of a murder; it was noted that while there was evidence of modest emotional /psychological improvement during her session there was evidence of emotional decompensation (panic attacks) following the police questioning her regarding whether she witnessed a recent gang-related murder in her apartment complex. (Id at 11, PX14, pgs.35-36)

Thereafter Dr. Kelley requested a peer psychological consultation examination, specifically with Dr. Diana Goldstein, whose opinions he highly values and he considers her an expert, as she is a skilled neuropsychologist who will examine, evaluate and assist a treating doctor with treatment recommendations. (Id at 11; PX14, pgs. 41, 45-46, 53) It was after that peer review with Dr. Goldstein that the 3-13-13 report was authored and included the aforementioned Personality Disorder diagnosis. It was also as of that date that Dr. Kelley recommended Petitioner not return to work in a safety sensitive position as a bus operator because she stated that she did not believe she could do so; that recommendation was

for that time period … "*this means right now. It doesn't mean forever*". (PX 14, pgs. 54-55)

As of Dr. Kelley's report dated 8-29-13 it is noted that Petitioner felt emotionally/psychologically overwhelmed secondary to daily life stressors, in addition to frequent financial and family stressors. (PX21, pgs. 15-16) The events noted included her mother suffering a stroke and the psychological effects that had on Petitioner to include psychotic behavior, auditory hallucinations. (Id at 16; PX14, pgs. 67-68 114-116)

Dr. Kelley opined that Petitioner's 7-19-11 assault affected her pre-existing cognitive schema of herself which was disrupted because she could not fight back, "she just stood there or sat there and took it", giving her a sense of not being good enough, not able to handle things although that was a theory… "*theme that literally we have not got real far on*" (PX 14, pgs. 44-45, 56) Dr. Kelley opined that the 7-19-11 assault and Petitioner's inability to fight back continued to be a cause of her psychological condition precluding her from driving a bus; the basis of his opinion was that Petitioner had life stressor before the 7-19-11 assault and was able to function in the capacity of a bus operator, but after that event she was not. (PX 14, pgs. 69-71)

Dr. Kelley testified that out of all the life stressors Petitioner identified, other than the work injury, her son's arrest became very significant to her as she felt tremendous guilt that occurred; the witnessing of a murder was also significant and her concern for the safety of herself and her family if the perpetrator learned of any police cooperation, although according to Dr.

Kelley it was Petitioner's mother who witnessed the murder and Petitioner wanted to protect her mother from the police. (PX 14, pg77-79)[15]

Dr. Kelley testified that his causal connection opinions where premised in large part to the history conveyed by Petitioner and her belief that the work injury was the cause of her psychological condition. (PX14, pgs. 80-95, 121) However Dr. Kelley testified Petitioner was a challenging patient with regards to how candid she was being.(PX 16, pg. 26) Dr. Kelley testified Petitioner withheld information of past histories before the work incident, i.e. the sexual assault of her daughter in 2010 (PX14, 86-88) and that the past history of her own physical /sexual abuse created a tremendous amount of baggage that comes with an adjustment disorder and resulting coping skills to the point that it was difficult for Dr. Kelley to definitively state that if not presented with more information that he would not have authored a different report as to Petitioner's condition. (PX 14, pgs. 141-143)

The last period in which Dr. Kelley treated Petitioner was from 11-16-13 through 2-10-14. It was during this period that Petitioner reported *she "was recently physically assaulted by a potential robbery ("I fought back") and evidenced a "black eye".* (PX 21, pgs.19, 74)[16]As of 2-10-14 Petitioner was released from Dr. Kelley's care with restrictions of no safety sensitive employment and no contact with the general public; she capable of returning to work in any other capacity full duty, 8 hours a day, 5days a week; after she started working then restrictions slowly would be modified and or removed as the aforementioned restrictions would not be permanent. (PX 21, pgs. 19-20, 80; PX16, pgs. 9, 11-12, 15, 32-34)

[15] Petitioner testified at trial that she did witness a murder in her building, contrary to what she stated to Dr. Kelley and to Dr. Goldstein. (T pgs. 68-69; RX10, pgs. 24-25)

[16] Petitioner testified that this assault was not an attempted robbery but an attempted rape. (T pgs. 54-55)

Dr. Diane Goldstein- IME evaluation report and deposition testimony

Dr. Diane Goldstein is a licensed clinical neuropsychologist and forensic neuropsychologist. (RX10, Ex1) Dr. Goldstein performed a psychological and neuropsychological evaluation on Petitioner over a three day period (1-8-13, 1-16-13 and 1-29-13), spending a total of 12.5 hours with Petitioner, conducting a collateral interview with Dr. Kelley and reviewing available records before authoring her report dated 2-18-13. (RX10, Ex3)[17]

Upon completing a clinical and background interview, psychological and neurocognitive testing Dr. Goldstein diagnosed Petitioner's psychological condition as: (1)Adjustment Disorder with Mixed Anxiety and Depression, Chronic (the basis of Dr. Goldstein's opinion as to said diagnosis of chronic adjustment disorder was because of duration and exposure to multiple serious non-work related stressors- the one attributable to her current state of adjustment disorder at the time of the IME identified as witnessing the murder in December, 2012; Dr. Goldstein relied on Dr. Kelley's summary report for the period of 10-13-12 to 1-8-13 that noted Petitioner's "decompensated"[18] mental state after the murder Petitioner witnessed on or about 12-31-12;Petitioner was no longer becoming anxious when she thought about what happened on the bus or envisioned what had happened to her through thoughts and images; by the time Petitioner presented for her IME evaluation Dr. Goldstein opined that her symptoms were no longer causally related to the 7-19-11 bus incident based on the lack of sufficient symptoms of anxiety, depressive symptoms maladaptive behavior related to buses or having been attacked that rose to the level of a

[17] Petitioner failed to report that she has gastric sleeve surgery in 2011 but instead stated she lost 90 pounds through diet and exercise; Petitioner denied a history of ant type of physical abuse by a spouse before 7-19-11;Petitioner did not disclose that her daughter had been sexually assaulted in 2010(RX10, pgs. 67-71

[18] Decompensation defined as signifying moving from a higher level of functioning to a lower level and/or an increase in symptoms. (RX10, pg. 56)

disorder) (RX10-Ex3,pg. 17; RX10 pgs.24-25, 55-56, 81-89,91-92,112-114) and depression, resulting after her son's arrest approximately fall 2012(RX10, pg.78) and (2)Personality Disorder. (Id at 60-61; RX10-EX3)

Dr. Goldstein opined that as of her IME evaluation Petitioner was not precluded from returning to work as a bus operator as a result of the 7-19-11 work injury; that even though Petitioner informed Dr. Goldstein that she was not anxious on buses she had made a personal decision that she did not want to return to work as a bus operator. (RX10, pgs. 93-101, 117-119; RX10-EX3) Lastly, Dr. Goldstein opined that as of the IME evaluation Petitioner was not suffering any persistent psychological effects from the 7-19-11 incident and thus she did not have any disability as a result of that occurrence. (RX10, pgs. 101-102)

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by the preponderance of credible evidence the elements of their claim. *Peoria County Nursing Home v. Industrial Comm'n, 115 Ill.2d 524, 505 N.E. 2d 1026 (1987)*

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator find's the Petitioner's testimony regarding her July 19, 2011 work accident to be credible in that it did occur, resulting in physical injuries on and about her face and neck. The petitioner testified that at present her whole body aches but identified that she still experiences throbbing pain at the right side of her neck.

The medical evidence presented as aforementioned established that Petitioner suffered a chipped right lower tooth (# 29) that was treated with a root canal procedure, facial contusions that have resolved and a sprain/strain of her cervical spine. The MRI of the cervical spine was indicative of minimal bulging from C4-5 through C6-7 without central canal or neural foraminal stenosis. Petitioner was diagnosed with a cervical sprain/ strain at Concentra, her treating practitioner at Advanced Physical Medicine, specifically Dr. Goldvekht, Dr. Alter and Dr. Benjamin Goldberg. Dr. Michael's initial evaluation was consistent with the radiologists finding of the aforesaid bulging discs with no clinical neurological findings, impingements or deficits.

There was no evidence presented that prior to 7-19-11petitioner had suffered a previous injury or received treatment to her cervical spine. Nor was there evidence that she sustained a subsequent injury to her cervical spine. **Accordingly Petitioner's current complaints attributable to her cervical spine are causally related to her 7-19-11 accident.**

The Arbitrator further finds that after the physical assault the Petitioner sustain a psychological injury, either in whole or in part, as a sequela of the incident. However the Arbitrator finds the Petitioner's testimony lacks credibility as to her assertion that the current condition of her psychological state is causally related to the 7-19-11 assault. Furthermore the Arbitrator finds that the medical testimony of Dr. Diane Goldstein is more persuasive and credible than that of Dr. Daniel Kelley.

Specifically the Arbitrator takes notice of the testimony from Drs. Kelley and Goldstein that Petitioner was at times anything but candid and or truthful, either by misrepresentation or omission, as to the effects of non-work related stressors in Petitioner's life, both before and after the work

injury. That is also consistent with how Petitioner testified during cross-examination when she denied any psychological effects from non-work related events that occurred, even though the medical records and medical testimony established otherwise, specifically: the sexual assault of her daughter before the 7-19-11 accident affected her psychologically as noted in Advocate-Dr. Alter records; her son's arrest on weapon charges in September, 2012 affected her psychologically as testified to by Drs. Kelley and Goldstein and the noted uptake of opioids by Dr. Alter and the assessment of depression when she was examined by Dr. Goldberg the day after her son's arrest; witnessing a murder in her building in December, 2012 affected her psychologically as testified to by Drs. Kelley and Goldstein; the attempted rape(or robbery depending on whose records are reviewed) on her person in November, 2013 affected her psychologically as noted by Drs. Alter and Kelley.

As to the medical testimony presented by the psychologists, the Arbitrator finds that Dr. Goldstein's evaluation was extremely thorough and the basis of her opinions were detailed. It cannot be ignored that even by Dr. Kelley's own testimony she is an expert in her field and he routinely requests evaluations and direction in treating his difficult patients.

Dr. Goldstein opined that as of the time Petitioner was evaluated in January, 2013 any psychological effects from the 7-19-11 assault would have resolved; that Petitioner's state of well-being, Adjustment Disorder with Mixed Anxiety and depression, which precluded her from working in a safety sensitive position, had everything to do with the arrest of her son and witnessing a murder, both events occurring in the fall/winter of 2012 (one could say analogous to an intervening accident that breaks the causal connection link). That opinion is consistent with what the Arbitrator would

conclude in review of the above-mentioned treatment records for Petitioner's physical injuries-there is a change from her progression on and before 8-26-12 when her son is arrested and her subsequent presentation to health providers.

Dr. Kelley testified the basis of his opinion that Petitioner was unable to return to operating a bus after the 7-19-11 assault was Petitioner's own assertions as to same as well as her feelings of guilt or inadequacy for her inability to fight back at the time the passenger physically assaulted her. Petitioner's own testimony had her standing at the time of the assault with both arms/hands up to protect her face-she was in a defensive stance when the passenger started hitting her. (RX1) That does not suggest that Petitioner did not attempt to fight back but likely if she did so she ran the risk of being physically injured worse if she didn't shield herself from being the contact.

Dr. Goldstein testified that as of her IME evaluations in January, 2013 the Petitioner would have been able to return to work as a bus operator from whatever psychological sequela effects Petitioner sustained in the 7-19-11 event; what precluded her from returning to work in that capacity as of the IME evaluation were non-work related stressors as aforementioned.

Furthermore, by choice, Petitioner made it clear that she no longer wanted to drive a bus. Dr. Goldstein testified that Petitioner stated she was not anxious on buses, no longer became anxious when she thought about what happened on the bus or envisioned what had happened to her on the bus. Even by Dr. Kelley's own testimony he did not preclude Petitioner from operating a bus on a permanent basis. The Arbitrator also takes notice of RX3 that shows in the course of approximately one year (August, 2013 to July, 2014) Petitioner availed herself to the CTA transit system 150 days

and many of those days rode the CTA multiple times within the day and at all hours of the day.

Accordingly Petitioner's current condition her psychological well-being is not causally related to the 7-19-11 accident.

In support of the Arbitrator's decision whether the medical services that were provided to Petitioner after 2-27-13 were reasonable and necessary, and whether Petitioner is due temporary total disability benefits after 2-27-13 the Arbitrator makes the following conclusions of law:

Based upon the above findings, the Arbitrator concludes that services rendered by Dr. Kelley after 2-27-13 were not causally related to Petitioner's work accident on 7-19-11.Accordingly Respondent is not liable for any outstanding charges for service dates after 2-27-13.

Based upon the above findings, the Arbitrator concludes that the only condition that precluded Petitioner from returning to work after 2-27-13 was related to her psychological condition which was not causally related to Petitioner's work accident on 7-19-11. Accordingly Petitioner is not entitled to any temporary total disability benefits after 2-27-13.

In support of the Arbitrator's decision as to what is the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusion:

The unrebutted evidence is that on 7-19-11 Petitioner was 38 years old; Petitioner's usual and customary employment with Respondent at the time of her 7-19-11 accident was as a bus operator;
Petitioner's earning capacity was not diminished as a result of her physical injuries to her face and cervical spine as she was not released from any of

the treating physicians with permanent restrictions for same as well as Dr. Benjamin Goldberg's opinion that Petitioner did not sustained any objective permanent partial disability relative to her musculoskeletal system; Dr. Goldstein's opinion that Petitioner did not sustain any persistent psychological effects from the 7-19-11 accident; and based on the aforementioned findings of facts and conclusions of law:

The Arbitrator awards Petitioner 7.5% person as a whole.

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fred Harmon,
Petitioner,

vs.

No. 10 WC 35376

Kane County Forest Preserve,
Respondent.

18IWCC0538

DECISION AND OPINION ON REMAND

This case now comes before the Commission on remand from the Appellate Court.

Briefly, this claim involves an August 23, 2008 work accident when the claimant was struck by a swinging gate, injuring his cervical spine. The case proceeded to hearing before Arbitrator O'Malley on three dates of hearing in 2014 and 2015, along with a consolidated claim, 08 WC 37092, which involved a 2006 motor vehicle accident. In regards to this matter, the Arbitrator awarded 115 weeks of TTD intermittently through 12/19/14, medical expenses of $40,707.36, permanent and total disability commencing on December 20, 2014, and a hold harmless against any providers' claims for related benefits, but denied penalties and fees.

On review, the Commission modified the Arbitrator's findings. In the case at bar, the Commission found that the claimant had attained maximum medical improvement (MMI) and awarded medical expenses only through March 12, 2012. The Commission reduced the TTD benefits to 49 & 2/7 weeks (from 8/24/08 to 11/30/08 and 4/9/09 to 12/10/09) and reduced the permanency award to 40% loss to the whole person under Section 8(d)2.

Following the Commission's decision, the claims were appealed to the Circuit Court, which confirmed the Commission's decision, and then to the Appellate Court. During the pendency of the appeal, the parties agreed to settle case number 08 WC 37092; settlement contracts were approved by the Commission prior to oral arguments before the Appellate Court, and case 08 WC 37092 is no longer part of this litigation.

On appeal, the Appellate Court affirmed the Commission's determinations as to Maximum Medical Improvement, the medical treatment award, and the nature and extent of the injury as not being against the manifest weight of the evidence, and further affirmed the Commission's denial of penalties and fees. However, the Appellate Court did determine that the Commission's assessment as to the TTD period was against the manifest weight of the evidence.

In accordance with the Appellate Court order, the Commission modifies the TTD award; the period of August 24, 2008 through November 30, 2008 is affirmed, and the period beginning April 9, 2009 is extended through May 23, 2012, pursuant to the Appellate Court order. This is a total period of 177 & 1/7 weeks of TTD.

All other findings and awards of the Commission were and are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Commission of June 20, 2016 is hereby modified as stated herein and otherwise affirmed pursuant to the Appellate Court Order of April 4, 2018.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner the sum of $634.57 per week, commencing August 24, 2008 through November 30, 2008 and from April 9, 2009 through May 23, 2012, totaling 177 & 1/7 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner those reasonable and necessary medical expenses related to his cervical spine injuries incurred through March 12, 2012, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay Petitioner permanent partial disability benefits of $571.12 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused a 40% loss of use of the person as a whole. Petitioner is not eligible for cost of living adjustments paid by the Rate Adjustment Fund pursuant to §8(g) of the Act, and the Arbitrator's award of such is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given credit for disability and medical benefits that have been paid to or on behalf of Petitioner on account of said accidental injuries. Respondent shall hold Petitioner harmless from any claims by any providers of the medical services incurred between August 23, 2008 and March 12, 2012, for which Respondent is receiving credit, as provided in §8(j) of the Act. The Commission notes the parties stipulated that $107,296.41 in TTD payments had been made relative to this case at time of the initial hearing and those benefits are awarded as credit against the above award.

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

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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 3 1 2018

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jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

J. Elizabeth Coppoletti