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

Anna Roleska,

19IWCC0401

Petitioner,

vs.

NO. 16WC 007886
15WC 018755

Glen Oaks Health & Home,

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 diseases, and permanent disability, and being advised of the facts and law, affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2018 are hereby affirmed and adopted.

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

No bond 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 1 - 2019

DATED:
SJM/sj
o-7/17/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROLESKA, ANNA
Employee/Petitioner

Case# **16WC007886**
15WC018755

GLEN OAKS HEALTH & HOME
Employer/Respondent

19IWCC0401

On 6/29/2018, 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 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 ROLESKA, ANNA
3510 N LONG
CHICAGO, IL 60641

5578 LAW OFFICES FRANCESCA LARSEN
150 N MARTINGALE RD
SUITE 225
SCHAUMBURG, IL 60173

19IWCC0401

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

Anna Roleska
Employee/Petitioner

v.

Glen Health & Home
Employer/Respondent

Case # **16** WC **7886**

Consolidated cases: **15 WC 18755**

An *Application for Adjustment 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 **June 11, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **9/26/2014**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner failed to meet her burden of proof on the issues of repetitive trauma and causal connection. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

In the year preceding the injury, Petitioner earned $**21,545.00**; the average weekly wage was $**414.32**.

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

Petitioner claims no unpaid medical expenses or temporary total disability benefits. Arb Exh 4.

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

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner failed to meet her burden of proof on the issues of accident/repetitive trauma and causal connection. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

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

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

Molly C Mason

Signature of Arbitrator

6/29/18
Date

JUN 29 2018

Arbitrator's Findings of Fact Relative to 16 WC 7886

The pro se Petitioner, Anna Roleska, filed an Application for Adjustment of Claim on March 10, 2016, alleging an accident of "9/2014" causing osteoarthritis in her left hip. The Application further states: "I had left hip pain after heavy pulling." RX 1.

Petitioner testified this claim, like her earlier filed claim [see the Arbitrator's decision in 15 WC 18755] involves repetitive trauma rather than a single event. Petitioner testified she experienced left hip pain while working. She attributed this pain to the following work activities: pushing a 500-pound cart that was loaded with trays of food, continually bending to reach the trays at the bottom of the cart, moving a heavy Hoyer lift around Respondent's facility and "pivot[ing] like a golfer." She went to Dr. Banas at Union Medical Center on September 26, 2014, a Friday. X-rays performed that day showed "mild degenerative osteoarthopathy of the left hip" (PX 6). She worked the following day. She subsequently received PX 7, a letter from a nurse at Union Medical Center. The letter is dated October 6, 2014. It states: "Dr. Banas would like to inform you that the left hip x-ray done on September 26, 2014 indicate that you have arthritis."

Petitioner did not offer any additional hip-related medical records into evidence.

Petitioner testified that, on October 22, 2014, she gave a copy of her X-ray results to Dennis Ong, Respondent's nursing director. She told Ong "I will be filing."

Petitioner identified PX 8 as a denial letter she received from PMA Companies. This letter is dated July 8, 2015. It was authored by Brian DeBias. In the letter, DeBias informed Petitioner that the investigation of her claim for workers' compensation benefits "has concluded" and that the claim was being denied because it did "not meet the requirements for a compensable workers' compensation injury in the state of Illinois."

Petitioner testified she continues to work full-time for Respondent. She occasionally takes a day off due to her left hip pain but is not seeking temporary total disability benefits. Arb Exh 4. She has not sought additional care because she feels nothing can be done about her condition.

Under cross-examination, Petitioner acknowledged the doctor she saw at the Union Medical Center did not causally link her left hip condition to her work activities. He simply advised her of the X-ray results.

Respondent did not call any witnesses. Respondent offered one document, i.e., the Application for Adjustment of Claim. RX 1.

Arbitrator's Conclusions of Law

Did Petitioner meet her burden of proof on the issues of repetitive trauma and causal connection?

It has long been held that an employee alleging an injury secondary to repetitive trauma must meet the same standard of proof as claimants alleging a single, definable accident. Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill.App.3d 880 (3rd Dist. 1985). In Peoria County Belwood, the Appellate Court found that the claimant, a nursing home employee, established left carpal tunnel injuries secondary to her laundry room duties. The Court noted the claimant's testimony concerning the duration of her employment, the precise nature of her laundry sorting and loading duties, the frequency of the washing machine operation and the weight of the laundry bags she carried. The Court also noted that the claimant "informed her physician that she

experienced extreme difficulty in gripping washer doors" due to the severity of her left wrist symptoms and that "both the claimant and [her doctor] related those symptoms to her employment." In the instant case, Petitioner identified certain work activities she perceived as causing her left hip pain but her testimony on this issue lacked specificity. She did not indicate the duration of her employment, her work schedule or the frequency with which she performed the activities she identified. More importantly, there is no evidence indicating she mentioned those activities to Dr. Banas when she saw him on September 26, 2014. Under cross-examination, she readily acknowledged the doctor did not relate her hip symptoms to any aspect of her employment. She admitted the doctor simply advised her of her X-ray results. She offered only one treatment note into evidence, namely the left hip X-ray report of September 26, 2014. That report contains no mention of the origin or duration of the left hip complaints. PX 6. She did offer excerpts from a nursing assistant textbook relating to ergonomics, musculoskeletal disorders and osteoarthritis [PX 9], which she said she received at a CNA training course, but the Arbitrator rejected this evidence based on Respondent's valid hearsay and foundational objections.

The Arbitrator finds that Petitioner failed to establish repetitive trauma injuries and causal connection. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

15WC 018755
16WC 007886

Page 1

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anna Roleska,

Petitioner,

vs.

19IWCC0402

NO. 15WC 018755
16WC 007886

Glenn Oaks Nursing Home,

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 diseases, and permanent disability, and being advised of the facts and law, affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 29, 2018 are hereby affirmed and adopted.

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

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

DATED: AUG 1 - 2019
SJM/sj
o-7/17/2019
44

Stephen J. Mathis

Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROLESKA, ANNA
Employee/Petitioner

Case# **15WC018755**

16WC007886

GLENN OAKS NURSING HOME
Employer/Respondent

19IWCC0402

On 6/29/2018, 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 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 ROLESKA, ANNA
3510 N LONG
CHICAGO, IL 60641

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
77 W WASHINGTON ST SUITE 1601
CHICAGO, IL 60602

19IWCC0402

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

Anna Roleska
Employee/Petitioner

v.

Glen Oaks Nursing Home
Employer/Respondent

Case # **15** WC **18755**

Consolidated cases: **16 WC 7886**

An *Application for Adjustment 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 **6/11/2018**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the 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 **"Was the Petitioner's Application for Adjustment of Claim timely filed?"**

FINDINGS

On **June 1, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner failed to meet her burden of proof on the issues of accident/repetitive trauma and causal connection. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

In the year preceding the injury, Petitioner earned $**19,760.00**; the average weekly wage was $**380.00**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

Petitioner claims no unpaid medical expenses or temporary total disability benefits. Arb Exh 1.

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

FOR THE REASONS SET FORTH IN THE ATTACHED DECISION, THE ARBITRATOR FINDS THAT PETITIONER FAILED TO MEET HER BURDEN OF PROOF ON THE ISSUES OF ACCIDENT/REPETITIVE TRAUMA AND CAUSAL CONNECTION. THE ARBITRATOR VIEWS THE REMAINING DISPUTED ISSUES AS MOOT AND MAKES NO FINDINGS AS TO THOSE ISSUES. COMPENSATION IS DENIED.

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

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

Molly C Mason

Signature of Arbitrator

6/29/18
Date

JUN 29 2018

Anna Roleska v. Glen Oaks Nursing Home
15 WC 18755 (consolidated with 16 WC 7886)

ARBITRATOR'S FINDINGS OF FACT RELATIVE TO 15 WC 18755

Petitioner, who is pro se, testified she works for Respondent, a nursing home. She alleges cervical spine injuries of June 1, 2011. Arb Exh 1. Although she did not testify in the instant case as to her work duties as of that date, she did describe those duties in the companion case, 16 WC 7886. She indicated her duties as of September 26, 2014 included pushing a cart that was loaded with trays of food, lifting her arms to remove trays from that cart and pushing a heavy Hoyer lift around Respondent's facility. She testified the loaded cart weighed 500 pounds and each tray weighed 6 pounds.

Petitioner testified she first sought treatment for her neck in 2009. She went to Union Medical Center and saw a provider who ordered cervical and dorsal spine X-rays. She offered into evidence X-ray reports dated May 29, 2009. The cervical spine X-rays showed mild degenerative disc disease of C6-C7 and flattening of the cervical curvature, which the radiologist indicated was likely "due to neck or muscle spasm." The dorsal spine X-rays were interpreted as normal. PX 1.

Petitioner testified she continued working for Respondent after undergoing the X-rays. She offered into evidence a work status note from Union Medical Center dated June 16, 2009. This note bears a physician's signature but the signature is not legible. The note is not accompanied by any treatment record. It

reflects a diagnosis of neck and upper back pain. The authoring physician indicated he saw Petitioner on June 16, 2009 and released her to restricted duty as of June 17, 2009, with no lifting over 5 pounds and no lifting overhead. PX 2. Petitioner also offered into evidence a prescription note from Union Medical Center dated June 16, 2009. The prescription is for Tylenol. The signature of the prescribing physician is not legible. The note is not accompanied by any treatment record. PX 5.

Petitioner testified she returned to Union Medical Center in 2011. She offered into evidence a work status note from Union Medical Center dated February 16, 2011. The note reflects a diagnosis of "LBP – work injury." The injury is not further described. Petitioner did not testify to any low back injury. The authoring physician, whose signature is not legible, recommended "f/u at occupational clinic" and released Petitioner to restricted duty as of February 17, 2011, with no lifting over 5 pounds and no bending. PX 3. Petitioner also offered into evidence a work status note from Union Medical Center dated June 21, 2011. The note, authored by H. Alvarez, M.D., reflects diagnoses of "osteoarthritis and cervical nerve compression." Dr. Alvarez released Petitioner to restricted duty as of June 24, 2011, with no overhead carrying/pulling and no lifting/pulling/pushing/carrying over 10 pounds. Petitioner testified she presented this note to Dennis Ong, Respondent's nursing director, the following day. She

indicated that Ong responded by smiling and asking her, "do you know how little weight that is, 10 pounds?" Respondent then provided her with light duty consisting of observing residents in the smoking room and on the patio. Petitioner testified she performed light duty for one month and then resumed her regular work tasks. She took medication and continued working. She experienced another injury in 2014 [see decision in 16 WC 7886].

Petitioner testified she did not file the instant claim in 2011 because it was only when she underwent X-rays in 2014, after her subsequent injury, that she realized what she had. On June 10, 2015, she filed an Application for Adjustment of Claim alleging cervical spine nerve compression of June 2011. On the Application, she indicated she had "neck pain, headaches and trouble moving the neck after pulling." She noted a return to work date of June 24, 2011. Arb Exh 3.

Petitioner testified she continues to work full-time for Respondent. She deals with her symptoms by occasionally taking a day off. She is not claiming unpaid medical expenses or temporary total disability benefits. Arb Exh 1.

Petitioner testified her condition is serious. She experiences symptoms while working but not at home. At work, she experiences headaches emanating from the neck, dizziness and neck pain. She has fallen in the street on three occasions.

In addition to the exhibits previously summarized, Petitioner offered into evidence extracts from a nursing assistant textbook relating to musculoskeletal disorders, ergonomics and osteoarthritis. Petitioner testified she obtained this information at a certified nursing assistant training course. The Arbitrator rejected this evidence based on Respondent's valid hearsay and foundational objections.

Respondent did not call any witnesses or offer any documentary evidence.

ARBITRATOR'S CONCLUSIONS OF LAW IN 15 WC 18755

Did Petitioner meet her burden of proof on the issues of repetitive trauma and causal connection?

Petitioner did not testify to a specific accident occurring on June 1, 2011. The gist of her testimony is that certain of her work activities caused osteoarthritis in the cervical spine.

It has long been held that an employee alleging an injury secondary to repetitive trauma must meet the same standard of proof as claimants alleging a single, definable accident. Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill.App.3d 880 (3rd Dist. 1985). In Peoria County Belwood, the Appellate Court found that the claimant, a nursing home employee, established left carpal tunnel injuries secondary to her laundry room duties. The Court noted the claimant's testimony concerning the duration of her employment, the precise nature of her laundry sorting and loading duties, the frequency of the washing

machine operation and the weight of the laundry bags she carried. The Court also noted that the claimant "informed her physician that she experienced extreme difficulty in gripping washer doors" due to the severity of her left wrist symptoms and that "both the claimant and [her doctor] related those symptoms to her employment." In the instant case, Petitioner identified certain work activities involving arm usage but her testimony on this issue lacked specificity. She did not indicate the duration of her employment, her work schedule or the frequency with which she performed the activities she identified. More importantly, there is no evidence indicating she mentioned those activities to the physicians she saw in 2009 and 2011. She provided work status notes reflecting diagnoses and restrictions but no context for those notes. The Arbitrator has no information as to what histories she provided to her treating physicians. The notes do not contain a medical opinion that her work activities caused her claimed cervical spine condition.

The Arbitrator finds that Petitioner failed to establish repetitive trauma injuries and causal connection. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SUE BAGLEY,

Petitioner,

vs. NO: 13 WC 37849

CARBONDALE MEMORIAL HOSPITAL,

Respondent.

19IWCC0403

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 of the lumbar spine condition of ill-being, medical expenses, temporary disability, and permanent disability 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.

Causation

Like the Arbitrator did, the Commission finds Dr. Zelby's opinions are highly persuasive and more credible than Dr. Gornet's. Certainly, Dr. Zelby's reputation as respondent-friendly is well known to the Commission; here, though, Petitioner's attack on Dr. Zelby's credentials and perceived bias is ineffective given Dr. Zelby's opinions are wholly consistent with and supported by the medical records. This case represents an instance where Dr. Gornet identified an "obvious" annular tear heretofore unobserved by any of the other physicians who reviewed the images. While the weight to be accorded medical opinion evidence is not simply a matter of adding up the number of experts (*Cinch Manufacturing Corp. v. Industrial Commission*, 393 Ill. 131, 134, 65 N.E.2d 383 (1946) (holding that the weight of the evidence in a workers' compensation case does not lie with the party producing a greater number of expert witnesses on its behalf); *ABF Freight System v. Illinois Workers' Compensation Commission*, 2015 IL App

(1st) 141306WC, ¶22, 45 N.E.3d 757 (holding that the number of witnesses testifying to a particular fact is not controlling)), the Commission believes it is significant that Dr. Gornet is the only physician who found an L5-S1 disc problem. The Commission affirms the finding that Petitioner's alleged injury at L5-S1 is not causally related to her undisputed work accident.

Temporary disability

The Commission makes the following correction to accurately incorporate the parties' stipulations. Respondent stipulated Petitioner was entitled to Temporary Total Disability benefits from November 1, 2013 through March 2, 2014. Respondent further claimed a credit of $5,914.76 for TTD benefits paid, to which Petitioner stipulated. The Arbitrator's decision awarded Respondent's credit but failed to award Petitioner the associated TTD benefits. Therefore, the Commission corrects the decision to award the stipulated TTD benefits from November 1, 2013 through March 2, 2014.

Medical

When addressing the reasonableness and necessity of the submitted medical charges, the Arbitrator denied "any prospective treatment directed at any lumbar disc condition" as well as prospective treatment for the accepted coccyx condition, "including but not limited to additional visits to Dr. Newcomb and any charges for narcotics." The Commission observes prospective care was not raised as an issue by the parties and was therefore not before the Arbitrator, and further, Respondent stipulated Petitioner's current coccyx condition of ill-being remains causally related to her undisputed accident. ArbX1. As the Arbitrator's finding could be construed as a bar to Petitioner pursuing her §8(a) rights associated with the accepted coccyx condition, the Commission strikes the language denying prospective care.

The Commission emphasizes, however, that it does find Petitioner engaged in drug-seeking behavior. This is borne out by its award of over $20,000 to IWP, the majority of these prescriptions are for Hydrocodone. Although the Commission finds these expenses reasonable and necessary under Section 8(a), the Commission is cognizant that Drs. Rende, Gornet, and Zelby all indicated Petitioner is on high-dose narcotic medication. Given this specific finding, any future request for narcotic medications will be examined carefully and our analysis of whether such is reasonable and necessary will necessarily take that finding into consideration.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's lumbar condition of ill-being is not causally related to her July 6, 2013 work accident. Pursuant to the parties' stipulation, Petitioner's current coccyx condition of ill-being remains causally connected to her work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $339.37 per week for a period of 17 3/7 weeks, representing November 1,

19IWCC0403

2013 through March 2, 2014, that being the stipulated period of temporary total incapacity for work under §8(b). Respondent shall have credit for $5,914.76 in TTD benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $23,287.00, that being the charges Petitioner incurred with IWP, for reasonable and necessary medical expenses as provided in Section 8(a), subject to Section 8.2. Respondent shall receive credit for amounts previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j). Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving this credit under Section 8(j).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $305.43 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 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 $30,700.00. 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 - 2019

L. Elizabeth Coppoletti

LEC/mck

O: 6/5/19

43

SPECIAL CONCURRENCE/DISSENT

I concur in all aspects of the majority decision other then the commentary characterizing Dr. Zelby's reputation as "respondent-friendly" and the suggestion that there have been instances where this Commission has failed to give due weight to Dr. Zelby's conclusions as a function of some perception that Dr. Zelby is "respondent-friendly". Both Dr. Zelby and Dr. Gornet are well-qualified and well- respected members of the medical community. They have expressed differing medical opinions in this case. The Arbitrator correctly determined that the opinion of Dr. Zelby was more persuasive than that expressed by Dr. Gornet in this case.

Additionally, I do not concur that the Petitioner has engaged in "drug -seeking behavior". Whether Petitioner suffers opioid dependence is a medical determination to be made

19IWCC0403

by medical professionals. If indeed Petitioner has developed opioid dependency it is not the province of this Commission to predetermine what future medical treatment may be deemed reasonable and necessary. If the issue of prospective medical treatment arises in the future the evidence presented in support of that request will be the determinant of what treatment is reasonable and necessary.

Since the comments of my co-panelist relative to opioid issues are not at issue in this proceeding I feel that my Special Concurrence is appropriate.

Stephen Mathis

SPECIAL CONCURRENCE/DISSENT

I agree with the Arbitrator's and majority's finding of no causal connection relative to the lumbar disc at L5-SI. I also agree that the Petitioner's coccygodynia is causally related to the accident. In that regard, I agree with the majority that Petitioner may be entitled to future medical care for her coccyx condition should the need arise. I further agree with the majority regarding the award of temporary total disability benefits.

I disagree with the majority, however, as I believe an award of 10% loss of use of the person-as-a-whole is warranted. I would place greater weight on subsection (ii) of Section 8.1(b). Petitioner testified that she had constant pain in the coccyx for over two years after the accident, finally showing relief after receiving injections in the summer of 2015. She was employed as a CNA during that period, which required lifting, bending and stooping. She now works as a home health caregiver, which also could involve those activities.

I would also give greater weight to subsection (v) of Section 8.1(b). Petitioner had objective findings consistent with coccyx injuries for over two years as documented by both Dr. Newcomb and Dr. Koth. Dr. Rende performed a Section 12 examination and records review in December 2015. Petitioner's exam showed the condition to be still present. Dr. Rende opined that Petitioner was not yet at maximum medical improvement (MMI) and stated that there was a possibility that her coccyx would have to be removed if her symptoms continued. I also find Petitioner's testimony as to her coccyx symptoms credible. Petitioner consistently reported her symptoms to her doctors. She appeared to be improved as of 2017 but she has not been performing her full job duties since being terminated by the hospital. Also, her main focus could have been the lumbar disc with radiation causing her to prioritize that condition over her coccyx.

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BAGLEY, SUE
Employee/Petitioner

Case# **13WC037849**

CARBONDALE MEMORIAL HOSPITAL
Employer/Respondent

19IWCC0403

On 6/12/2018, 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 2.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPARTICK LAW OFFICES
ERIC KIRKPATRICK
#3 EXECUTIVE WOODS CT #100
BELLEVILLE, IL 62226

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

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

SUE BAGLEY
Employee/Petitioner

v.

CARBONDALE MEMORIAL HOSPITAL
Employer/Respondent

Case # **13** WC **37849**

Consolidated cases: ____

19IWCC0403

An *Application for Adjustment 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 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. ☒ 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 6, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**26,470.79**; the average weekly wage was $**509.05**.

On the date of accident, Petitioner was **50** 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 $**5,914.76** for TTD, $**0** for TPD, $**0** for maintenance, and $**396.85** for other benefits, for a total credit of $**6,311.61**.

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

ORDER

As explained in the Arbitration Decision, Petitioner's alleged L5-S1 disc issue is not causally related to her work accident of July 6, 2013. All benefits related thereto are denied. With regard to Petitioner's accepted coccyx condition, Petitioner reached maximum medical improvement on May 2, 2017.

Respondent shall pay medical services to IWP totaling $23,287.00, as detailed in the Arbitration Decision and reflected in Petitioner's Exhibit 15, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts previously paid, including those paid through its group medical plan, for which credit is allowed under Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers for which Respondent is receiving credit under Section 8(j).

Respondent is not liable for any additional temporary total disability.

Respondent shall pay Petitioner the sum of **$305.43 per week** for a period of **25 weeks**, as provided in **Section 8(d)2**, because the injuries sustained caused a **5% loss of use of the body as a whole**.

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

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

Signature of Arbitrator

June 7, 2018
Date

JUN 12 2018

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

19IWCC0403

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SUE BAGLEY
Employee/Petitioner

v. Case #: **13 WC 37849**

CARBONDALE MEMORIAL HOSPITAL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Arbitrator notes at the outset that at the time of hearing, Petitioner moved to amend the Application for Adjustment of Claim to reflect the date of accident as **July 6, 2013**, rather than June 6, 2013. Respondent had no objection and the Application was amended *instanter*. The parties stipulated that on July 6, 2013, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent, resulting in injury to her coccyx. The issues at trial were causal connection of Petitioner's alleged lumbar condition and/or disc injury, past and prospective treatment related thereto, temporary total disability benefits, and nature and extent of the injury. With regard to TTD, Petitioner claimed entitlement to two periods: (1) 11/1/13-3/2/14; and (2) 10/29/14-6/15/15. Respondent did not dispute the first period, and the parties agreed that Respondent had paid benefits for that period totaling $5,914.76. Respondent disputes liability for the second period. The parties further agreed that Respondent had paid non-occupational disability benefits in the amount of $396.85, covering some of the second period. The parties stipulated that Respondent had paid $7,577.79 in medical benefits.

The Arbitrator further notes that Petitioner's testimony seemed to suggest that she had arguably sustained a reduction in earnings and may be entitled to a wage differential if the Arbitrator ruled in her favor. Prior to the closing of proofs, however, Petitioner specifically and affirmatively waived any such award.

On the date of accident, Petitioner was 50 years old, married, and had one dependent child. She was employed by Respondent as a nurse's aide (CNA) and had been so employed since 2004. She did not provide details as to her job duties or responsibilities. Petitioner testified that on July 6, 2013, she went into the soiled utility room to change the linen hampers. As she was changing the bag in one of the hampers, she used her foot to push the pedal to keep the lid up. As she proceeded to walk away, her foot got stuck in the pedal and she fell. Her bottom hit the floor and

her head hit a wall. She testified that she experienced horrible pain in her bottom and her lower back.

Petitioner testified that she went to the emergency room that day and followed up with her family physician, Dr. Newcomb, who treated her up through May 2017. Throughout her treatment, she underwent two rounds of physical therapy, which only somewhat helped with her symptoms, which she related were in her tailbone and her lower back, just below the waistline. She testified that her pain was dull and would not go away. She also underwent four or five injections between 2014 and 2017, which provided relief of her tailbone pain for about a week each. She testified she also saw a Dr. Criste, who did nothing for her. Over the course of treatment, Dr. Newcomb prescribed various medications, including Norco, Mobic, Amitriptyline, and a muscle relaxer. Petitioner testified that she "couldn't do without" the pain medication, due to her pain.

Petitioner testified she saw Dr. Rende, at Respondent's request, but she could not remember the diagnosis that he made. She also so Dr. Gornet, who believed her problem was in her low back versus the coccyx. Petitioner acknowledged that she presented to the emergency room in January of 2015 because she "had a horrible catch" in her right buttock after she bent down to get in her bathroom cabinet. She was given a morphine injection and a muscle relaxer.

Petitioner testified that she received weekly checks for a period of time, which stopped after she was examined by Dr. Petkovich at Respondent's request. At some point, she attempted to return to work, though could not remember the dates, and testified that it was light duty work in the kitchen. Thereafter, she had carpal tunnel surgery on her right hand and was off work for a time. She eventually returned to work in her regular position and the pain in her lower back and tailbone started back. She testified that she was unable to work her 12-hour shifts and she was ultimately fired because she missed too much work. Since that time, she has worked two other jobs. She worked at Casey's, which she testified was "okay at first" because she was a cashier. However, she was moved to making subs, which she testified was a lot of responsibility, and she had pain and spasms in her low back and pain in her tailbone. She worked for Casey's for almost a year. She currently works for Addus Home Care, taking care of clients in their homes. She has three clients and testified that her clientele is "super easy". She does no lifting whatsoever. She bathes only one client, who weighs only 75 pounds and steps in and out of the tub on her own. Petitioner testified that she earned $8.25 an hour working for Casey's, currently earns $9.95 an hour at Addus, and earned $14.03 an hour working for Respondent.

With regard to her current condition, Petitioner testified that she has spasms in her buttocks, pain in her tailbone if she sits too long, and low back pain at the end of the day. She testified that due to her symptoms she does not go out with her friends, does not play bingo or go shopping, has trouble lifting, and no longer has a sex life. She has a garden in the summer but can only spend about ten minutes at a time picking tomatoes. She used to be able to work a whole garden after work with a tiller and a hoe.

On cross-examination, Petitioner testified that she returned to work for Respondent in a light duty capacity in the kitchen in June of 2015, and in July of 2015 she returned to full duty work in her regular unit, with no restrictions. She acknowledged that since Dr. Newcomb's full duty release in July of 2015, no doctor has subsequently ever placed work restrictions on her.

Petitioner conceded that, other than Dr. Gornet, no physician has recommended any type of surgery. She testified that Dr. Gornet told her she was on too much medication and was not recommending any surgery at this point, or until she gets off the medication. She testified she would be glad to get off the medication, but she needs "fixed", and "it's either fixed or medication".

Following the accident, Petitioner presented to the emergency room at Memorial Hospital on July 6, 2013. She reported a history of the accident consistent with her testimony, and reported that her pain was located in her tailbone, without radiation. In the review of systems section of the record, Petitioner identified her tailbone and her pelvis as the locations of her pain. Neurological examination was normal. A lumbar CT scan showed mild L5-S1 facet arthropathy, no acute fracture or subluxation, and no herniation. A cervical CT scan showed no acute findings. A head CT scan showed no intracranial injury. Petitioner was given prescriptions for Vicodin and Naprosyn, referred to physical therapy, and was instructed to follow up with her physician on August 16, 2013. Diagnosis on the therapy referral was "mid-line sacro-coccygeal with mild lower lumbosacral strain". PX1, PX6.

On July 10, 2013, Petitioner presented to Dr. Mark Austin of WorkCare and reported a consistent history of the accident. She complained of tailbone pain, which was documented as "hurting very bad", headaches, and occasional spasms in her left hip. She specifically denied any increased low back pain or radiating symptoms into her lower extremities. On examination, motor, sensory, and reflex examinations were within normal limits. She had full flexion and extension in her lumbar spine without low back pain, and unrestricted side bend. She had full range of motion in her hips; however, she had increased pulling discomfort and pain to the central tailbone midline with Fabre's/Patrick's testing. Straight leg raise testing was negative for low back pain, but a mild increase in tailbone pain was noted during this test. There was tenderness to the midline sacrococcygeal joint and to the midline coccyx. There was no swelling, numbness, tingling, or radiating pain. RX5, PX9.

Dr. Austin reviewed Petitioner's July 6, 2013, lumbar CT scan and stated it was negative for any acute trauma. He assessed Petitioner with a tailbone contusion, stating that Petitioner had a nearly normal exam functionally, and that there was no evidence of any secondary low back strain of any significance. He released Petitioner to full duty work without restrictions, and prescribed a donut cushion for when she was sitting. RX5, PX9.

On July 17, 2013, Petitioner returned to Dr. Austin with complaints of tailbone pain and occasional spasms in her hips and buttocks. She denied any increased low back pain with cough, and denied any radiating pain, numbness, tingling or weakness into her lower extremities. Her neurological examination was normal. Dr. Austin noted Petitioner was still very tender to midline lower sacrum and coccyx, but the other components of her musculoskeletal exam were normal. Examination of her lumbar spine exam elicited only tailbone pain. Straight leg raise and Fabre's/Patrick's testing were both negative. X-rays taken that day showed degenerative spurring at the lower right and left SI joints, but no fractures or dislocations. Dr. Austin's assessment was tailbone (sacrum-coccygeal) contusion. Petitioner was allowed to continue working full duty without restrictions. RX5, PX9.

On July 26, 2013, Petitioner returned to Dr. Austin's office and again reported pain, soreness, and occasional spasms in her buttocks, but denied any paresthesias to her lower extremities past her buttocks. On examination, there was tenderness in the SI joint and numbness and tingling in both buttocks. Petitioner reported sharp pain at the tailbone while sitting on the exam table. Neurological exam was normal. Assessment was lumbar pain and sacroiliac pain with radiculopathy into bilateral buttocks/lumbar radiculitis, and lumbar/sacral sprain and strain. Petitioner was given light duty work restrictions and referred for physical therapy. RX5, PX9.

On July 31, 2013, Petitioner followed up with Dr. Austin and reported continued tailbone soreness with occasional spasms in her right hip/buttock area. She denied any increase in low back pain with cough, and denied any radiating pain, numbness, tingling, or weakness in her lower extremities. On examination, she described radiating pain in her right and left buttocks, and a "tightness" in her upper posterior thighs. Sensation and reflexes were normal. Lumbar range of motion was full, but with some sacrococcygeal and midline low back pain at the extremes of motion. Hip range of motion testing elicited pain in the SI joints and increased tailbone and low back pain. Straight leg testing was negative, but was noted as painful to the sacrococcygeal area. Fabre's/Patrick's testing was negative for hip joint pain, but did pull uncomfortably to the midline at the sacrum-coccyx, and to the posterolateral SI joint. Assessment was slowly improving midline sacrococcygeal contusion and pain. Dr. Austin noted Petitioner was still tender, but had full range of motion. He also noted evidence of a minimal, mild lower midline lumbosacral strain. Petitioner was given light duty restrictions, and again referred for physical therapy. RX5, PX9.

On August 7, 2013, Petitioner presented to her family physician, Dr. Aaron Newcomb at Shawnee Healthcare Carbondale. She gave a consistent history of falling on her tailbone and hitting her head. Dr. Newcomb noted that CT scans of her head and cervical and lumbar spine were normal. Petitioner complained of pain in her tailbone area, sharp jolting pains through her buttocks like a muscle spasm, and recent onset of urinary incontinence when bending over. She denied loss of sensation, numbness, or tingling in her groin or down her legs. On examination, there was lumbar spine tenderness and mild pain with motion. Physical and neurological exams were otherwise normal. Assessment was low back pain and urinary incontinence. Petitioner was to continue with physical therapy and pain medications, and was referred for a lumbar MRI. PX2.

On August 21, 2013, Petitioner returned to Dr. Austin with continued complaints of soreness in the buttocks and tailbone and periodic spasms. She reported her pain was worse after physical therapy, but the record noted that Petitioner had only attended her initial therapy evaluation and two PT sessions. She denied increased low back pain with cough, and denied any radiating pain, numbness, tingling, or weakness into her lower extremities. On examination, there was tenderness in the area of her tailbone/buttocks. She also had radiating pain, into both buttocks only. Sensory and reflex exams were normal and straight leg raise testing was negative. Fabre's/Patrick's testing was negative for her hip joints, but demonstrated tenderness in the SI joint and to midline sacrum and coccyx. There was full range of motion, but with midline sacrum-coccygeal pain. Twisting also caused mild lower midline lumbar pain at the extremes of motion. Dr. Austin continued to assess a midline sacrococcygeal contusion with pain, and directed Petitioner to continue with physical therapy. RX5, PX9.

Petitioner attended six physical therapy sessions in August of 2013. On August 6, she complained of buttock pain with prolonged sitting. There was tenderness in the sacrum. Diagnosis was noted to be midline sacrococcygeal with mild lower lumbosacral strain. On August 28, it was noted she was working light duty, her pain was decreased to 3/10, and she was able to sit for an hour without buttock pain. She reported decreased coccyx pain but had concerns about increased left hip pain with working a 12-hour shift under restrictions. On August 30, she reported pain in the bilateral buttock area. The Arbitrator notes the records do not contain any specific reference to lumbar pain. PX3.

On September 4, 2013, Petitioner returned to Dr. Austin and reported that her tailbone pain was worse. The Arbitrator notes this is somewhat contradictory to the physical therapy notes. She continued to deny any radiating symptoms into her lower extremities, but only into her lower buttocks. Sensory and reflex exams were normal, straight leg raise testing was negative, and Fabre's/Patrick's testing revealed pain only to the midline sacrum and coccyx. Dr. Austin noted that Petitioner had concluded physical therapy with no improvements. Again, this is somewhat contradictory to the therapy notes. Dr. Austin indicated that he could not exclude the possibility of a healing subcortical fracture or intersegmental ligament injury, and recommended an MRI of Petitioner's sacrum and coccyx. RX5, PX9.

Petitioner followed up with Dr. Austin on September 24, 2013. She had no complaints of radiating symptoms into her lower extremities, and specifically denied any low back pain. On examination, there was tenderness to the midline sacrum and coccyx, and to the bilateral SI joints. There was no lumbar tenderness or spasms. Neurological exam was normal, with no sensory or motor deficits. Dr. Austin noted that Petitioner's pelvic MRI showed no fractures, dislocations, or ligamentous injuries, but did show subchondral cysts to the interior portion of the left sacral area nearing the inferior SI joint, as well as osteophytes at the left and right inferior SI joints. His continued assessment was sacrum and coccyx contusions and pain, and he referred Petitioner for pain management. RX5, PX9. The Arbitrator notes this is the final record from Dr. Austin.

On September 27, 2013, Petitioner was seen by Dr. Newcomb for a routine preventative physical. There is no mention of tailbone or low back pain anywhere in this record. Dr. Newcomb recorded normal range of motion, muscle strength, and stability in all extremities with no pain during his exam. He documented no sensory loss, no deep tendon reflex deficits, and no physical exam findings that would be consistent with any tailbone or low back issue. PX2.

On October 29, 2013, Petitioner returned to Dr. Newcomb and reported moderate to severe low back pain that sometimes radiated down to the right thigh. She stated that symptoms were relieved with pain medicine, specifically Vicodin. She reported she was unable to sit or stand for any length of time without substantial pain. The note indicated Petitioner was there to discuss being taken off work. On examination, bilateral lower extremity strength was normal without any weakness or numbness. There was tenderness in the lumbar paraspinous area. There is no other documentation as to any sort of physical exam on this date. Dr. Newcomb agreed to write Petitioner off work for two weeks in advance of her pain management appointment. PX2.

On November 1, 2013, Petitioner presented to Dr. Gerston Criste at SIH Neurosciences, upon referral by Dr. Newcomb. She reported achy pain in the gluteal area and buttock with no

radiation, occasional numbness and tingling down the right thigh, and muscle spasms in the right leg. Symptoms were aggravated by sitting and standing too long, and were relieved by heat, ice, lying down, and pain medication. Neurological examination was normal; physical examination was normal except for mild tenderness over the sacrococcygeal joint. Dr. Criste reviewed Petitioner's pelvic x-rays, pelvic MRI, and lumbar CT scan, and stated that none of the studies showed any fracture or significant SI pathology. His assessment was coccydynia. Dr. Criste stated he had nothing to offer Petitioner from a pain procedure standpoint, as her diagnostic scans had been "pretty unremarkable". He recommended continued conservative treatment, particularly pelvic rehabilitation, and possibly work rehab/hardening. PX12. The Arbitrator notes this is the only record from Dr. Criste.

Petitioner attended one physical therapy evaluation session on November 11, 2013. On that date, she described pain in her coccyx region and occasional pain in her right posterior thigh and spasms in her gluteals. Diagnosis was listed as coccydynia. She did not return to physical therapy and was discharged on December 13, 2013. PX3.

On November 12, 2013, Petitioner returned to Dr. Newcomb and reported pain in the sacral/coccyx with no radiation. She reported she was given a Lidoderm patch from pain management that did not help much, and that she had resumed physical therapy. The only physical exam finding documented was tenderness in the lumbar paraspinous and sacral coccyx regions. Dr. Newcomb agreed that physical therapy was a good idea and recommended she take Naprosyn on a regular basis. He took Petitioner off work for two weeks, as she reported she was not able to tolerate work activities. PX2.

On November 25, 2013, Petitioner returned to Dr. Newcomb and reported continued sacral pain that was not any better. With regard to the examination, Dr. Newcomb again noted tenderness in the paraspinous, lumbar, and sacral coccyx regions. Dr. Newcomb concurred with Petitioner's decision to stop taking Lyrica, due to side effects. She was to return in one month. No other instructions were given. PX2.

On December 12, 2013, Petitioner returned to Dr. Newcomb and reported mild improvement of her tailbone pain. She stated her tailbone pain was stable with medication, therapy, and rest. Physical examination findings were identical to her prior two visits: tenderness in the paraspinous, lumbar, and sacral coccyx regions, with no other documented findings. Dr. Newcomb recommended Petitioner continue with the same treatment plan, and he completed paperwork for "continuous leave time". PX2.

Only eight days later, on December 20, 2013, Petitioner returned to Dr. Newcomb complaining of moderate and constant tailbone pain. She reported she was not able to function due to pain, and that she was awaiting physical therapy. (The Arbitrator notes the physical therapy record of December 13, 2013, states she was discharged because she "stopped attending". PX3.) Examination findings again were noted to be tenderness in the paraspinous, lumbar, and sacral coccyx regions, and no other documented findings. Dr. Newcomb again recommended physical therapy. PX2.

On January 16, 2014, Petitioner returned to Dr. Newcomb and noted she had not begun physical therapy. She reported that her tailbone symptoms were gradually improving; she still had pain and spasms, but less frequently. Examination findings were noted to be exactly the same as the prior examinations. Dr. Newcomb continued to recommend physical therapy. PX2.

On January 29, 2014, Petitioner was again evaluated for physical therapy. She again complained of pain in her coccyx region, occasional pain in her right posterior thigh, and occasional gluteal spasms. She attended 14 therapy sessions between January 29 and April 2, 2014. PX4. The Arbitrator notes that Petitioner testified her pain was located in her tailbone and lower back when she was undergoing physical therapy, which she described to be just below her waistline, and in her tailbone.

On February 17, 2014, Petitioner returned to Dr. Newcomb and reported continued tailbone pain, worsened lately with physical therapy. The only positive physical exam finding was tenderness in the paraspinous, lumbar, and sacral coccyx regions. Nno other findings were documented. The Arbitrator notes the wording for this section of Dr. Newcomb's record is exactly the same as in prior records. Assessment was coccydynia. Dr. Newcomb noted Petitioner was scheduled for an orthopedic evaluation and he concurred with the need for same. PX2.

On February 24, 2014, Petitioner was evaluated by Dr. Frank Petkovich, Respondent's Section 12 examiner. She described her current symptoms as intermittent aching pain in her lower back and sacrum area. She denied pain, numbness, or tingling in either lower extremity. On the intake form, she wrote that her chief complaint was "coccyx and sacrum pain." On examination, she reported mild tenderness to palpation in the right and left lower lumbar areas from L4 to the sacrum, and tenderness to palpation directly over the lower sacrum and coccyx. Neurologic exam showed normal reflexes, strength, and sensation. Petitioner was able to stand on her heels and toes, straight leg raise did not produce any radicular symptoms bilaterally, and range of motion of both hips was full and without pain. Sacrum x-rays that day were normal. Dr. Petkovich diagnosed sacrum and lumbar contusions. He recommended continued physical therapy, after which he believed Petitioner would be at maximum medical improvement. He did not believe Petitioner should be off work, and recommended light duty restrictions of no lifting more than ten pounds, and limited bending, stooping, kneeling, and squatting. RX4.

On March 26, 2014, Petitioner returned to Dr. Newcomb with a new complaint of numbness and tingling in the right hand, and numbness in her right foot and pinky toe. She also reported pain and spasms in her left buttock and increased anxiety. She denied extremity weakness. No physical or neurological exams of Petitioner's coccyx area or lower extremities were documented. Assessment was uncontrolled anxiety, as well as paresthesias, which Dr. Newcomb described as a "new problem" for which he recommended only monitoring. PX2.

On April 28, 2014, Petitioner returned to Dr. Newcomb. She reported numbness in both feet for the past month. The only mention of any positive physical exam findings on this date was that her pulses were present in her distal extremities. Dr. Newcomb referred Petitioner for a neurological consultation. PX2.

On June 24, 2014, Petitioner underwent a lumbar MRI at Memorial Hospital of Carbondale. The radiologist noted mild facet arthropathy at L5-S1, as well as a superimposed small central broad-based disc protrusion. The radiologist described this as mild degenerative disease and disc bulge. Nowhere in the report does the radiologist identify an annular tear at any level, including L5-S1. PX6.

On June 25, 2014, Petitioner returned to Dr. Newcomb. She reported continued pain in her tailbone region dating back one year. She also reported carpal tunnel symptoms, which the Arbitrator notes she testified were unrelated to her work accident. The only notation of any pertinent physical exam finding is under "Rectum" exam, indicating the presence of prolapsed hemorrhoids, and noting that "lifting coccyx posteriorly seemed to improve pain somewhat during exam done with M. Corley present." There is no other examination of the coccyx or lumbosacral region noted. Dr. Newcomb increased Petitioner's Norco and stated he would work on a referral to a surgeon. PX2.

On July 24, 2014, Petitioner was seen by Dr. Newcomb's physician's assistant Marcia Scott. She complained of intermittent neuropathy, but the note is unclear as to the anatomic location of these complaints. There is a nursing comment indicating Petitioner had "hx of neuropathy c/o bilateral leg pain and muscle cramps"; however, the Arbitrator notes this notation is inconsistent with Petitioner's medical records. The physical exam documented in this note did not appear to involve Petitioner's low back, coccyx region, or lower extremities. Assessment was merely "polyneuropathy", with no reference to the anatomic location of the condition. PX2.

On August 12, 2014, Petitioner underwent an MRI of her pelvis at Memorial Hospital of Carbondale. The radiologist's impression was mild degenerative changes of the hips and SI joints, and degenerative changes involving the coccyx without evidence of an acute osseous injury at that site. PX6.

On September 5, 2014, Petitioner returned to Dr. Newcomb with unrelated complaints of carpal tunnel symptoms, for which she reported she was to undergo surgery. Dr. Newcomb noted that Petitioner had undergone an MRI of her pelvis, which he stated showed some abnormalities, including degenerative joint disease of the coccyx and SI joints. No relevant physical exam was documented. PX2.

On September 24, 2014, Petitioner was seen by Dr. Kevin Koth at Orthopaedic Institute of Southern Illinois ("OISI"), upon referral from Dr. Newcomb. Her chief complaint was low back pain, mostly over her coccyx region. Dr. Koth reviewed Petitioner's pelvis MRI and stated it showed some bilateral sacroiliitis and degenerative changes without fracture. His assessment was coccydynia. He advised Petitioner to follow up after a scheduled coccyx injection. PX12. The Arbitrator notes this is the only record from Dr. Koth, and presumably Petitioner never returned for evaluation or treatment of coccydynia.

On October 21, 2014, Petitioner returned to Dr. Newcomb. She reported prominent pain in her coccyx region, despite medications. The only positive physical exam findings were of tenderness to the paraspinous, lumbar, and sacral/coccyx regions, which the Arbitrator notes was,

word-for-word, the same findings documented in multiple prior notes. Dr. Newcomb added Lyrica to Petitioner's use of Cymbalta and Norco. PX2.

On October 29, 2014, Petitioner presented to Dr. Newcomb for a "routine preventive physical". Under the review of systems portion of this note, Dr. Newcomb noted Petitioner was positive for "chronic tailbone." Interestingly, Dr. Newcomb documented completely normal physical and neurological examinations on this date. He noted Petitioner had normal range of motion, muscle strength, and stability in all extremities with no pain, no sensory loss, and preserved deep tendon reflexes. Despite what appeared to be a normal, routine physical, with no specific subjective complaints and no positive exam findings, Dr. Newcomb wrote Petitioner off work for two weeks on this date. PX2. During her testimony, Petitioner attributed this time off work to her work accident.

On November 13, 2014, Petitioner returned to Dr. Newcomb, complaining of tailbone pain. She reported being unable to sit or stand for any significant length of time without prominent tailbone pain, and was requesting a work release. Despite documenting no relevant physical or neurological exams in this note, Dr. Newcomb wrote Petitioner off work for one month. PX2.

On December 10, 2014, Petitioner was seen by Dr. Newcomb for a variety of ailments, including tailbone pain and unrelated right great toe pain (ingrown toenail). No relevant physical or neurological exams were documented. PX2.

On December 15, 2014, Petitioner was again seen by Dr. Newcomb. She described tailbone pain that was aching and dull, and that was unresolved with medication. Once again, no relevant physical or neurological exams were documented, yet Dr. Newcomb wrote Petitioner off work for three months and adjusted her medications. PX2.

On December 24, 2014, Petitioner underwent a CT-guided sacral coccygeal junction nerve root blockade, as ordered by Dr. Newcomb. The clinical history in the diagnostic imaging report lists only coccydynia/algia. PX5.

The Arbitrator notes the record reflects that Petitioner reported to Dr. Rende (discussed in more detail later) that she was involved in a motor vehicle accident on December 26, 2014, which caused pain in her neck, shoulder, and low back. She advised Dr. Rende that she went to the emergency room following the accident and did not see Dr. Newcomb again until May 19, 2015.

On January 15, 2015, Dr. Newcomb authored a letter to Cigna Short Term Disability on behalf of Petitioner. He described Petitioner's work accident as her falling directly onto her tailbone, and subsequently developing a pain syndrome called coccydynia. He stated, "I have clinically concluded that (Petitioner) has developed chronic coccydynia pain syndrome from this trauma." At no point in this letter does Dr. Newcomb address any purported low back condition, subjective complaints of low back or lower extremity symptoms, objective physical or neurological findings supporting a diagnosis of any low back condition, and no diagnostic studies revealing any lumbar/low back findings. PX2.

On January 28, 2015, Petitioner presented to the emergency room at Memorial Hospital of Carbondale. She described bending down to pick up a trash bag and feeling a catch in her right buttock, lower back, and tailbone. The note indicated that Petitioner stated she usually took Norco, but was out of her medication on that date. On examination, there was lumbar paraspinal tenderness, sacral paraspinal tenderness, and right buttock tenderness. Left straight leg raising was positive at 20 degrees. The remainder of Petitioner's physical and neurological examination was normal. She was discharged and instructed to follow up with Dr. Newcomb. PX11.

On March 2, 2015, Petitioner was seen by Dr. Newcomb with complaints which were redacted from the records submitted by Petitioner, and which do not appear from context to be related to her coccyx issue. Dr. Newcomb did not document any relevant physical or neurological exams on this date and his assessment, though redacted, appears related to mental health issues, and not her coccyx. Despite a complete lack of any meaningful subjective complaints or objective physical findings related to her coccyx condition, Dr. Newcomb nevertheless wrote Petitioner off work for an additional two months. The off work slip references Petitioner pursuing physical therapy and chiropractic therapy to address her current "medical problem." PX2.

On April 16, 2015, Petitioner returned to Dr. Newcomb. The note documented complaints of lower back and sacral pain. Dr. Newcomb documented paraspinous, lumbar, and sacral/coccyx tenderness, the same as in past notes, but documented no other positive exam findings. Assessment was disorder of the sacrum, and he recommended referral to a neurosurgeon in St. Louis. He also assessed lumbar degenerative joint disease; however, it is unclear on what basis Dr. Newcomb made this assessment, or whether he related it to Petitioner's work accident. There is no indication that he reviewed Petitioner's lumbar MRI of June 24, 2014. Dr. Newcomb wrote Petitioner off work for an additional three months. PX2.

On May 19, 2015, Petitioner underwent a CT-guided ganglion impair block for chronic coccygeal pain. The diagnostic imaging report contained no reference to Petitioner's pre- or post-injection pain level, but stated Petitioner seemed to tolerate the procedure well. Petitioner's records indicate only a history of coccydynia in relation to this injection. PX6; see also PX5.

On June 8, 2015, Petitioner returned to Dr. Newcomb and reported her lower back and coccyx pain had improved since undergoing a cortisol injection in her coccyx region. She reported feeling much better, and stated she was ready to try to go back to work. Dr. Newcomb noted the same paraspinous, lumbar, and sacral/coccyx tenderness he noted in several previous records, but no other positive exam findings. He released Petitioner to return to work light duty. The Arbitrator notes that Dr. Newcomb replaced Petitioner's Norco on this date, which Petitioner reported she accidentally threw out while cleaning her home. PX2.

On July 10, 2015, approximately two years post-accident, Dr. Newcomb released Petitioner to return to work full duty without restrictions. PX2. Petitioner testified that no physician, including Dr. Newcomb, had placed work restrictions on her since this full duty release.

On August 8, 2015, Petitioner returned to Dr. Newcomb with a five-day history of unrelated abdominal pain. Interestingly, however, the note documented Petitioner "exercises 2-3 times a week." Dr. Newcomb documented no relevant physical or neurological exams, and

documented no subjective complaints of tailbone or low back pain whatsoever. Petitioner was not given any light duty restrictions. PX2.

On August 26, 2015, Petitioner was seen by Dr. Newcomb. Much of the history of present illness section was redacted from the records submitted by Petitioner, and from context the redacted complaints appear to be related to an unrelated mental health condition; however, it appears Petitioner was seeking a Norco refill for low back pain. Dr. Newcomb documented a completely normal physical exam on this date. His lone assessment was redacted. PX2.

On October 2, 2015, Petitioner returned to Dr. Newcomb complaining of nondescript back pain, as well as tailbone pain described as moderate, constant, chronic, and uncontrolled. She reported her pain was much worse lately. Dr. Newcomb noted moderate lumbar spasms and tenderness of the paraspinous, lumbar, and sacrum on exam. Extremity and neurological exams were normal. Dr. Newcomb's assessment on this date was disorder of the sacrum, and he refilled Petitioner's Norco. PX2.

On November 5, 2015, Petitioner underwent a CT-guided ganglion impar nerve block. The diagnostic imaging report contained no reference to Petitioner's pre- or post-injection pain level, but stated Petitioner seemed to tolerate the procedure well. PX5.

On December 18, 2015, Petitioner was evaluated by Dr. Richard Rende, Respondent's Section 12 examiner. In addition to the history of her work accident, Petitioner advised that she had been in a motor vehicle accident on December 26, 2014, when another driver struck her on the side of her vehicle. She went to the emergency room with complaints of primarily neck and shoulder pain, but also reported some back complaints. She stated to Dr. Rende that no change in her sacral symptoms occurred as a result of the accident, and that she did not receive any additional care until May 29, 2015. RX3, PX7. The Arbitrator notes, however, that Petitioner, in fact, went to the emergency room on January 28, 2016, with complaints of pain in her right buttock, lower back, and tailbone after picking up a trash bag and reported she was out of the Norco she normally took for her pain. In addition, she saw Dr. Newcomb on April 16, 2016, for continued complaints.

Dr. Rende noted that Petitioner's subjective complaints were very difficult to pin down. He stated she complained of pain when sitting on her buttock for a long period of time, but she also described diffuse pain in both buttocks. There were no reported radicular symptoms, and Petitioner denied significant numbness or tingling in either of her feet. She stated her pain was initially more typical in the midline and over the tip of her tailbone, but had now extended diffusely. Dr. Rende stated these symptoms were "rather vague." RX3, PX7.

On examination, Dr. Rende noted that Petitioner had a great deal of difficulty pointing to exactly where her pain occurred. She had full and normal extension and side bending. She had no sensory deficits, and her deep tendon reflexes were symmetrically brisk. Straight leg raise testing was negative bilaterally. Dr. Rende noted mild tenderness over both SI joints on palpation, and a slight amount of tenderness at the apex of her coccyx, approximately 3 cm proximal to the tip. He stated, "As I palpate her coccyx, I feel she is exaggerating her complaints." RX3, PX7.

Dr. Rende's assessment was coccydynia, which the Arbitrator notes was consistent with every other physician who examined and assessed Petitioner's condition to that point. He opined that Petitioner's tailbone condition was related to her work accident and that she had not yet reached MMI, due to her continued tenderness over the tip of her coccyx and her persistent symptoms. He stated that Petitioner's MRI ruled out any lumbar disc disease. He further stated that any lower extremity neuropathy Petitioner may have experienced was possibly similar to her upper extremity neuropathy/carpal tunnel syndrome, and was not traumatic. RX3, PX7.

Dr. Rende opined that Petitioner's coccyx condition would require only a sitting restriction, and there would be no reason to have kept Petitioner off work during the times Dr. Newcomb wrote her off work. He stated that Petitioner's absence from work beginning in late October of 2014, which the Arbitrator notes is the disputed TTD period in this case, was not causally related to Petitioner's work accident. He further noted that it was not reasonable or valid for Dr. Newcomb to take Petitioner off work for the diagnosis of coccydynia. RX3, PX7.

Dr. Rende noted that a coccygectomy was a potential surgical treatment for Petitioner's condition; however, he stated that the results of that surgery are not predictable, and that frequently symptoms persist after the terminal segment of the coccyx is removed. He stated this was particularly true in patients who exaggerate their complaints for the purpose of additional treatment. RX3, PX7. The Arbitrator notes that neither Dr. Rende nor any other physician has recommended Petitioner undergo a coccygectomy.

On March 2, 2016, without seeing Petitioner, Dr. Newcomb wrote a referral for a corticosteroid injection of the coccyx. His lone assessment was disorder of the sacrum. PX2.

On March 25, 2016, without seeing Petitioner, Dr. Newcomb wrote a referral for an orthopedic surgery consultation for her. His lone assessment was chronic coccygeal pain. PX2.

On March 28, 2016, Petitioner underwent a CT-guided sacral coccygeal impar block. The clinical history contained in the report was "Coccydynia. Recurrence of pain at sacrococcygeal junction." Petitioner also underwent a CT-guided L5-S1 epidural steroid injection. The clinical history indicates a "[R]ightward disc protrusion along the posterior L5-S1 disc displacing the adjacent nerve root. Associated low back and right buttock pain." PX5. The Arbitrator notes that nowhere in Petitioner's medical records did any physician or radiologist interpret Petitioner's diagnostic studies to have shown any disc protrusion at L5-S1 displacing any adjacent nerve root.

On May 2, 2016, Petitioner returned to Dr. Newcomb with complaints of worsening low back pain radiating to her right buttocks. The Arbitrator notes this is the first documentation of complaints of radiating pain in Dr. Newcomb's records for several months. Petitioner reported she tried an epidural steroid injection that did not help. Dr. Newcomb documented the same paraspinous and lumbar tenderness, and lumbar spasms, as previously; however, he also documented, for the first time, a positive straight leg raise test radiating to the right, and with back pain only on the left. His assessment was "chronic bilateral low back pain with right-sided sciatica." PX2. The Arbitrator notes this is inconsistent with Dr. Newcomb's other records, as he had never previously diagnosed Petitioner with bilateral low back pain with right-sided sciatica.

On July 27, 2016, approximately three years following her work accident, Petitioner again returned to Dr. Newcomb. She complained of low back pain radiating to her right buttock and requested a muscle relaxer. Dr. Newcomb documented moderate lumbar spasms and tenderness at L1 of the lumbar spine. There is no mention of any positive straight leg raise testing. Assessment was spondylosis without myelopathy or radiculopathy, in the lumbosacral region. PX2. The Arbitrator notes this is the first mention in any record of this particular diagnosis.

On November 9, 2016, Petitioner returned to Dr. Newcomb for medication management. No relevant subjective complaints were documented, nor was an assessment concerning Petitioner's low back or tailbone. The documented physical exam was completely normal. PX2.

On February 7, 2017, Petitioner returned to Dr. Newcomb for a variety of unrelated ailments, including left knee pain and a tooth fracture. No relevant subjective complaints were documented, nor was an assessment concerning Petitioner's low back or tailbone. The physical exam findings were related to her left knee only, and the exam was otherwise normal. PX2.

On March 1, 2017, nearly four years post-accident, Petitioner was seen by Dr. Matthew Gornet. His report does not indicate that this was a referral by another physician. Dr. Gornet documented subjective complaints of low back pain to both sides and to both buttocks, particularly the right side, and right intermittent leg pain. PX8. The Arbitrator notes this is the first documentation of right intermittent leg pain contained in Petitioner's records.

Dr. Gornet noted that Petitioner had been placed on a chronic high dose of narcotics, taking at least six Hydrocodone per day. He documented Petitioner stated she had "intervening issues" including a trip to the emergency room for a flare up in January of 2015, and a 2014 motor vehicle accident. PX8.

On physical exam, Dr. Gornet stated Petitioner "motions pain" in her lower back to the right side, right buttock, and occasionally to the left side and into her upper thigh. She was able to bend and forward flex with her hands to mid lower legs, and returned to standing with smooth rhythm. Her motor exam revealed a possible mild decrease in EHL function on the right at 4/5, otherwise Petitioner was 5/5 in all groups. The Arbitrator notes that none of Petitioner's other medical records documented any motor deficit at any time. Deep tendon reflexes were trace, and sensation was normal. PX8.

Dr. Gornet reviewed Petitioner's July 6, 2013, lumbar CT scan and opined that it showed some mild lateral recess stenosis at L4-5 and, to a lesser extent, at L5-S1. He further opined that there appeared to be a central herniation at L5-S1, slightly more to the right. Dr. Gornet also reviewed Petitioner's June 24, 2014, lumbar MRI and opined that it revealed an "obvious" annular tear central and right at L5-S1. He stated this alleged annular tear "correlates well with her symptoms," but did not elaborate. He saw no other evidence of other pathology other than the alleged annular tear. PX8.

Dr. Gornet opined that Petitioner's diagnosis from multiple doctors of coccydynia was "probably an error," and he believed instead that Petitioner suffered a "disc injury" at L5-S1 as a result of her work accident. He conceded that he did not have all of Petitioner's medical records.

Dr. Gornet recommended a new lumbar MRI, but did not state the reason he believed such a study was reasonable and necessary. He stated that given Petitioner's high dose of narcotics, "any treatment right now would be fraught with failure and unless she can be weaned off of all narcotics, I would not consider her a surgical candidate." Dr. Gornet believed Petitioner could continue to work full duty. PX8.

On March 7, 2017, Petitioner underwent a CT-guided ganglion impair block. The diagnostic imaging report documented Petitioner describing 8/10 pain, predominately involving her tailbone, with no mention of low back or radicular symptoms. She reported her pain was 4/10 immediately following the injection. PX5.

On May 2, 2017, Petitioner returned to Dr. Newcomb. Under chief complaint, the note stated, "none documented." No relevant subjective complaints were documented, and no relevant physical or neurological exam was documented. Dr. Newcomb reaffirmed Petitioner's continued use of Norco. PX2.

Petitioner testified that she has not been seen by any physician, including Dr. Newcomb, since May of 2017.

On September 28, 2017, Dr. Andrew Zelby of Neurological Surgery & Spine Surgery, reviewed several of Petitioner's medical records and was asked to provide opinions concerning Dr. Gornet's diagnosis of a disc injury at L5-S1. RX2.

Dr. Zelby testified by way of deposition on October 9, 2017. He is a Board Certified Neurosurgeon. Approximately 95 percent of his practice is dedicated to seeing and treating patients. In addition to his practice, he is an assistant professor of neurosurgery at Rush-Presbyterian St. Luke's Medical Center in Chicago. Dr. Zelby testified he was asked to address whether Petitioner had any condition in her lumbar spine, specifically any injury to the L5-S1 disc, attributable to her claimed work accident. He testified he was not offering any opinions regarding whether Petitioner's coccydynia was causally related to her work accident. RX1.

Dr. Zelby reviewed Dr. Gornet's note of March 1, 2017, and testified that Dr. Gornet diagnosed an L5-S1 disc injury, but the basis for the diagnosis was not contained in the note. He stated that Dr. Gornet related this alleged L5-S1 disc injury to Petitioner's work accident. He further noted that Dr. Gornet indicated he believed Petitioner's diagnosis of coccydynia, made by all of her other physicians since 2013, was probably an error. Dr. Zelby testified that no physician or surgeon who evaluated Petitioner, ***other than Dr. Gornet***, diagnosed any structural disc injury at L5-S1. RX1.

Dr. Zelby reviewed the lumbar CT scan of July 6, 2013, and testified that it showed mild degenerative changes, less than would be expected for a typical 51-year-old. He noted modest loss of disc space height posteriorly at L5-S1, as well as modest degenerative changes in the facets at L3-4, L4-5, and L5-S1 without hypertrophy. There was a broad-based bulging disc, a little more prominent to the right, at L5-S1, causing a suggestion of very mild right greater than left lateral recess stenosis. Dr. Zelby found no evidence on this CT scan to support Dr. Gornet's opinion of any injury to the L5-S1 disc, and disagreed with Dr. Gornet's assertion that this study correlated

to such a disc injury. Dr. Zelby also disagreed with Dr. Gornet's assertion that this study showed a central herniation at L5-S1. RX1.

Dr. Zelby also reviewed the lumbar MRI of June 24, 2014, and testified that it showed modest degenerative disc disease, with modest loss of disc space height posteriorly at L5-S1. There was a small broad-based central bulging disc at L5-S1 that mildly effaced the ventral thecal sac centrally. Dr. Zelby believed the degenerative changes shown on this MRI were less than would be expected for an almost 52-year-old, and believed the study was normal for Petitioner. Dr. Zelby did not agree at all with Dr. Gornet's comment in his note that this study correlated to some sort of disc injury at L5-S1. Dr. Zelby testified that neither the 2013 CT scan nor the 2014 MRI showed any acute process. Further, there were no acute posttraumatic abnormalities on either study. RX1.

Dr. Zelby disagreed with Dr. Gornet that the 2014 MRI showed any annular tear. He explained that an annular tear is a tear of the fibers that comprise the annulus, or outer portion of the disc. An annular tear finding on MRI that is acute is associated with edema and irritation, which shows up as very bright white on certain sequences on MRI. He noted that annular tears can also be chronic, which are less prominent on MRI, but would be seen in perpetuity on MRI. He noted that most annular tears in those 50 years old and greater are degenerative in nature, as opposed to acute or traumatic. RX1.

Dr. Zelby testified that an annular tear is not a reliable indicator for low back pain, and it is considered a self-limiting process. He explained that even an acute annular tear only produces irritants for three or four months, at which point the collagen heals itself. An annular tear will always be present on MRI, but such a finding is inconsequential as it relates to a patient and symptoms. Further, a patient can have an annular tear present on MRI with no accompanying symptoms. RX1.

Dr. Zelby testified that he did not see any annular tear at L5-S1 on the 2014 MRI, and further there was no mention of any annular tear at L5-S1 in the report from the radiologist who interpreted the MRI. He noted that no other surgeon or physician who reviewed the 2014 MRI, ***other than Dr. Gornet***, noted the presence of any annular tear at L5-S1. Dr. Zelby testified that, even assuming an annular tear was present on the 2014 MRI, he did not at all agree with Dr. Gornet that such an annular tear correlated to any of Petitioner's subjective symptoms documented by Dr. Gornet on March 1, 2017. Dr. Zelby testified that even if such an annular tear was present on a 2014 MRI, it would have become inconsequential for Petitioner by March of 2017, despite its presence on the MRI. RX1.

Dr. Zelby testified that Petitioner's subjective complaints on March 1, 2017, did not correlate to anything he observed on either the 2013 CT scan or the 2014 MRI. He noted that Dr. Gornet documented bilateral low back pain that radiated into the right greater than left buttock and intermittently down the right leg, and that Petitioner's essentially normal studies for a 52-year-old patient would not produce anything of consequence. RX1.

Dr. Zelby testified that none of the objective physical or neurological findings documented by Dr. Gornet on March 1, 2017, correlated to anything he observed on either the 2013 CT scan

or the 2014 MRI. He noted that Dr. Gornet documented a mild decrease in extensor hallucis longus function on the right, which actually correlates to L4-5, not L5-S1. He further pointed out that Petitioner's motor strength was otherwise normal, her deep tendon reflexes were trace, and her sensory testing was normal. RX1.

Dr. Zelby testified that he reviewed several of Petitioner's medical records from prior to her single visit with Dr. Gornet, and testified that Petitioner fairly consistently complained of central midline buttock pain without radiation, which did not correlate to any condition at L5-S1. Similarly, there were no neurological deficits documented in Petitioner's medical records. He disagreed that Petitioner's records showed consistent complaints of low back pain. He noted there were consistent complaints of tailbone, coccyx, and buttock pain, but the complaints of low back pain were not consistent. RX1.

Dr. Zelby testified that the purpose of an epidural steroid injection is to reduce symptoms in a person with neural impingement and radiculopathy. He testified it was not surprising that Petitioner reported no relief following an epidural steroid injection at L5-S1, because she never had any condition for which there was any medical indication to pursue such an injection. RX1.

Dr. Zelby testified that a positive straight leg raise test is not a neurological deficit, and that neurological deficits are loss of sensory function and weakness. Taken in and of itself, a positive straight leg test has no significance, but must be taken in the context of additional parts of a patient's exam and, more importantly, findings on diagnostic studies. Other findings on exam that would make a straight leg raise test more significant include whether the patient has a positive exam on sitting or lying, whether the elicited pain shoots down the leg, whether the pain is in the back, whether there is a reflex change or motor change or sensory change; and then, whether there is any abnormality on MRI that correlates with the complaint. RX1.

Dr. Zelby testified that even though no physician has recommended any treatment directed at L5-S1, no such treatment would be reasonable and necessary, including any surgery, irrespective of cause. He testified that "[I]t's hard to improve on normal, and no attempt should really be made to try." Further, "No good could possibly come to Ms. Bagley by trying to do anything invasive on her spine." Dr. Zelby testified that a new lumbar MRI was not reasonable and necessary. In addition, he testified that Petitioner has no condition in her spine, irrespective of cause, that should be treated with the ongoing use of narcotics. 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 (F), whether Petitioner's current condition of ill-being is related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Comm'n*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

It is undisputed that Petitioner sustained an accident which arose out of and in the course of her employment on July 6, 2013. Respondent has accepted liability for her undisputed tailbone/coccyx condition. The Arbitrator's inquiry as it relates to causal connection is two-fold: (1) Respondent disputes Petitioner's claim that she also sustained an L5-S1 disc injury as a result of her work accident. The Arbitrator must therefore first determine whether Petitioner has met her burden to prove her L5-S1 condition, if any, is causally related to her work accident. (2) After determining whether Petitioner's L5-S1 condition, if any, is causally related to her work accident, the Arbitrator must then determine the status of Petitioner's condition of ill-being as it relates to her work accident.

Petitioner's L5-S1 Condition

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that any condition involving her L5-S1 disc is causally related to her work accident of July 6, 2013.

Petitioner's coccyx issues following her work accident are well-documented. She presented to the emergency room at Memorial Hospital of Carbondale on the date of accident complaining of tailbone pain. She gave a history of falling directly on her tailbone, and gave the same or substantially similar history to each physician who evaluated her.

From the beginning, Petitioner's physicians, as well as Respondent's experts, have all diagnosed tailbone issues. Dr. Austin diagnosed a tailbone contusion four days after Petitioner's work accident, and continued to attribute Petitioner's subjective complaints to a tailbone/coccyx issue throughout his treatment of Petitioner.

Petitioner's family physician, Dr. Newcomb, also steadfastly diagnosed a tailbone/coccyx issue beginning with Petitioner's first post-accident visit. Dr. Newcomb felt so strongly that Petitioner had a tailbone issue that he wrote a strongly worded letter on January 15, 2015 in which he stated, "I have clinically concluded that (Petitioner) has developed chronic coccydynia pain syndrome from this trauma."

No fewer than four other physicians confirmed the diagnosis of coccydynia, or some similar tailbone issue. Pain management physician Dr. Criste, and orthopedic surgeon Dr. Koth, both of whom were chosen by Petitioner, both assessed a coccyx issue in 2013 and 2014, respectively. Similarly, both orthopedic surgeons engaged by Respondent, Dr. Petkovich and Dr. Rende, also diagnosed tailbone issues.

Petitioner's two lumbar diagnostic studies do not support any symptomatic condition at L5-S1. Dr. Zelby was the only physician to testify in this case. He explained that both Petitioner's lumbar CT scan and her lumbar MRI revealed no acute processes, but rather showed only normal degeneration for a person of Petitioner's age. Dr. Zelby testified that these scans revealed no

herniation at L5-S1, which was consistent with the radiologists' reports for the studies, as well as the interpretations of every physician who reviewed them.

The only subjective complaints that were constant throughout Petitioner's voluminous medical records were of tailbone pain. All of her other subjective complaints were sporadic and intermittent. At various times, Petitioner complained of spasms in either her left or right buttocks, and occasionally complained of radiating pain in her right thigh. These symptoms, however, were never consistently documented, even in Dr. Newcomb's records, which recorded multiple visits per year.

Similarly, the only objective physical exam findings documented in Petitioner's records were of tenderness in the area of the coccyx, sacrum, and SI joints. At varying points, Dr. Newcomb documented unspecified lumbar tenderness; however, those notations were word-for-word in multiple different notes, causing the Arbitrator to wonder how thorough Dr. Newcomb's physical examinations were.

At no point until Petitioner was seen by Dr. Gornet was any motor deficit noted on examination, and the possible motor deficit documented by Dr. Gornet was slight, and not attributable to L5-S1 according to the testimony of Dr. Zelby. Petitioner never had documented sensory deficits. Her range of motion exams varied throughout her records; however, her initial treatment records with Dr. Austin consistently documented only pain in the coccyx, sacrum, and SI joint area on range of motion testing.

While cross-examining Dr. Zelby, Petitioner made much about a positive straight leg raise test documented by Dr. Newcomb in May of 2016. The Arbitrator is not persuaded that a single positive straight leg raise test proves a symptomatic condition at L5-S1, especially in the face of the multiple negative straight leg raise tests documented by Petitioner's treating physicians. The Arbitrator notes that Dr. Zelby explained that a single straight leg raise test in isolation is not a meaningful finding. In addition, this reported finding was nearly three years after Petitioner's work accident.

Dr. Zelby testified that neither Petitioner's subjective complaints nor her objective physical and neurological findings, as documented by Dr. Gornet, correlated to the mild degeneration observed on either the lumbar CT scan or the lumbar MRI. Even the lone motor deficit of decreased EHL function, if present, would have correlated to a different level of the lumbar spine, not the L5-S1 level.

The Arbitrator places greater weight on Dr. Zelby's testimony than on the record of Dr. Gornet. First, Dr. Gornet described a "central herniation" present on the lumbar CT scan. This is inconsistent with the interpretation of the radiologist, Dr. Zelby, and every other physician who reviewed this study. Second, and critically, Dr. Gornet stated the lumbar MRI showed "an obvious annular tear central and right at L5-S1, which correlates well with her symptoms." This interpretation is also inconsistent with every other physician who reviewed this study, including the radiologist, who documented no such "obvious annular tear" at L5-S1.

Even assuming an annular tear was visible on the MRI at L5-S1, Dr. Gornet's statement that such an annular tear correlated with Petitioner's symptoms is unsupported by anything else in his note. Dr. Gornet did not testify in this case. The Arbitrator places greater weight on the testimony of Dr. Zelby, who explained that annular tears are: a) mostly chronic in people of Petitioner's age; b) a self-limiting process, and any associated symptoms are resolved in a matter of months; and c) are always present on an MRI even after they become asymptomatic.

The overwhelming preponderance of the evidence supports the conclusion that Petitioner sustained a coccyx injury as a result of her work accident. Petitioner failed to prove she has any symptomatic condition at L5-S1, let alone one that is causally related to her work accident. Her diagnostic scans, documented subjective complaints, and documented physical exam findings do not support Dr. Gornet's lone-wolf diagnosis of a disc injury at L5-S1.

Based on the foregoing and the record in its entirety, Petitioner's claim of an L5-S1 disc injury is denied.

Petitioner's current condition of ill-being

Having determined that Petitioner sustained an injury to her coccyx, but not her lumbar spine, the Arbitrator finds that Petitioner has reached maximum medical improvement as it relates to her coccyx.

Petitioner's treatment for her coccyx condition consisted of two rounds of physical therapy and five injections. She was released to return to work full duty without restrictions by Dr. Newcomb, on July 10, 2015, and no physician has placed or recommended any additional work restrictions since that full duty release.

Petitioner's most recent injection occurred in early 2017, and had no real lasting impact on her purported condition.

The last time Dr. Newcomb documented any subjective complaints of tailbone pain was in July of 2016. Since that time, he has seen Petitioner at least three times, with no documented mention of present subjective complaints or any relevant physical examination. Despite this, however, Dr. Newcomb continues to write Petitioner prescriptions of high doses of narcotics. The Arbitrator is concerned with this plan of care for Petitioner. It is clear, even from Petitioner's redacted medical records, that she suffers from mental health issues. The high levels of potentially addictive narcotics were mentioned by Dr. Gornet, Dr. Rende, and Dr. Zelby. Even Dr. Gornet declined further work up for Petitioner in light of her narcotic drug use.

There is evidence that Petitioner has exaggerated the severity of her condition. Dr. Rende commented in December of 2015 that Petitioner was exaggerating her complaints on physical exam, and stated that coccygectomies in patients who so exaggerate their symptoms frequently have return of symptoms following surgery.

The Arbitrator is also troubled by a notation in Dr. Newcomb's records from June 8, 2015, which indicated that Petitioner sought an early refill of Norco after claiming to have accidentally thrown her Norco away while cleaning her house.

Petitioner has failed to demonstrate how her only treatment since May 2, 2017, and for the foreseeable future, *to wit*, continued use of high doses of narcotics, is reasonable and necessary to cure the only condition causally related to her work accident. No physician has recommended any additional physical therapy, additional injections, or any surgery. She is still cleared to work full duty without restrictions.

Based on the foregoing and the record in its entirety, the Arbitrator finds that, as it relates to her accepted coccyx condition, Petitioner reached maximum medical improvement no later than May 2, 2017, and arguably prior thereto.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of his employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

Respondent has accepted Petitioner's coccyx condition and has assumed liability for medical treatment directed at that condition.

In light of the Arbitrator's findings with respect to issue (F), that Petitioner's L5-S1 condition, if any, is not causally related to her work accident, the Arbitrator finds that medical services related to treatment of any such condition is denied. This specifically includes Petitioner's March 1, 2017, visit to Dr. Gornet and her L5-S1 epidural steroid injection of March 28, 2016. With regard to the injection, the Arbitrator notes that the ordering physician for this procedure was "Tom Brumitt, D.O.", and further notes that there is no treatment record from Dr. Brumitt.

Further, any prospective treatment directed at any lumbar disc condition is also denied. This specifically includes the lumbar MRI recommended by Dr. Gornet. The Arbitrator notes that Dr. Gornet declined to perform any additional surgical work up on this Petitioner due to her high dose of narcotics; however, the Arbitrator finds that any such work up is also denied.

Finally, given the Arbitrator's finding that Petitioner has reached maximum medical improvement as it relates to her coccyx condition, any claim for prospective treatment for that condition, including but not limited to additional visits to Dr. Newcomb and any charges for narcotics, is denied. Petitioner presented no medical evidence that continued use of high doses of narcotics is reasonable and necessary and, in fact, Dr. Gornet declined to consider further work up for her alleged L5-S1 condition due to her continued use of narcotics.

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered for treatment to Petitioner's coccyx condition were reasonable and necessary relative to her accident of July 6, 2013. Respondent is liable for only one of the outstanding medical bills as set forth in Petitioner's Exhibit 15, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any amounts previously paid, including those made pursuant to Section 8(j), for which a credit is allowed. Specifically, Respondent is liable only for the bill from **IWP, for dates of service 4/3/14-12/1/16, in the amount of $23,287.00**. The Arbitrator **declines** to award the following charges:

1. Memorial Medical Center/Occupational Therapy
   10/13/14-10/29/14 $2,788.00
   11/3/14-11/24/14 $3,572.00
   12/1/14-12/17/14 $2,408.00
   The record is void of any treatment records pertaining to these dates of service. Further, the record indicates that Petitioner underwent left carpal tunnel surgery around this time, as she was cleared for such surgery by Dr. Newcomb on September 5, 2014. It is reasonable to infer that such treatment was related to this surgery; however, by no means is the Arbitrator able to determine from the record that this treatment was related to Petitioner's work accident.
2. Shawnee Health Services/Dr. Newcomb
   8/6/15 $15.00
   8/7/15 $15.00
   8/26/15 $15.00
   The record establishes that treatment on these days was for unrelated medical issues. Although Dr. Newcomb also refilled Petitioner's Norco on these days, the reason for Petitioner's examinations was unrelated to her accident. In addition, these appear to be "balance due" charges, above and beyond that which is payable under the fee schedule.
   8/21/15 $15.00
   The record is void of any treatment record for this date.
   10/2/15 $15.00
   This appears to be a "balance due" charge, above and beyond that which is payable under the fee schedule.
3. Dr. Kevin Koth, 9/24/14, $13.88
   This appears to be a "balance due" charge, above and beyond that which is payable under the fee schedule.
4. Cape Radiology, 3/28/16, $2,060.00
   No bill was submitted for this date of service. The charge is merely listed on the summary page of Petitioner's Exhibit 15, with no corresponding bill included.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1990).

Petitioner alleged she was temporarily and totally disabled for two separate periods: (1) November 1, 2013, through March 2, 2014, which Respondent does not dispute; and (2) October 29, 2014, through June 15, 2015, which Respondent disputes.

In support of her claim, Petitioner offers the off-work slips from Dr. Newcomb. In response, Respondent offers the opinion of Dr. Rende, who stated it was not reasonable or necessary for Petitioner to be off work for her coccyx condition.

More to the point, the Arbitrator examines the ***basis*** for Dr. Newcomb's provision of the off-work slips in question. On October 29, 2014, Dr. Newcomb wrote Petitioner off work following a completely normal physical and neurological examination. The note documented nothing about Petitioner's ability to work, any subjective complaints, or any positive exam findings. On November 13, 2014, Petitioner requested an off work slip from Dr. Newcomb. Even though Dr. Newcomb did not document any relevant exam findings on this date, he saw fit to write Petitioner off work for a month. The same result occurred on December 20, 2014, and March 2, 2015, with Dr. Newcomb writing Petitioner off work for three months and two months on those dates, respectively.

The basis for Dr. Newcomb taking Petitioner off work on any of these dates is unclear to the Arbitrator, and is unsupported by his own records from these dates. The Arbitrator places greater weight on Dr. Rende's opinions. Dr. Rende explained that Petitioner's condition of coccydynia required restrictions only as to sitting, and there was no reason a sitting restriction would have kept Petitioner out of work during this period. Dr. Rende stated Petitioner's absence from work during this period was not related to her work accident, and that it was not appropriate for Dr. Newcomb to have taken Petitioner off work.

Based on the foregoing and the record in its entirety, Petitioner's claim for TTD benefits for the period of October 29, 2014, to June 15, 2015 is denied.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

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 this 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 CNA at the time of the accident and that she was released by her treating doctor to return to that position without restrictions as a result of said injury. However, Dr. Rende opined that taking Petitioner off work for any time for her coccydynia was not

reasonable or necessary. Although Petitioner testified that she lost her job with Respondent because she missed too much work, the Arbitrator finds little relevance in this assertion, as respects this factor. The Arbitrator places some weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 50 years old at the time of the accident and can be expected to work for several more years. Over the coming years her condition could improve, stay the same, or get worse. There was no evidence to indicate with any degree of likelihood how her age would impact her disability. The Arbitrator places some weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner testified that following her termination from Respondent she sought and obtained two subsequent jobs, including her current job, both of which pay less than her CNA job with Respondent. The record is clear, however, that there is no medical reason why Petitioner could not work as a CNA, either currently or in the future. The Arbitrator places little weight on this factor.

In regard to factor **(v) evidence of disability corroborated by treating medical records**, the Arbitrator notes that Petitioner sustained an injury to her coccyx/sacrum, diagnosed by all doctors (except Dr. Gornet) as a sacrococcygeal contusion and resulting coccydynia. Treatment consisted of injections, physical therapy, rest, and pain medication. The Arbitrator finds Petitioner's descriptions of her purported subjective complaints to be well out of proportion to both the subjective complaints and the objective examination findings documented in her treating records. Petitioner was last seen by Dr. Newcomb on May 2, 2017, approximately five months before trial, at which time Dr. Newcomb did not document a single subjective complaint or objective exam finding related to Petitioner's tailbone condition. The same is true for his records of February 7, 2017, and November 9, 2016. In fact, Dr. Newcomb had not documented any subjective complaints from Petitioner since July 27, 2016, nearly fifteen months prior to trial.

Petitioner testified that her coccyx condition has had a dramatic impact on her life; however, her testimony is not consistent with her medical records. No treating physician ever documented symptoms of such a severity that Petitioner was unable to lift, tend her garden, have a sex life, go out and have fun, go out with friends, play bingo, or go shopping. Petitioner testified she is unable to do any of these things subsequent to, and because of, her work accident. None of Petitioner's claimed issues (with the possible exception of playing bingo, assuming such activity requires prolonged sitting) are substantiated in the slightest by her medical records, especially her records from the past calendar year. In fact, her records made reference to her being able to exercise two or three times per week in August of 2015.

The only true subjective complaint that was consistently documented until July of 2016 was difficulty sitting for long periods. Dr. Rende's description of coccydynia as requiring only sitting restrictions is consistent with this subjective complaint and is persuasive to the Arbitrator as respects evidence of disability. Further, the Arbitrator found Petitioner to be exaggerating and to be lacking in credibility as she explained the many activities she could no longer enjoy. Most telling is the fact that the one consistent subjective complaint—difficulty sitting—did not appear to be an issue in the slightest on the day of trial. The Arbitrator noted at that time that Petitioner

demonstrated no signs of pain or discomfort throughout the entirety of the hearing. She did not fidget in her chair, move around, or re-position herself in any way.

Taking all of the foregoing into consideration, the Arbitrator places only some 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 as a result of her accident of July 6, 2013, Petitioner sustained a 5% loss of use of the body as a whole (25 weeks), pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $509.05. The Arbitrator finds her permanent partial disability rate is $305.43.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON COCHRAN,
Petitioner,

vs. NO: 17 WC 23152

PEABODY ENERGY,

Respondent.

19IWCC0404

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 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.

We affirm the Arbitrator's analysis of permanency factors (i), (iii), and (iv) under §8.1b of the Act. Regarding factor (ii), occupation, we find that Petitioner was released to full duty without restrictions by Dr. Gornet. Petitioner testified that his underground job involved being bent over, which caused him pain, and he was eventually put on the surface driving a truck. *T.17.* However, on cross-examination, he testified that he was not transferred to the surface because of any work restrictions and that anybody could ask for that type of transfer at any point. *T.23-24.* The medical records indicate that Dr. Gornet returned him to full duty on February 22, 2018, and stated "I see no reason why [underground work] would potentially cause harm, although he may become more symptomatic and I may have to put permanent restrictions on him of no underground work." On April 5, 2018, Dr. Gornet wrote that Petitioner had continued to do well with 5/5 strength and minimal pain, although he had some limitation of motion in extension. Dr. Gornet continued Petitioner on full duty, but he had apparently already transferred to the surface truck driving job by this time, and Dr. Gornet saw "no problems with this." Although Petitioner's previous job underground may be strenuous, there is no medical opinion stating that he is unable to do that job. Nevertheless, we find Petitioner's testimony that he has some pain when bending over to be credible and give this factor "some" weight. Petitioner was also asked about his strength and what he notices "at the end of a shift:"

Q: How is the strength in your arms and your neck? What do you notice at the end of a

shift?
A: I don't have the strength like I used to.
Q: How so?
A: Just not as much manual labor like I used to, and I just don't – I haven't recovered from being laid around for over nine months with no exercise and stuff, sir.
Q: Have you gained weight as a result?
A: Yes, sir.
Q: What are you going to do about it?
A: I'm going to try to get into an exercise program, sir. *T.19-20.*

On cross-examination, Petitioner testified that, as he is continuing to work, his strength is improving "a little bit." *T.25.* The medical records indicate he has 5/5 strength. We find that, although Petitioner might have some reduced strength, he has failed to prove that this is a permanent condition related to his injury. Rather, it is because he hasn't yet "recovered from being laid around for over nine months with no exercise." *T.19.*

Regarding factor (v), evidence of disability corroborated by the treating medical records, we initially note that the Arbitrator's inclusion of certain facts regarding how Petitioner's condition is affected by his job and vice versa should more properly have been included in the analysis of factor (ii), "occupation," as we have done, and should not be considered again under this factor. We also make several modifications regarding the findings and their relevance under factor (v). The Arbitrator found that Petitioner had "pain with range of motion in all directions, which was confirmed by Dr. Gornet's last office note." *Dec. 4.* This makes it sound as though Petitioner had difficulty moving his head at all without pain. However, Petitioner actually testified:

Q: Tell the Court, please, about your range of motion in your neck, sideways, up, down, rotational, what do you notice and what do you feel?
A: The farther I go, I still have pain in it, but it's something I'll probably have to live with. *T.18.*

Dr. Gornet's last record, on August 23, 2018, states that Petitioner has "*some* pain with *extreme* range of motion and we have talked that this will probably be permanent." *(Emphasis added.)* The cervical x-rays showed "good motion on flexion/extension, but still blocked at the *extremes*." *(Emphasis added.)* In other words, Petitioner only has corroborated complaints of pain with extreme range of motion. The Arbitrator found Petitioner has "occasional headaches for which he takes Ibuprofen or Tylenol." *Dec. 4.* Petitioner did testify that he had "occasional" headaches. *T.18.* However, on cross-examination, he testified:

Q: Did you have any headaches prior to this accident?
A: No, sir.
Q: You never had a headache?
A: Just a typical headache here and there.
Q: Okay. And you have just a headache here and there now?
A: Yes, sir. *T.24-25.*

We find it significant that Petitioner did *not* testify his headaches "here and there" are any worse or more frequent now as a result of his cervical condition. The Arbitrator wrote, "While Petitioner's sleep is improved, he still wakes up once or twice a week from neck pain." *Dec. 4.* We find that,

although Petitioner did testify to this (*T.20*), there is no mention in the medical records regarding any current sleep problems. The Arbitrator described how Petitioner's condition has affected his volunteer firefighting endeavors. *Dec. 4.* However, Petitioner was released without restrictions and the medical records do not contain any information about how his condition affects these volunteer activities. Based on our analysis under this factor, we find that it deserves some weight in determining permanency.

For all of the above reasons, we modify the Arbitrator's decision and find Petitioner is entitled to 27.5% loss of use of the person as a whole under §8(d)2 of the Act.

We also strike the citations, on page 4 of the decision, to *Miller v. City of Pontiac* and *Vera [sic] Eldridge v. Centralia Manor*. Both of these are Commission decisions involving accidents prior to September 1, 2011, so the awards are not based on an analysis of the five permanency factors in §8.1b of the Act. *Miller v. City of Pontiac*, 08 IWCC 1109, involves a *herniation* and single-level *fusion*. In the case at bar, Petitioner's diagnosis was "discogenic neck pain" and the surgery was a three-level *disc replacement*. The second decision, *Verna Eldridge v. Centralia Manor*, 10 IWCC 378, involved a two-level *lumbar* decompression with disc replacement so it is not very relevant to the *cervical* injury Petitioner sustained. Based on the above distinctions, we find that those Commission decisions are not relevant to our analysis.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $682.80 per week for a period of 137.50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 27.5% 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 $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 2 - 2019

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Deborah L. Simpson
Deborah L. Simpson

SE/
O: 7/9/19
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COCHRAN, JASON
Employee/Petitioner

Case# **17WC023152**

PEABODY ENERGY
Employer/Respondent

19IWCC0404

On 2/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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

JASON COCHRAN
Employee/Petitioner

v.

PEABODY ENERGY
Employer/Respondent

Case # 17 WC 23152

Consolidated cases: _____

19IWCC0404

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Herrin**, on **December 14, 2018**. By stipulation, the parties agree:

On the date of accident, **May 2, 2017**, 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 **$59,176.00**, and the average weekly wage was **$1,138.00**.

At the time of injury, Petitioner was **40** years of age, ***married*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have been or will be 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 **$682.80**/week for a further period of **150** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **the 30% loss of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **August 23, 2018,** through **December 14, 2018,** and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

2/21/2019
Date

FEB 20 2019

19IWCC0404

Procedural History

This matter was tried on December 14, 2018. The only issue in dispute was the nature and extend of Petitioner's injury. (Arb. Ex. #1).

Findings of Fact

Jason Cochran (hereafter referred to as "Petitioner" was employed as a laborer for Peabody Energy (hereafter referred to as "Respondent" (T.9). Petitioner injured his neck, on May 2, 2017, while working underground. Petitioner was in a Getman tractor when it hit a pole causing Petitioner's head to strike the steel canopy of the tractor. (T.9-10) Prior to the incident, Petitioner suffered no injuries and required no tests or treatment related to his cervical spine. (T.10)

Within minutes following the accident, Petitioner's head and neck pain gradually worsened. (T.10) Petitioner told his supervisor of the injury and his increasing symptoms, and Respondent sent Petitioner to Harrisburg Medical Center Emergency Room, where the history of the injury was taken. (T.10-11) Petitioner's cervical spine was immobilized, and he was given x-rays which were negative. (PX3, 5/2/17) Petitioner was discharged with medication and advised to follow up with a physician. *Id.*

The following day, Petitioner presented in the office Respondent's company physician at Harrisburg Medical Center, Dr. James Alexander. (PX4, 5/3/17; T.11) He was evaluated by Dr. Alexander's partner, Dr. Clayton Ford, who took the same history of the injury and noted that Petitioner had shoulder and neck pain. *Id.* He noted that Petitioner was evaluated at Harrisburg Medical Center, and while the head and neck films were negative for fracture, the cervical spine film showed bulging discs and foraminal stenosis. (PX3, 5/2/17) When Dr. Ford's examination showed limited cervical spine range of motion secondary to pain, he prescribed a muscle relaxer/cyclobenzaprine, recommended Prednisone and Naprosyn for pain, and instructed Petitioner to return for follow-up. *Id.* Petitioner was seen five days later by nurse practitioner Loni Banks with complaints of burning neck pain radiating down his right arm to the elbow that worsened with neck movement. (PX3, 5/8/17) Examination showed tenderness to palpation both in the trapezius and cervical spine. *Id.* NP Banks also noted muscle spasm in the sternocleidomastoid neck muscle, and Petitioner still had a limited range of motion along in addition to his radicular symptoms. *Id.* Petitioner was referred for physical therapy. *Id.*

When physical therapy failed to relieve Petitioner's symptoms, Respondent referred Petitioner to Dr. Coyle. (PX6) Dr. Coyle saw Petitioner on June 7, 2017, took a consistent history of the injury, and noted that Petitioner was having symptoms of headaches and neck pain radiating into both his right upper and lower extremity. *Id.* Dr. Coyle's examination was markedly positive for diminished strength in Petitioner's right side, numbness and tingling in the left upper extremity, tenderness to palpation directly at C5-6, and pain distally in the upper thoracic spine. *Id.* Dr. Coyle reviewed the CAT scan which he believed showed loss of cervical lordosis with some mild spondylotic changes at C5-6 and C5-7. *Id.* Dr. Coyle recommended an MRI. *Id.* This was

completed the same day and showed central broad based protrusions at C5-6 and 6-7 and bilateral foraminal disc protrusions at C4-5 creating severe foraminal stenosis, and ventral cord flattening at all three levels. (PX7, 6/7/17) Dr. Coyle referred Petitioner to Dr. Grey Smith for injections at C5-6 and C5-7. (PX6, 6/7/17)

Prior thereto, Petitioner utilized his first personal choice of physician and sought treatment on his own with Dr. Matthew Gornet, a board certified spine specialist. (PX8) Dr. Gornet took the history of the injury, noted Petitioner's medical care and treatment thus far including Dr. Coyle's referral to Dr. Smith for pain management. (PX8, 6/19/17) He also reviewed the MRI scan performed on June 7, 2017, and found it to be of moderate quality. *Id.* He believed the scans showed clear central annular tears and disc protrusions at C6-7 and to a lesser extent at C4-5 and C5-6. *Id.* Dr. Gornet agreed with the radiologist that these three levels were the main culprit of Petitioners symptoms. *Id.* Dr. Gornet noted that Petitioner had been given Hydrocodone, which he quickly stopped and tried to expedite an injection for Petitioner the same day. *Id.*

When Petitioner returned to Dr. Gornet on July 13, 2017, Dr. Gornet noted that Petitioner did not receive benefit from the injections and was miserable. (PX8, 7/13/17) Dr. Gornet believed that he could get Petitioner back to work full-duty with no restrictions by performing a three level disc replacement. *Id.* Prior to surgery, however, he needed to obtain both a high quality and high resolution MRI and a CT Myelogram. *Id.* The MRI was done the same day and showed significant herniations at C4-5, C5-6, and C6-7. (PX10, 7/13/17) The CT Myelogram, which Dr. Gornet discussed at Petitioner's next visit, was confirmatory of the MRI showing pathology at C4-5, C5-6, and C6-7. (PX8, 9/11/17) Because Petitioners symptoms were ongoing and severe, Dr. Gornet recommended surgery. *Id.*

Surgery was done on September 20, 2017, in the form of a three level disc replacement at C4-5, C5-6, and C6-7. (PX9, 9/20/17) During surgery, Dr. Gornet identified markedly positive intraoperative findings of a central annular tear and a right sided fragment at C6-7, a collapsed disc with a central herniation and small right and left free fragments at C5-6, and a midline central annular tear and avulsion with another fragment and a right sided herniation at C4-5. *Id.* Following surgery, Petitioner was referred for additional physical therapy at Joyner Therapy Services. (PX8, 1/4/18) Petitioner testified that both the surgery and the postoperative physical therapy improved his condition. (T.16) Dr. Gornet continued to monitor Petitioner's postoperative recovery, and on August 23, 2018, placed Petitioner at maximum medical improvement. (PX8, 8/23/18). Petitioner was still doing well, but still had pain with end and active ranges of motion. *Id.* Dr. Gornet advised Petitioner that this would likely be permanent. *Id.*

Petitioner testified that despite the improvement resulting from surgery and the subsequent postoperative physical therapy, he still retained some symptoms. (T.18) He notices pain with range of motion in all directions, which was confirmed by Dr. Gornet's last office note. (T.18; PX8, 8/23/18) He has occasional headaches for which he takes Ibuprofen or Tylenol. (T.18; 19) He also testified to a loss of strength in his right arm and neck with resulting weight gain from hindered

physical activity. (T.19) While Petitioner's sleep improved, he still wakes up once or twice a week from neck pain. (T.20) Petitioner also testified that he is a volunteer firefighter, but he is not "the firefighter he used to be." (T.20) He stays outside the conflagration to assist and does not go inside. (T.20-21) He testified he does not get paid for these volunteer endeavors. (T.21) Petitioner still works as a coal miner, but asked to be moved "up top" with a slight pay cut out of concern of hitting his head on low spots in the ceiling of the mine or on Respondent's equipment and the physical stress on his injury. (T.25-27) Petitioner stated that bending over and performing heavy lifting also caused him pain. (T.25)

Respondent did not obtain an impairment rating. The Arbitrator found the Petitioner's testimony to be credible.

Conclusions of Law

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither party submitted an AMA rating. Therefore, the Arbitrator assigns no weight to this factor.

(ii) **Occupation**: Petitioner is employed as a laborer in a coal mine. (T.25-27) Given the laborious nature of his employment and his credible reports of pain with heavy lifting, the Arbitrator finds that this factor weighs in favor of increased permanence.

(iii) **Age**: Petitioner was 40 years old at the time of his injury. He is very young and will have to live and work with his disability for a considerable number of years. Pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time), the Arbitrator finds that this factor weighs in favor of increased permanence.

(iv) **Earning Capacity**: There was no evidence presented indicating that Petitioner's earning capacity has been adversely impacted as a result of his injury. As such, the arbitrator finds that this factor weighs in favor of decreased permanence.

(v) **Evidence of Disability Corroborated by the Medical Records**: As a result of his undisputed accidental injury, Petitioner sustained disc herniations from C4 through C7, which necessitated a three-level disc replacement. Despite the improvement from surgery and postoperative therapy, he still suffers residual symptoms. (T.18) He notices pain with range of

motion in all directions, which was confirmed by Dr. Gornet's last office note. (T.18; PX8, 8/23/18) He has occasional headaches for which he takes Ibuprofen or Tylenol. (T.18; 19) He also testified to a loss of strength in his right arm and neck with resulting weight gain from hindered physical activity. (T.19) While Petitioner's sleep improved, he still wakes up once or twice a week from neck pain. (T.20) Petitioner also testified that he is a volunteer firefighter, but he is not "the firefighter he used to be." (T.20) He stays outside the conflagration to assist and does not go inside. (T.20-21) He testified he does not get paid for these volunteer endeavors. (T.21) Petitioner still works as a coal miner, but asked to be moved "up top" with a slight pay cut out of concern of hitting his head on low spots in the ceiling of the mine or on Respondent's equipment and the physical stress on his injury. (T.25-27) Petitioner stated that bending over and performing heavy lifting also caused him pain. (T.25) The Arbitrator finds that this factor weighs in favor of an increased permanence.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 30% loss of his body as a whole. *Miller v. City of Pontiac*, 08 I.W.C.C. 1109; *Vera Eldridge v. Centralia Manor*, 10 I.W.C.C. 0378.

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

YVOHNNE HANKINS,

Petitioner,

vs.

NO: 10 WC 5417
12 WC 6223 (cons)

STATE OF ILLINOIS,
DEPARTMENT OF HUMAN CAPITAL DEVELOPMENT,

Respondent.

19IWCC0405

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, manifestation date, notice, 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.

Manifestation Date

The manifestation date "means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026 (1987). It is well-settled the date of manifestation of a repetitive trauma injury is subject to a "flexible standard" that "ensures a fair result for both the faithful employee and the employer's insurance carrier." *Three 'D' Discount Store v. Industrial Commission*, 198 Ill. App. 3d 43, 49, 556 N.E.2d 261 (1989). The test of when an injury manifests itself is an objective one, determined from the facts and circumstances of each case. *Id* at 47. In deciding the manifestation date of a repetitive-trauma injury, courts consider various factors, including the dates on which (1) the claimant first sought medical

attention for the condition, (2) the claimant was first informed by a physician that the condition is work-related, (3) the claimant was first unable to work as a result of the condition, (4) the symptoms became more acute at work, and (5) the claimant first noticed the symptoms of the condition. See *Durand v Industrial Commission*, 224 Ill. 2d 53, 68-70, 862 N.E.2d 918 (2006) (citing *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 531, 505 N.E.2d 1026, 1029, 106 Ill. Dec. 235 (1987); *Three "D" Discount Store*, 198 Ill. App. 3d at 47-48, 556 N.E.2d at 266-65; and *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 611-12, 531 N.E.2d 174, 176-77, 126 Ill. Dec. 41 (1988)). The Commission does not believe January 1, 2009 meets any of the above criteria.

At the outset, the Commission emphasizes January 1, 2009 is a holiday and Petitioner conceded she would not have worked that day. Moreover, there are no medical records to corroborate a January 1, 2009 manifestation date. Petitioner testified she experienced pain in her right shoulder and up to her neck in January 2009 which led her to present to the emergency room and they "eventually" told her the pain was coming from her carpal tunnel. T. 17. The earliest medical record in evidence, however, is Dr. Desai's March 6, 2009 evaluation (PX2), and while Petitioner described working at a computer and complained of pain in her right wrist and up her arm when typing, she stated her complaints began the month prior, *i.e.*, February 2009. This is consistent with her further statement that she was evaluated in the Christ Hospital emergency room on February 9, 2009.

Instead, the Commission finds March 27, 2009 is the date Petitioner's condition manifested itself. Contrary to Respondent's assertion that "there are no medical records, visits, or tests performed that day," the Commission observes March 27, 2009 is the date Petitioner followed up with Dr. Desai to review her EMG and cervical spine MRI; it was at that visit that Dr. Desai concluded "she does have significant physical exam findings and also an EMG which points toward the carpal tunnel syndrome as the cause of most of her symptoms" and recommended surgery. PX2. To be clear, March 27, 2009 is the date a cervical component was ruled out and instead carpal tunnel syndrome was confirmed as the cause of Petitioner's symptoms. As such, the Commission *sua sponte* amends Petitioner's Application for Adjustment of Claim to reflect a March 27, 2009 manifestation date. *Caterpillar Tractor Co. v. Industrial Commission*, 215 Ill. App. 3d 229, 238, 574 N.E.2d 1198 (1991) (An amendment of an application for adjustment of claim is allowed where the amendment was to conform the pleadings to proof presented in the record.)

PPD Calculation Correction

The Commission affirms the finding that Petitioner sustained a 15% loss of use of her right hand; however, the calculation of that award must be corrected. Section 8(e)9 provides that, for accidental injuries sustained on or after February 1, 2006, the loss of a hand is based on 205 weeks of compensation. While the Act was amended to decrease the starting compensation value for injuries involving carpal tunnel syndrome due to repetitive or cumulative trauma, this diminution applies only "if the accidental injury occurs on or after June 28, 2011." *820 ILCS 305/8(e)9*. Given Petitioner's injury occurred in 2009, her loss of use of the right hand award is predicated on 205 weeks (205 weeks x 15% = 30.75 weeks).

19IWCC0405

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 6, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Application for Adjustment of Claim is amended to reflect a date of accident of March 27, 2009.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $753.57 per week for a period of 12 1/7 weeks, representing May 26, 2009 through August 18, 2009, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that, of the medical bills contained in Petitioner's Exhibits 10 through 15, Respondent shall pay the charges associated with treatment of Petitioner's right hand rendered through December 10, 2010, which the Commission finds reasonable and necessary as provided in Section 8(a), subject to Section 8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 30.75 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right hand.

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: AUG 2 - 2019

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

mck

D: 6/19/19

43

DISSENT

As the Supreme Court of Illinois noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the

result of a normal degenerative aging process." Petitioner failed to prove her condition is work-related. Therefore, I respectfully dissent.

Petitioner testified she was employed by Respondent as a Well Public Aid Case Worker. T. 5. Her job duties required her to interview applicants in order to determine their needs. As part of the interview process, Petitioner typed the necessary data into her computer. T. 10; 12. Petitioner testified she would perform a minimum of five interviews per day. T. 14.

Dr. Vender, the only physician to testify, stated unequivocally that Petitioner's job duties did not cause nor aggravate her condition of ill-being - carpal tunnel syndrome. RX9, p. 20, 36. Dr. Vender further explained Petitioner's work duties were not forceful and repetitive. *Id.*

"There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005). Instead, the Commission may review the manner and method of a claimant's job to determine if such duties are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory of recovery. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993), citing *Perkins Product Co. v. Industrial Commission*, 379 Ill 115, 120 (1942) ("the claimant's injury 'was directly connected with the manner and method in which she was required to do her work, and to use her arm in the discharge of her duties'").

Petitioner failed to prove a causal relationship between her work duties and her conditions of ill-being (carpal tunnel syndrome). I would afford greater weight to the opinions of Dr. Vender. Therefore, I respectfully dissent.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANKINS, YVONNE
Employee/Petitioner

Case# **10WC005417**

12WC006223

SOI DEPT OF HUMAN CAPITAL DEVELOPMENT
Employer/Respondent

19IWCC0405

On 4/6/2018, 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 1.90% shall accrue from the date listed above to the day before the 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 LLP
JIM M VAINKOS
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CHICAGO, IL 60602

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P BLEWITT
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1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
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0502 STATE EMPLOYEES RETIREMENT
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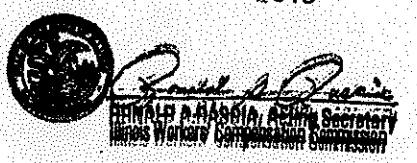
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

APR 6 - 2018



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

YVOHNNE HANKINS
Employee/Petitioner

v.

STATE OF ILLINOIS,
DEPARTMENT OF HUMAN CAPITAL DEVELOPMENT
Employer/Respondent

Case # **10** WC **5417**

Consolidated cases: **12WC6223**

19IWCC0405

An *Application for Adjustment 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 **March 19, 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 **January 1, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**58,778.00**; the average weekly wage was $**1,130.35**.

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

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

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

Respondent shall be given a credit of $**5,705.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,705.00**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner and his attorney, temporary total disability benefits of **$753.56**/week for **12 weeks**, commencing **May 26, 2009** through **August 18, 2009**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$5,705.00** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$18,400.50**, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72**/week for **28.5** weeks, because the injuries sustained caused **15% loss of use the right hand**, as provided in Section 8(e) of the Act.

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

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

#001 Arb. George Andros — Signature of Arbitrator

April 5, 2018 — Date

APR 6 - 2018

STATEMENT OF FACTS

The Petitioner was hired by the Respondent in 1998, about 11 years prior to her date of injury of January 1, 2009. She was employed as a Public Aid Caseworker/Eligibility Interviewer. As the title states, she would interview applicants for public assistance, i.e., medical card and food stamps. Her job shift was 8:00 am to 4:30 pm. She had two 15 minute breaks and a half hour lunch. Her office was a cubicle with four foot tall walls. She had a desk with the keyboard situated on top of the desk. She had two monitors, a computer mouse, telephone, stapler, scissors, keyhole punch, file cabinet with file folders. Petitioner credibly testified that she would type for 7.5 hours a day. She explained that she interviews at least a minimum of 5 applicants a day and on many days more than five. It takes approximately 1 hour or more to interview each applicant. If Petitioner was not interviewing an applicant in person, she would be typing information that an applicant mailed to her office. Petitioner stated that the office was paperless. All information had to be typed and there was constant use of the keyboard and computer. She testified on cross examination that she attended meetings for work by email. Thus requiring more use of her hands typing. She also stated that she used a 3-hole punch to create files for each applicant. She would have to punch at least 20 pages per applicant. Petitioner is right hand dominant.

In January, 2009, Petitioner testified that she started noticing pain in her neck and felt a knot in her neck. She had pain radiating down to her right hand. Petitioner credibly testified that she gave notice of her condition to her supervisor, Gearhart Hoffman, intake supervisor. There was no contrary evidence submitted by the Respondent. She was first seen at Little Company of Mary on March 6, 2009. Her medical history in the record was consistent with the manifestation of pain to which she testified. The initial impression was right hand carpal tunnel syndrome. An EMG was performed on March 20, 2009, and the findings were consistent with moderate right carpal tunnel syndrome. On March 27, 2009, Dr. Desai took over the care of the Petitioner. In the medical history, Dr. Desai quotes Petitioner as saying the pain worsens while typing at work. He had prescribed a cockup splint but it did not resolve Petitioner's condition. On June 6, 2009, Dr. Desai placed Petitioner on light duty consisting of typing only 4 hours a day. Finally, on June 18, 2009, Petitioner had an open right carpal tunnel release. She followed up with Dr. Desai, and had extensive physical therapy in July and August, 2009. Petitioner was off work from May 26. 2009 through August 18, 2009 and was paid temporary total disability benefits.

Petitioner returned to the same job duties and work station that caused or aggravated her carpal tunnel syndrome. By February 22, 2010, Petitioner was having complaints with her left hand similar to her right. On March 3, 2010, Dr. Desai requested an ergonomic evaluation of Petitioner's work station. He suggested frequent work breaks, an ergonomic keyboard, and wrist padding on the keyboard.

On April 16, 2010, Dr. Baylis took over the care of Petitioner. Dr. Baylis' history also includes the phrase, "She types all day". He diagnosed Petitioner with left hand carpal tunnel syndrome. An EMG was performed on April 26, 2010, and there was evidence of moderate to severe carpal tunnel syndrome. On April 30, 2010, Dr. Baylis wrote, "With respect to her issues using the computer, she's at a computer for almost 7.5 hours a day...I feel that this is work aggravated and that release is warranted. She certainly needs ergonomic evaluation and correction of her work station". Petitioner had surgery to her left hand on June 14, 2010. Dr. Baylis ordered physical therapy starting in July, 2010, and continued through August, 2010. On August 27, 2010, Petitioner was released to return to work with the following restrictions: Monday, Wednesday, and Friday 4 hours a day for 2 weeks. This restriction was extended for 3 months on September 10, 2010. On October 29, 2010, the left wrist was injected with depomedrol at the base of the thumb. Dr. Baylis referred Petitioner to a rheumatologist and she was seen by Dr. Connolly on November 19, 2010.

His assessment was diffuse demineralization with tendonitis of the left hand. On December 10, 2010, Dr. Baylis placed permanent restrictions of limited typing 2-3 hours a day and placed her at maximum medical improvement (MMI).

On January 31, 2012, Respondent had Petitioner seen by a section 12 physician, Dr. Vender, for an independent medical examination. He disputed the causal connection between Petitioner's job duties and her bilateral carpal tunnel releases. He stated, "Being office based and sedentary, and assuming normal use of the hands,..." he did not find causation. He released Petitioner to full duty work. Petitioner's temporary total disability benefits were terminated on February 6, 2012.

In the meantime, Petitioner was referred to the Chicago Pain Center and was seen by Dr. Padron. On August 1, 2012, he assessed her with chronic pain. Petitioner also started treating with a chiropractor, Dr. Krueger, on August 1, 2012. Dr. Krueger saw Petitioner a few times a month from that point on. On August 21, 2013, Petitioner was seen by Dr. Morgan, at the Pinnacle Interventional Pain Association for treatment. Dr. Morgan opined, "It is my opinion to a reasonable degree of medical certainty that the patient did have an underlying degenerative condition that was silent and asymptomatic, commensurate with her age and not likely to be symptomatic over her lifetime or in need of treatment. As a result of the injury, the condition was rendered symptomatic and in need of the treatment that was recommended or rendered by acceleration, precipitation, or aggravation of the asymptomatic condition." Dr. Morgan wrote a medical disability report keeping Petitioner off work permanently. Petitioner was kept on light duty or off work from February 7, 2012 to May 1, 2014, when she finally retired from employment. Petitioner testified she did not receive any temporary total disability benefits from February 7, 2012 through May 1, 2014.

In regards to her medical bills, Petitioner testified that she believes the Respondent paid the bills through workers' compensation insurance through the date her benefits were terminated, February 6, 2012. After this date, Petitioner's group health insurance paid the bills.

Petitioner continues to notice weakness, pain, and numbness in her right hand. She notices difficulty lifting cooking pots, unscrewing jars, and peeling vegetables. She notices numbness in her right hand when she holds her hand above her shoulders such as when she is on the cell phone. She also has difficulty braiding her granddaughter's hair. In regards to her left hand, Petitioner testified she continues to have the same weakness and pain as in her right hand. In addition, she notices pain in her left thumb, index, and middle fingers. She uses wrist braces at night when she sleeps.

CONCLUSIONS OF LAW

"C" (Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?) and "F" (Is Petitioner's current condition of ill-being causally related to the injury?)

The Arbitrator finds that Petitioner did sustain an accident arising out of and in the course of her employment with Respondent. The uncontroverted testimony showed that Petitioner, in fact, did type for 7.5 hours a day. Her office work required Petitioner to be interviewing applicants and typing all their data into the computer. There was a clear attempt to make her office paperless. The paper that was generated required a 3-hole punch to punch through 20 pages of paper per applicant. Petitioner's treating physicians, Dr. Desai, Dr. Baylis, and Dr. Morgan all opined that her extensive typing aggravated both her hands to the point she had carpal tunnel releases. The IME, Dr. Vender, was not persuasive in his denial of causation. In his deposition, he stated he assumed normal sedentary office work for Petitioner.

The job description Dr. Vender relied upon did not mention the extent or amount of typing per day. The Arbitrator finds that fourteen years of repetitive typing for 7.5 hours each work day is not normal use of a person's hands. Dr. Vender did admit that having the keyboard on the desk top could create an ergonomic problem.

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

The Arbitrator finds that Petitioner gave proper notice to the Respondent of her repetitive trauma to both her hands. Respondent did not provide any evidence to contradict Petitioner's testimony that she gave notice to her supervisor, Gearhart Hoffman.

"J" (Were 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, having found in favor of Petitioner for accident, notice, and causation, also finds that Respondent is liable for all related medical bills totaling $18,400.50 as provided in sections 8a and 8.2 of the Act.

"K" (What temporary benefits are in dispute?)

The Arbitrator, having found in favor of Petitioner for accident, notice, and causation finds that Petitioner was entitled to temporary total disability benefits from May 26, 2009 through August 18, 2009. The testimony and medical records indicate that Petitioner was kept off work for this time period by Dr. Baylis. Respondent is entitled to a credit for temporary total disability benefits paid for this time period.

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

The Arbitrator finds that Respondent should pay Petitioner permanent partial disability benefits in the amount of 15% of the right hand as provided in section 8e of the Act.

Petitioner continues to notice weakness, pain, and numbness in her right hand. She notices difficulty lifting cooking pots, unscrewing jars, and peeling vegetables. She notices numbness in her right hand when she holds her hand above her shoulders such as when she is on the cell phone. She also has difficulty braiding her granddaughter's hair. In regards to her left hand, Petitioner testified she continues to have the same weakness and pain as in her right hand. In addition, she notices pain in her left thumb, index, and middle fingers. She uses wrist braces at night when she sleeps.

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 Temporary Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YVOHNNE HANKINS,

Petitioner,

vs.

NO: 12 WC 6223
10 WC 5417 (cons)

STATE OF ILLINOIS,
DEPARTMENT OF HUMAN CAPITAL DEVELOPMENT,

Respondent.

19IWCC0406

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 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.

Temporary Disability

The Arbitrator awarded 202 weeks of temporary total disability benefits representing June 14, 2010 through March 1, 2014. The Commission views the evidence differently and finds Petitioner reached maximum medical improvement on December 10, 2010.

On September 10, 2010, Dr. Baylis noted Petitioner's complaints were now located near her thumb and first dorsal compartment. After an examination, Dr. Baylis concluded Petitioner's carpal tunnel syndrome complaints had essentially resolved and the source of her ongoing complaints was unknown:

> Basically, through WC, this is carpal tunnel and surgery has eliminated those symptoms. These other tendinitis type symptoms I can't find evidence of

> obvious examable de Quervain's or trigger digits. The pain to her thumb, with respect to loading, I cannot reproduce any crepitus consistent with arthritis. Therefore it is unclear this bilateral hand pain she is having. I feel the CT releases to both hands have pretty much taken away her nerve symptoms but she has some tendinosis and possibly some cryptic joint pain that does not seem to be improved. She does a data entry job where there is a significant amount of typing daily.

Dr. Baylis recommended an evaluation by a rheumatologist and restricted Petitioner to light duty, two to three hours of typing daily. PX5.

On December 10, 2010, Petitioner saw Dr. Baylis for the last time. Petitioner complained of pain from her shoulder down her arm and some soreness at the left carpal tunnel release, although the paresthesia was gone. Dr. Baylis's examination findings included possible slight tenderness of the flexor carpi ulnaris tendon but Petitioner otherwise had a quiet scar with normal strength, circulation and sensation. Dr. Baylis concluded,

> At this point, with respect to my surgery for carpal tunnel that she was approved for work, she has done well. She has cryptic arm pain that I don't have an answer to. I have no reproducible tenderness over the CMC joint or the 1st dorsal compartment. She has been off work for this period of time and is no better. One would think that some of this should improve.
> At this point in time, from my standpoint, she made need to be on some permanent work restrictions of limited typing, 2-3 hours a day and I think she is at maximum medical improvement from her carpal tunnel. PX5 (Emphasis added).

Given that Dr. Baylis placed Petitioner at maximum medical improvement with a decent result from her carpal tunnel syndrome surgery, as well as the transition of Petitioner's complaints into nebulous and "cryptic" arm pain thereafter, the Commission finds Petitioner's work-related condition of ill-being reached maximum medical improvement on December 10, 2010. As such, Petitioner is entitled to TTD benefits from June 14, 2010 through December 10, 2010.

PPD Calculation Correction

The Commission affirms the finding that Petitioner sustained a 15% loss of use of her left hand; however, the calculation of that award must be corrected. Section 8(e)9 provides that, for accidental injuries sustained on or after February 1, 2006, the loss of a hand is based on 205 weeks of compensation. While the Act was amended to decrease the starting compensation value for injuries involving carpal tunnel syndrome due to repetitive or cumulative trauma, this diminution applies only "if the accidental injury occurs on or after June 28, 2011." *820 ILCS 305/8(e)9*. Given Petitioner's injury occurred in 2010, her loss of use of the left hand award is predicated on 205 weeks (205 weeks x 15% = 30.75 weeks).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 6, 2018, as modified above, is hereby affirmed and adopted.

19IWCC0406

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $773.77 per week for a period of 25 5/7 weeks, representing June 14, 2010 through December 10, 2010, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits from December 11, 2010 through March 1, 2014 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that, of the medical bills contained in Petitioner's Exhibits 10 through 15, Respondent shall pay the charges associated with treatment of Petitioner's left hand rendered through December 10, 2010, which the Commission finds reasonable and necessary as provided in Section 8(a), subject to Section 8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 30.75 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the 15% 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 amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: AUG 2 - 2019

Stephen Mathis

D. Douglas McCarthy

mck

D: 6/19/19

43

DISSENT

As the Supreme Court of Illinois noted in *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 530, 505 N.E.2d 1026 (1987), "an employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. There must be a showing that the injury is work related and not the result of a normal degenerative aging process." Petitioner failed to prove her condition is work-related. Therefore, I respectfully dissent.

Petitioner testified she was employed by Respondent as a Well Public Aid Case Worker. T. 5. Her job duties required her to interview applicants in order to determine their needs. As part of the interview process, Petitioner typed the necessary data into her computer. T. 10; 12. Petitioner testified she would perform a minimum of five interviews per day. T. 14.

Dr. Vender, the only physician to testify, stated unequivocally that Petitioner's job duties did not cause nor aggravate her condition of ill-being - carpal tunnel syndrome. RX9, p. 20, 36. Dr. Vender further explained Petitioner's work duties were not forceful and repetitive. *Id.*

"There is no requirement that a certain percentage of time be spent on a task in order for the duties to meet the legal definition of 'repetitive.'" *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 192, 825 N.E.2d 773 (2005). Instead, the Commission may review the manner and method of a claimant's job to determine if such duties are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory of recovery. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993), citing *Perkins Product Co. v. Industrial Commission*, 379 Ill 115, 120 (1942) ("the claimant's injury 'was directly connected with the manner and method in which she was required to do her work, and to use her arm in the discharge of her duties'").

Petitioner failed to prove a causal relationship between her work duties and her conditions of ill-being (carpal tunnel syndrome). I would afford greater weight to the opinions of Dr. Vender. Therefore, I respectfully dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANKINS, YVOHNNE
Employee/Petitioner

Case# **12WC006223**

10WC005417

SOI DEPT OF HUMAN CAPITAL DEVELOPMENT
Employer/Respondent

19IWCC0406

On 4/6/2018, 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 1.90% shall accrue from the date listed above to the day before the 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 LLP
JIM M VAINKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

5002 ASSISTANT ATTORNEY GENERAL
JOSEPH P 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

APR 6 2018

RONALD A. RASCIA, 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

YVOHNNE HANKINS
Employee/Petitioner

v.

STATE OF ILLINOIS
DEPARTMENT OF HUMAN CAPITAL DEVELOPMENT
Employer/Respondent

Case # **12** WC **6223**

Consolidated cases: **10WC5417**

19IWCC0406

An *Application for Adjustment 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 **March 19, 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 **FEBRUARY 22,2010**, 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 $**60,354.00**; the average weekly wage was $**1,160.65**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**65,566.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**65,566.00**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner and his attorney, temporary total disability benefits of **$773.76**/week for **202** weeks, commencing **June 14, 2010** through **February 6, 2012** and **February 7, 2012** through **May 1, 2014**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$65,566.00** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$18,400.50**, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72**/week for **28.5** weeks, because the injuries sustained caused **15% loss of use of the left hand**, as provided in Section 8(e) of the Act.

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

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

George J. Andros

Signature of Arbitrator

April 5, 2018

Date

APR 6 - 2018

STATEMENT OF FACTS

The Petitioner was hired by the Respondent in 1998, about 11 years prior to her date of injury of January 1, 2009. She was employed as a Public Aid Caseworker/Eligibility Interviewer. As the title states, she would interview applicants for public assistance, i.e., medical card and food stamps. Her job shift was 8:00 am to 4:30 pm. She had two 15 minute breaks and a half hour lunch. Her office was a cubicle with four foot tall walls. She had a desk with the keyboard situated on top of the desk. She had two monitors, a computer mouse, telephone, stapler, scissors, keyhole punch, file cabinet with file folders. Petitioner credibly testified that she would type for 7.5 hours a day. She explained that she interviews at least a minimum of 5 applicants a day and many days more than five. It takes approximately 1 hour or more to interview each applicant. If Petitioner was not interviewing an applicant in person, she would be typing information that an applicant mailed to her office. Petitioner stated that the office was paperless. All information had to be typed and there was constant use of the keyboard and computer. She testified on cross examination that she attended meetings for work by email. Thus requiring more use of her hands typing. She also stated that she used a 3-hole punch to create files for each applicant. She would have to punch at least 20 pages per applicant. Petitioner is right hand dominant.

In January, 2009, Petitioner testified that she started noticing pain in her neck and felt a knot in her neck. She had pain radiating down to her right hand. Petitioner credibly testified that she gave notice of her condition to her supervisor, Gearhart Hoffman, intake supervisor. There was no contrary evidence submitted by the Respondent. She was first seen at Little Company of Mary on March 6, 2009. Her medical history in the record was consistent with the manifestation of pain to which she testified. The initial impression was right hand carpal tunnel syndrome. An EMG was performed on March 20, 2009, and the findings were consistent with moderate right carpal tunnel syndrome. On March 27, 2009, Dr. Desai took over the care of the Petitioner. In the medical history, Dr. Desai quotes Petitioner as saying the pain worsens while typing at work. He had prescribed a cockup splint but it did not resolve Petitioner's condition. On June 6, 2009, Dr. Desai placed Petitioner on light duty consisting of typing only 4 hours a day. Finally, on June 18, 2009, Petitioner had an open right carpal tunnel release. She followed up with Dr. Desai, and had extensive physical therapy in July and August, 2009. Petitioner was off work from May 26. 2009 through August 18, 2009 and was paid temporary total disability benefits.

Petitioner returned to the same job duties and work station that caused or aggravated her carpal tunnel syndrome. By February 22, 2010 Petitioner was having complaints with her left hand similar to her right. On March 3, 2010, Dr. Desai requested an ergonomic evaluation of Petitioner's work station. He suggested frequent work breaks, an ergonomic keyboard, and wrist padding on the keyboard.

On April 16, 2010, Dr. Baylis took over the care of Petitioner. Dr. Baylis' history also includes the phrase, "She types all day". He diagnosed Petitioner with left hand carpal tunnel syndrome. An EMG was performed on April 26, 2010, and there was evidence of moderate to severe carpal tunnel syndrome. On April 30, 2010, Dr. Baylis wrote, "With respect to her issues using the computer, she's at a computer for almost 7.5 hours a day…I feel that this is work aggravated and that release is warranted. She certainly needs ergonomic evaluation and correction of her work station". Petitioner had surgery to her left hand on June 14, 2010. Dr. Baylis ordered physical therapy starting in July, 2010, and continued through August, 2010. On August 27, 2010, Petitioner was released to return to work with the following restrictions: Monday, Wednesday, and Friday 4 hours a day for 2 weeks. This restriction was extended for 3 months on September 10, 2010. On October 29, 2010, the left wrist was injected with depomedrol at the base of the thumb. Dr. Baylis referred Petitioner to a rheumatologist and she was seen by Dr. Connolly on November 19, 2010.

His assessment was diffuse demineralization with tendonitis of the left hand. On December 10, 2010, Dr. Baylis placed permanent restrictions of limited typing 2-3 hours a day and placed her at maximum medical improvement (MMI).

On January 31, 2012, Respondent had Petitioner seen by a section 12 physician, Dr. Vender, for an independent medical examination. He disputed the causal connection between Petitioner's job duties and her bilateral carpal tunnel releases. He stated, "Being office based and sedentary, and assuming normal use of the hands,..." he did not find causation. He released Petitioner to full duty work. Petitioner's temporary total disability benefits were terminated on February 6, 2012.

In the meantime, Petitioner was referred to the Chicago Pain Center and was seen by Dr. Padron. On August 1, 2012, he assessed her with chronic pain. Petitioner also started treating with a chiropractor, Dr. Krueger, on August 1, 2012. Dr. Krueger saw Petitioner a few times a month from that point on. On August 21, 2013, Petitioner was seen by Dr. Morgan, at the Pinnacle Interventional Pain Association for treatment. Dr. Morgan opined, "It is my opinion to a reasonable degree of medical certainty that the patient did have an underlying degenerative condition that was silent and asymptomatic, commensurate with her age and not likely to be symptomatic over her lifetime or in need of treatment. As a result of the injury, the condition was rendered symptomatic and in need of the treatment that was recommended or rendered by acceleration, precipitation, or aggravation of the asymptomatic condition." Dr. Morgan wrote a medical disability report keeping Petitioner off work permanently. Petitioner was kept on light duty or off work from February 7, 2012 to May 1, 2014, when she finally retired from employment. Petitioner testified she did not receive any temporary total disability benefits from February 7, 2012 through May 1, 2014.

In regards to her medical bills, Petitioner testified that she believes the Respondent paid the bills through workers' compensation insurance through the date her benefits were terminated, February 6, 2012. After this date, Petitioner's group health insurance paid the bills.

Petitioner continues to notice weakness, pain, and numbness in her right hand. She notices difficulty lifting cooking pots, unscrewing jars, and peeling vegetables. She notices numbness in her right hand when she holds her hand above her shoulders such as when she is on the cell phone. She also has difficulty braiding her granddaughter's hair. In regards to her left hand, Petitioner testified she continues to have the same weakness and pain as in her right hand. In addition, she notices pain in her left thumb, index, and middle fingers. She uses wrist braces at night when she sleeps.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner did sustain an accident arising out of and in the course of her employment with Respondent. The uncontroverted testimony showed that Petitioner, in fact, did type for 7.5 hours a day. Her office work required Petitioner to be interviewing applicants and typing all their data into the computer. There was a clear attempt to make her office paperless. The paper that was generated required a 3-hole punch to punch through 20 pages of paper per applicant. Petitioner's treating physicians, Dr. Desai, Dr. Baylis, and Dr. Morgan all opined that her extensive typing aggravated both her hands to the point she had carpal tunnel releases. The IME, Dr. Vender, was not persuasive in his denial of causation. In his deposition, he stated he assumed normal sedentary office work for Petitioner. The job description Dr. Vender relied upon did not mention the extent or amount of typing per day.

The Arbitrator finds that fourteen years of repetitive typing for 7.5 hours each work day is not normal use of a person's hands. Dr. Vender did admit that having the keyboard on the desk top could create an ergonomic problem.

"J" (Were 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, having found in favor of Petitioner for accident, notice, and causation, also finds that Respondent is liable for all related medical bills totaling $18,400.50 as provided in Sections 8a and 8.2 of the Act.

"K" (What temporary benefits are in dispute?)

The Arbitrator, having found in favor of Petitioner for accident, notice, and causation finds that Petitioner was entitled to temporary total disability benefits from June 14, 2010 through February 6, 2012 and February 7, 20102 through May 1, 2014. The testimony and medical records indicate that Petitioner was kept off work for this time period by Dr. Baylis and Dr. Morgan. Respondent is entitled to a credit for temporary total disability benefits paid for this time period.

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

The Arbitrator finds that Respondent shall pay to the Petitioner and his attorney permanent partial disability benefits in the amount of 15% of the left hand as provided in Section 8e of the Act.

Petitioner continues to notice weakness, pain, and numbness in her right hand. She notices difficulty lifting cooking pots, unscrewing jars, and peeling vegetables. She notices numbness in her right hand when she holds her hand above her shoulders such as when she is on the cell phone. She also has difficulty braiding her granddaughter's hair. In regards to her left hand, Petitioner testified she continues to have the same weakness and pain as in her right hand. In addition, she notices pain in her left thumb, index, and middle fingers. She uses wrist braces at night when she sleeps.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRYSTAL WRAGGS,

Petitioner,

vs. NO: 08 WC 43781

JEWEL BUS CO. and
THE ILLINOIS STATE TREASURER AS
EX-OFFICIO CUSTODIAN OF THE INJURED
WORKERS' BENEFIT FUND,

19IWCC0407

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, the Injured Workers' Benefit Fund (IWBF), herein and notice given to all parties, the Commission, after considering the issues of accident, benefits, notice, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, vacates the Decision of the Arbitrator and remands the matter to the Arbitrator for trial on the merits with proper notice of same.

Procedurally, Petitioner filed her Application for Adjustment of Claim on October 7, 2008 naming Jewel Bus Company as the Respondent. Jewel Bus Company failed to file an appearance. Petitioner subsequently filed an Amended Application naming the Injured Workers' Benefit Fund (IWBF) as an additional Respondent. The IWBF filed its appearance on December 5, 2013.

This matter was subsequently dismissed for want of prosecution on January 8, 2018. Petitioner filed a timely Petition to Reinstate that was granted by the Arbitrator on March 13, 2018. The Arbitrator set this matter for a final hearing on May 9, 2018. Jewel Bus Company failed to appear at the May 9, 2018 hearing.

19IWCC0407

Prior to the start of the May 9, 2018 hearing, the IWBF objected to the hearing arguing that the Petitioner failed to properly serve the Respondent, Jewel Bus Company, with the Notice of Hearing as required under the Rules Governing Practice Before the Illinois Workers' Compensation Commission. When questioned about its effort to notify Jewel Bus Company of the May 9, 2018 hearing, Petitioner's counsel stated that he called the company directly and their telephone was disconnected. He also searched the internet and found that the owner of Jewel Bus Company was indicted for tax evasion in 2016. No other attempts were made to notify Jewel Bus Company of the May 9, 2018 hearing. The Arbitrator overruled the IWBFs objection and the matter proceeded to hearing *ex parte*.

Rule 9030.20(c)(2) provides, in relevant part:

> If any party fails, without good cause, to appear, the Arbitrator will hear the motion for trial date ex parte and, if the Arbitrator determines the matter is ready for trial, will set a trial date convenient to the Arbitrator and the party that appeared. The party that appeared shall notify the opposing party of the trial date.

Despite Jewel Bus Company having never appeared in this matter, Petitioner's attempt to notify them of the May 9, 2018 hearing was insufficient. The Commission finds that the Petitioner failed to properly notify Jewel Bus Company of the trial date as required by Rule 9030.20(c)(2). Due to the lack of proper notice, the Arbitrator was without jurisdiction to conduct an *ex parte* hearing. Therefore, the Commission vacates the Arbitrator's May 24, 2018 decision and remands the matter to the Arbitrator for a new hearing on the merits with proper notice of same.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed May 24, 2018 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for a hearing on the merits with proper notice of same.

DATED: AUG 2 - 2019

D Douglas McCarthy
Douglas McCarthy

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

Stephen J. Mathis
Stephen Mathis

DDM/tdm
O: 7-17-19
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WRAGGS, CRYSTAL
Employee/Petitioner

Case# **08WC043781**

JEWEL BUS COMPANY AND THE ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

19IWCC0407

On 5/24/2018, 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 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

3149 NICHOLIS J STEIN
6 LYNN DR
HAWTHORN WOODS, IL 60047

0000 JEWEL BUS COMPANY
1035 W 111TH
CHICAGO, IL 60643

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

19IWCC0407

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

Crystal Wraggs,
Employee/Petitioner

v.

Jewel Bus Company and the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund,
Employer/Respondent

Case # **08** WC **43781**

Consolidated cases: D/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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **May 9, 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 Jewel Bus Company?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Did Petitioner establish adequate notice of the hearing and lack of coverage?**

FINDINGS

On **September 22, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to neck, back and leg injuries that required treatment and causation as to a lumbar disc herniation that remained symptomatic as of the hearing.

The Arbitrator finds the average weekly wage to be $396.00, based on Petitioner's credible testimony.

On the date of accident, Petitioner was **24** years of age, **single** with **no** dependent children.

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

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

Respondent shall be given a credit of **$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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established adequate notice, under the existing circumstances, and lack of workers' compensation coverage. The Fund raised no objection to the coverage-related documents offered by Petitioner. PX 2.

Respondent shall pay Petitioner temporary total disability benefits of $264.00/week for 11 weeks commencing October 2, 2008 through December 17, 2008, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the following reasonable and necessary medical expenses, subject to the fee schedule: 1) Roseland Community Hospital, $1,822.50 (PX 3); and 2) Hyde Park Medical Center, $4,111.11 (PX 4). The Arbitrator rejected the records and bills of a third provider, Fullerton Surgery Center (PX 5), due to lack of certification, and awards no medical expenses associated with the treatment this provider rendered.

Respondent shall pay Petitioner permanent partial disability benefits of $237.60/week for 20 weeks, because the injuries sustained resulted in permanency equivalent to 4% loss of the person as a whole under Section 8(d)2 of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Molly C Mason

Signature of Arbitrator

5/24/18
Date

MAY 24 2018

Crystal Wraggs v. Jewel Bus Company
and Injured Workers' Benefit Fund
08 WC 43781

19IWCC0407

Procedural History

Petitioner filed an Application for Adjustment of Claim, naming Jewel Bus Company as Respondent, on October 7, 2008. Arb Exh 3. The case was continued on multiple occasions thereafter. At some point in 2013, Petitioner filed an Amended Application naming the Injured Workers' Benefit Fund [hereafter "the Fund"] as an additional respondent. The Fund filed an appearance on December 5, 2013. The Arbitrator dismissed the case for want of prosecution on January 8, 2018. Petitioner filed a timely Petition to Reinstate thereafter. The Fund raised no objection to reinstatement when the petition came before the Arbitrator on March 13, 2018. The Arbitrator reinstated the case that day and set the case for final disposition on May 9, 2018. Arb Exh 2. No one appeared on behalf of Jewel Bus Company [hereafter "Respondent"] on that date.

Did Petitioner provide Respondent with adequate notice of the hearing? Did Petitioner establish Respondent lacked workers' compensation coverage as of the date of the claimed accident?

Petitioner's counsel acknowledged he did not send written notice of the May 9, 2018 hearing to Respondent at its last known address. He represented to the Arbitrator he conducted Internet searches two weeks prior to, and the night before, the hearing, with the searches indicating Respondent's owner was indicted for tax evasion in 2016. It was his belief the owner was incarcerated at the time of the hearing, although he was not able to provide documentary evidence of this. In response to the Arbitrator's inquiry, he produced a letter his co-counsel sent to Respondent on October 2, 2008, via certified mail, notifying Respondent of the claim, inquiring as to potential third party liability for the accident and demanding benefits under the Act. He also produced a certified mail "green card" receipt bearing an illegible signature dated October 14th. PX 1.

On direct examination, Petitioner testified it was also her belief that Respondent's owner was indicted.

Over the Fund's notice-related objection, the Arbitrator allowed the hearing to proceed. The Fund maintains this was error, citing the motion-related notice provisions of the rules. Based on PX 1, Respondent received notice of the claim within a few weeks of the accident yet, over the course of many years, failed to appear or otherwise respond to counsel's request for information and the payment of benefits. The Arbitrator, acting in her discretion and considering the underlying purpose of the Fund, relied on PX 1 and the representations of Petitioner's counsel, an officer of the court, in overruling the Fund's objection.

Did Petitioner establish that Respondent lacked workers' compensation coverage as of the claimed September 22, 2008 accident?

On the issue of coverage, Petitioner offered into evidence PX 2, records certified by Bertha Parker, formerly Acting Secretary of the Commission, showing that, as of May 22, 2008, Respondent had a policy of workers' compensation insurance through New Hampshire Insurance Company, but that said policy was cancelled due to non-payment of premium effective August 18, 2008, about a month before the claimed accident. The Fund raised no objection to the admission of PX 2 at the hearing but argues

that the documents in that exhibit are insufficient to establish lack of coverage since they are not from the National Council on Compensation Insurance [NCCI] and do not specifically show Respondent had no coverage as of September 22, 2008. The Arbitrator views the Fund as having waived this argument but notes the information certified by the Commission was apparently obtained from the NCCI website. The website's address appears at the bottom of each page in PX 2.

Arbitrator's Findings of Fact

Petitioner testified she was born on October 17, 1983. She is single and has a 3-year-old son. She works for the Chicago Public School system as a preschool assistant.

Petitioner testified she went to Respondent's offices in Chicago in early September 2008 because Respondent was hiring school bus drivers. As of that time, she was 23 years old and single. She had no children. At Respondent's offices, she met with Carshena Ross and completed an application and W2 tax form. Respondent hired her to be a full-time school bus driver. She was told she would be paid $11 per hour and expected to work 36 hours per week.

Petitioner testified she already had a permit when Respondent hired her. She spent her first couple of days at work doing tasks in the office, while Respondent conducted a class for other new hires who did not yet have their permits. On September 22, 2008, Petitioner arrived at work at 6 AM. She signed in, as required, by entering a pre-assigned number into Respondent's system.

Petitioner testified the drivers received written assignments each morning and then retrieved the corresponding vehicle keys from a board. On the morning of September 22nd, Ross handed Petitioner a written driving assignment. Petitioner looked at the assignment and reminded Ross she did not have a license [CDL] to operate a bus. Ross then instructed her to take different keys off the board. Petitioner retrieved the keys and went out into the fenced lot where Respondent stored its buses and other vehicles. Petitioner testified her assigned vehicle that day was a yellow school bus that was about half the size of a conventional school bus. The bus was marked with Respondent's name. She assumed she could legally operate this vehicle since Ross had directed her to take the keys. Her assignment was to pick up children along a route and take them to a public school in Chicago that was near 90th or 95th, east of Halsted. She got in the bus and began driving. No one else was in the bus at that time. Immediately before the accident, she was driving north on Michigan, approaching a red light at 107th. She had not yet picked up any children. She observed two CTA buses parked along the curb, one behind the other. The rear section of the rear bus was jutting out into traffic. The bus in front began to pull out. At that point, the light changed and another vehicle came behind her. She maneuvered the bus to get out of the way and struck the back of the second bus, which was still parked. She described the impact as heavy, indicating that glass shattered. She was able to pull the bus over to the curb. The driver of the bus she struck got out of his vehicle and came to her aid. With his assistance, she exited her bus and went to lie down on the grass. The police department and an ambulance came to the scene. The paramedics placed her on a stretcher. At that point, a female co-worker, who was operating a different Respondent bus, pulled over and asked her if she was okay. She told this person, whose name she does not recall, she was experiencing back pain. This person called Respondent, via speaker phone, and notified someone of the accident. The person who answered on behalf of Respondent asked whether Petitioner felt well enough to drive the bus back to Respondent's location. The co-worker said, "no, they are about to take her [Petitioner] away in an ambulance."

Petitioner testified the paramedics transported her to the Emergency Room at Roseland Community Hospital. At that point, she was experiencing pain in her neck, back and right thigh. The paramedic run sheet reflects Petitioner was in an accident involving a bus and complained of neck, hip and lower back pain. Some of the Emergency Room records are handwritten and difficult to read but the typed patient statement indicates: "MVA (school bus driver) neck, thigh and low back pain." The "guarantor information" section of the records describes Petitioner as a bus driver employee. Handwritten notes reflect Petitioner arrived via ambulance after being involved in a motor vehicle accident and complained of 10/10 pain in her neck, right leg and back. These notes also reflect that Petitioner denied any past medical history. The examining physician, Dr. Javier, ordered a cervical spine CT scan, which showed no evidence of fracture or subluxation. PX 3. The records and bill reflect he also ordered lumbar spine X-rays, which showed spondylolisthesis at L5-S1. PX 4. Petitioner was given Toradol for pain. Dr. Javier diagnosed multiple contusions. He provided Petitioner with crutches and discharged her with instructions to seek follow-up care within one to two days. PX 3.

Petitioner testified she later received a bill in the amount of $1,822.50 from the hospital. PX 3.

Petitioner testified that Respondent's offices were closed by the time she left the hospital. She called the offices the next day, from home, and reached Carshena Ross. She told Ross about the accident and her injuries. She asked Ross what the next step would be. Ross told Petitioner she was busy and would call her back. Petitioner testified she called Respondent's offices later the same day because Ross did not get back to her. She reached Ross, who told her she was "never officially hired." Petitioner testified she was "stunned" to hear this since Respondent had provided her with keys to its vehicle and had sent her out on an assignment.

On October 2, 2008, Petitioner's counsel sent a letter to Respondent, via regular and certified mail, notifying Respondent of the claim and demanding the payment of benefits. PX 1.

Petitioner testified she sought follow-up care at Hyde Park Medical Center on October 2, 2008. Her leg had improved by that time but she was still experiencing neck and back pain.

The initial records from Hyde Park Medical Center set forth a history of the September 22, 2008 accident. The history reflects Petitioner was slowing down for a light, while driving for Jewel Bus Company, when the car behind her passed into oncoming traffic and then pulled back into her lane, causing her to pull the bus to the right and strike a parked bus. The records also reflect Petitioner hurt her leg by forcefully applying the brakes and was "jerked forward" on impact. The examining physician, apparently Dr. Sharma, noted complaints of pain in the right leg, neck and back. Dr. Sharma also noted that Petitioner had been off work since the accident. He diagnosed strains of the right knee, cervical spine and lumbar spine. He indicated that Petitioner denied any prior accidents. He took Petitioner off work and recommended therapy. PX 4.

The records from Hyde Park Medical Center include a "patient acknowledgement form for work-related injuries" dated October 2, 2008. Petitioner's signature appears at the bottom of this form. On this form, Petitioner identified Jewel Bus Company as her employer at the time of the accident and Carshena Ross as the person handling her claim. PX 4..

Petitioner returned to Hyde Park Medical Center on October 8, 2008 and complained of intermittent low back and bilateral shoulder pain as well as giving out of the right leg. The examining provider prescribed Ibuprofen and Flexeril as well as therapy three times per week.

On October 9, 2008, Dr. Sharma of Hyde Park Medical Center issued a note finding Petitioner medically unable to work from October 2, 2008 through October 23, 2008, secondary to the work accident of September 22, 2008. PX 4.

Petitioner began attending therapy on October 10, 2008. PX 4.

Petitioner returned to Hyde Park Medical Center on October 23, 2008 and complained of intermittent headaches as well as pain in her back and right knee and thigh. The examining provider refilled the medication and directed Petitioner to remain off work and continue attending therapy. PX 4.

On November 6, 2008, a provider at Hyde Park Medical Center noted that Petitioner denied neck and leg pain but complained of intermittent, 6-10/10 low back pain, aggravated by prolonged standing, bending and sitting. The provider prescribed a lumbar spine MRI and directed Petitioner to continue therapy. PX 4.

The lumbar spine MRI, performed without contrast on November 10, 2008, demonstrated a central disc herniation at L5-S1 with impression on the dural sac but no foramen compromise or thecal sac stenosis. PX 4.

Petitioner continued undergoing care at Hyde Park Medical Center through December 17, 2008.

In a report dated December 30, 2008, Dr. Sharma noted that Petitioner was still experiencing low back pain as of her last visit, on December 17, 2008. Dr. Sharma indicated he referred Petitioner to a neurosurgeon on that date and discharged her from care. He linked the pathology noted on the lumbar spine MRI to the work accident. PX 4.

Petitioner testified she then began a course of treatment at Fullerton Surgery Center, where she eventually underwent three epidural steroid injections. She testified the injections "helped at the moment." [The Fund objected to the records and bill from Fullerton Surgery Center (PX 5), based on lack of certification. The Arbitrator sustained this objection and marked PX 5 as a rejected exhibit.]

Petitioner testified she was released to return to work in late February or early March 2009. At that point, she went to Respondent's offices and presented her doctor's release. Carshena Ross again told her she was "never officially hired." She did not resume working for Respondent and had no subsequent contact with Respondent. In approximately April 2009, she began working for Dollar Tree. At this point, she was still experiencing low back pain but was no longer having neck or leg problems.

A letter in PX 4 reflects that the billing department of Hyde Park Medical Center forwarded Petitioner's records and itemized bills to Respondent on November 8, 2009 and requested payment within sixty days, in accordance with Section 8.2 of the Act.

Petitioner testified she continues to experience low back problems. She is unable to bend or sit for extended periods. She has difficulty playing with her 3-year-old son. Her current job consists of playing with very young children.

Petitioner acknowledged she has had no additional injury-related care since her last visit to Fullerton Surgery Center in 2009. She continues to take over the counter medication, including Ibuprofen and Bayer, for her persistent back symptoms.

Under cross-examination, Petitioner testified she began working for Respondent about a week before the September 22, 2008 accident. She did not sign a contract with Respondent but she did sign paperwork, including a W2 tax form. She never received a W2 form from Respondent because she never received a paycheck. A woman named "Jewel" owned Jewel Bus Company. When she returned to Respondent's offices in late February or early March 2009, she gave Ross a copy of the police report. She did not give her medical bills to Ross because she had an attorney by that time. She never underwent surgery relating to her work injuries. She underwent neck therapy at Hyde Park Medical Center but is unsure of how many therapy sessions she attended. She was discharged from care in February 2009. She is not currently undergoing any injury-related care. She told Ross she did not have a CDL. Respondent offered classes to help employees obtain permits but she (Petitioner) already had a permit before she started working for Respondent. She paid for this permit. Before she started working for Respondent she did not drive for another company. When she obtained the keys on September 22, 2008, she did not anticipate driving a bus.

The Fund did not call any witnesses or offer any documentary evidence.

Arbitrator's Credibility Assessment

Despite the inordinate delay in bringing this case to hearing, Petitioner had a very good recollection of her hiring and the accident. The Arbitrator found her very credible.

Arbitrator's Conclusions of Law

Did Petitioner establish she and Respondent were operating under the Act as of the September 22, 2008 accident? Did Petitioner establish an employment relationship as of that date?

The Arbitrator finds that the provisions of the Act applied to Respondent, automatically, and without election, as of September 22, 2008 because Respondent was engaged in an "extra hazardous" enterprise, i.e., carriage by land using gasoline driven vehicles. See subsections (3) and (15) of Section 3 of the Act.

The Arbitrator further finds that Petitioner established her relationship with Respondent as of September 22, 2008 was that of employee and employer. Petitioner credibly testified she sought employment at Respondent, and was hired, after she learned Respondent was looking for school bus drivers. Petitioner also credibly testified she received an assignment and keys from Respondent on the morning of September 22, 2008, after she presented to Respondent's offices, with the keys affording her access to the Respondent vehicle she was operating at the time of the accident. There is no evidence suggesting Petitioner deviated from her route or was using the vehicle for personal purposes at the time of the accident. Petitioner established both that Respondent controlled her work and that the services she provided were "in the nature of" Respondent's business. Roberson v. Industrial Commission, 225 Ill.2d 159 (2007).

Did Petitioner sustain an accident on September 22, 2008 arising out of and in the course of her employment by Respondent?

The Arbitrator finds that Petitioner sustained an accident on September 22, 2008 arising out of and in the course of her employment by Respondent. In so finding, the Arbitrator relies in part on Petitioner's credible testimony concerning her hiring (which included completion of a W2 form), Respondent's requirement that she log in and out each workday, her exchange with her supervisor, Carshena Ross, on the morning of the accident, and the circumstances of the accident. Petitioner testified that, after Ross gave her an assignment, she reminded Ross she did not have a license to drive a bus, at which point Ross directed her to take different keys. These keys were for a smaller vehicle. Petitioner testified she took Ross's directive to mean she was qualified to drive the smaller vehicle. Petitioner was operating this vehicle, with the intention of performing her assigned route, when the accident took place.

The Fund argues this claim should be denied because Petitioner's conduct at the time of the accident was willful and wanton. Specifically, the Fund maintains Petitioner "knew" it was not legal for her to operate the smaller vehicle and yet she proceeded to do so. The Arbitrator rejects the Fund's argument. There is no evidence suggesting Petitioner misrepresented her licensure to Respondent. In fact, her credible testimony establishes it was she, on receiving the initial set of keys, who reminded Ross she did not have a CDL. Ross responded by changing the vehicle assignment. In the Arbitrator's view, it was incumbent on Respondent, a commercial school bus line, and not Petitioner, to ensure that an employee could legally operate an assigned vehicle.

Did Petitioner provide Respondent with timely notice of her accident?

The Arbitrator finds that Petitioner provided timely notice of her accident to Respondent. In so finding, the Arbitrator relies on Petitioner's credible testimony as to her co-worker's telephonic communication with Respondent shortly after the accident and as to her own telephonic conversation with her supervisor, Carshena Ross, the day after the accident. When Petitioner first sought care at Hyde Park Medical Center, on October 2, 2008, she identified Ross as the Respondent representative in charge of her claim.

The Arbitrator also notes that Petitioner's counsel sent a letter to Respondent, via certified mail, on October 2, 2008, notifying Respondent of the claim and his representation. Counsel filed Petitioner's Application for Adjustment of Claim five days later. The letter and Application were transmitted well within the 45-day statutory notice period. Arb Exh 3. PX 1.

Did Petitioner establish a causal connection between the September 22, 2008 and her claimed current condition of ill-being?

The Arbitrator finds that Petitioner established causation as to neck, low back and right leg conditions that required a course of treatment. The Arbitrator further finds that Petitioner established causation as to a lumbar spine disc herniation that continues to produce symptoms. In making these findings, the Arbitrator relies on the following: 1) Petitioner's credible testimony as to the force of the impact and the near immediate onset of symptoms; 2) the Emergency Room records, which document the accident and symptoms involving the neck, low back and right leg; 3) the Hyde Park Medical Center records, which reflect that Petitioner denied pre-accident neck, low back or right leg problems, that the neck and right leg symptoms resolved over time but that Petitioner's low back remained symptomatic, resulting in the need for a lumbar spine MRI and neurosurgical referral; 4) the lumbar spine MRI report, which documents a herniation at L5-S1; 5) Petitioner's credible testimony that she continues to

experience intermittent, activity-related low back symptoms; and 6) the fact that none of the admitted medical records reflect a pre-accident history of neck, low back or right leg problems.

What was Petitioner's average weekly wage?

The Arbitrator finds Petitioner's average weekly wage to be $396. In so finding, the Arbitrator relies on Petitioner's credible testimony concerning her hiring and her understanding that she was required to work 36 hours per week and would be paid at the rate of $11 per hour. There is no documentary evidence supporting this testimony but that is understandable, since the accident took place within about three days of Petitioner starting to work for Respondent and on the first day Petitioner drove for Respondent. Petitioner credibly testified that Respondent never paid her and asserted, after the accident, that she was "never officially hired."

What was Petitioner's age at the time of the accident? What was Petitioner's marital status and did she have any dependent children?

The Arbitrator finds that Petitioner was 24 years old at the time of the accident. Petitioner testified she was 23, not 24, but she also testified she was born on October 17, 1983. This is the birth date listed on her Application (Arb Exh 3) and in her medical records (PX 3-4). The Arbitrator further finds that Petitioner was single and had no dependent children as of the accident. Petitioner credibly testified to these circumstances and her Emergency Room records describe her as single. PX 3.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Request for Hearing form lists claimed medical bills from three providers: Roseland Community Hospital, Hyde Park Medical Center and Fullerton Surgery Center. Arb Exh 1. The Arbitrator rejected the records and bills from Fullerton Surgery Center (PX 5) after the Fund raised an objection based on lack of certification.

The Arbitrator awards the $1,822.50 bill from Roseland Community Hospital (PX 3), subject to the fee schedule. The Arbitrator finds it reasonable and necessary for Petitioner to have undergone Emergency Room care, including CT scanning and X-rays, on the date of the accident, given the nature of the trauma. The Arbitrator also awards $4,111.00 of the claimed $4,161.00 from Hyde Park Medical Center (PX 4), subject to the fee schedule. The Arbitrator declines to award the additional claimed $50.00 since this charge relates to the preparation of a narrative report rather than actual treatment. The Arbitrator finds it reasonable for Petitioner to have undergone conservative care, including therapy, for three months following the accident, especially given her persistent low back complaints and the results of the lumbar spine MRI.

Having rejected PX 5, the Arbitrator declines to award any of the claimed expenses relating to care rendered by Fullerton Surgery Center.

Is Petitioner entitled to temporary total disability benefits?

The Request for Hearing reflects a claim for temporary total disability benefits from September 22, 2008, the date of the accident, through April 20, 2009. Arb Exh 1. Petitioner did not, however, testify to being kept off work through April 20, 2009. She acknowledged being released to work in late February or early March 2009.

The Arbitrator, in reliance on the admitted records from Roseland Community Hospital and Hyde Park Medical Center, finds that Petitioner was temporarily totally disabled from October 2, 2008 (the date of her first visit to Hyde Park Medical Center) through December 17, 2008 (the date of her last visit to Hyde Park Medical Center). This is a period of 11 weeks. The Arbitrator declines to award benefits prior to October 2nd because there is no evidence that the Emergency Room doctor who saw Petitioner on the day of the accident imposed restrictions. PX 3. The Arbitrator declines to award benefits after December 17, 2008, having rejected the uncertified records from Petitioner's last provider, Fullerton Surgery Center (PX 5). The Arbitrator notes that, even if no objection had been raised to PX 5, the documents in that exhibit are limited in scope and do not include any "off work" notes.

The Arbitrator, having previously found Petitioner's average weekly wage to be $396.00, finds the temporary total disability rate to be $264.00.

What is the nature and extent of the injury?

This case is pre-amendatory, since the accident occurred prior to September 1, 2011. In assessing permanency, the Arbitrator considers the admitted treatment records, including the lumbar spine MRI report, and Petitioner's credible testimony concerning her ongoing low back complaints. The Arbitrator also notes that Petitioner was only 24 years old as of the accident and that no one viewed her as a surgical candidate.

The Arbitrator finds that Petitioner is permanently partially disabled to the extent of 4% loss of use of the person as a whole, equivalent to 20 weeks of benefits, under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

- [x] 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

Illinois Workers' Compensation Commission,
Insurance Compliance Division,
Petitioner,

vs.

No. 16 INC 00016
19 WC 20255

Michael Fulkerson, Individually and as
President of Steelcad Industrial Services,
Respondent.

19IWCC0408

DECISION AND OPINION RE: INSURANCE NON-COMPLIANCE

Petitioner Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action by and through the Office of the Illinois Attorney General, against the above-captioned Respondent. Petitioner alleges a violation of Section 4(a) of the Illinois Workers' Compensation Act (the Act), for Respondent's failure to procure mandatory worker's compensation insurance. Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance for a total of 2,629 days during the following periods: (1) July 20, 2005 through November 24, 2008, and (2) March 14, 2012 through January 20, 2016.

An *ex parte* hearing was held before Commissioner Marc Parker in Mt. Vernon, Illinois, on May 13, 2019. Respondent, Michael Fulkerson, did not appear. Petitioner presented the testimony of Michael Cummins, Investigator for the Illinois Workers' Compensation Commission.

19IWCC0408

The Commission, after considering the evidence and being advised of the applicable law, finds that Respondent was not properly served with Notice of Hearing as required by Commission Rule 9100.90(d)(1)(A).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Investigator Cummins testified he is familiar with Steelcad Industrial Services because a workers' compensation claim, 15 WC 35400, was filed against that company (T. 8). Steelcad Industrial Services was found to not have workers' compensation insurance, so the employee's attorney in that claim named the Injured Workers' Benefit Fund as a second Respondent to that claim (T. 8).

2. The Investigator read the claim of injury regarding 15 WC 35400 and visited Steelcad's place of business. Steelcad Industrial Services had been a manufacturing business. At the time of the investigator's visit, he observed a closed down, vacant warehouse in the outskirts of Cutler, Illinois (T. 9). As of January 21, 2016, Respondent was no longer in business (T. 15).

3. The Investigator conducted additional steps in his investigation of Steelcad Industrial Services. He searched several databases that indicate employer's revenue and insurance history. He searched the National Council on Compensation Insurance which indicated that although Steelcad Industrial Services had insurance for a period of time, it was without workers' compensation insurance from July 20, 2005 through November 24, 2008 and from March 14, 2012 through January 20, 2016. He concluded that Steelcad Industrial Services was operating for an extended period of time in violation of the Illinois Workers' Compensation Act (T. 10-11).

4. The Investigator served Respondent with a Notice of Non-Compliance dated January 20, 2016, for the periods of non-compliance from July 20, 2005 to November 24, 2008, and from March 14, 2012 to January 20, 2016 (PX 11; T. 11). A copy of Petitioner's Notice of Non-Compliance was attached to the record as Petitioner's Exhibit 11. No certificate of service was included as part of that exhibit.

5. Commission Rule 9100.90(c)(1) provides that Notice of Non-Compliance shall be given to the employer, along with a certificate of service, at their last known address or to the employer's representative.

6. Commission Rule 9100.90(c)(3) provides that when a Notice of Non-Compliance has been sent, the Commission shall, at the request of the employer or its attorney, or may on its own initiative, schedule the matter for an informal conference at which a designated representative of the Commission shall meet with the employer in an attempt to resolve the matter. The notice of non-compliance informs the employer of the Commission's allegations and provides a process whereby the alleged violations can be resolved short of a formal hearing. In this instance, no informal conference regarding Respondent's alleged non-compliance was requested or took place.

7. Commission Rule 9100.90(d)(1)(A) states in pertinent part, "A matter under this Section is commenced by the Commission by service of a Notice of Hearing upon the employer at least 30 days prior to the time fixed for hearing. *If service cannot be made by personal service,* service of the Notice shall be by United States registered or certified mail addressed to the employer at the last known address or to the employer's representative." *(Emphasis added.)*

8. The Investigator mailed Mr. Fulkerson a notice of hearing that went unclaimed (T. 12). Mr. Cummins' Affidavit of Service for that Notice, sent on April 21, 2017, via certified mail, return receipt requested, states the Insurance Compliance Hearing was set for July 11, 2017 (PX 10). The Commission finds that the April 21, 2017 mailed Notice was not personal service, as mandated by Commission Rule 9100.90(d)(1)(A).

9. Thereafter, on July 11, 2017, the Investigator left another Notice for the same hearing date at Mr. Fulkerson's Willisville residence. He testified he left a copy of it in Mr. Fulkerson's door jamb (T. 12-13). The Affidavit of Service for that Notice stated there was no response when he knocked, and therefore he, "affixed notice to front door…" (PX 1). Further, the Affidavit of Service, which was neither notarized nor certified, stated that it was "served" just two hours prior to the hearing which was set to begin at 1:00 pm on July 11, 2017.

10. The Commission finds that the act of leaving the Notice of Hearing in Mr. Fulkerson's door jamb on July 11, 2017 did not constitute personal service. Further, the Notice of Hearing which Mr. Cummins left on that date did not comply with Rule 9100.90(d)(1)(A) because it was for a hearing scheduled just two hours later, at 1:00 pm on July 11, 2017. The Rule requires Notice be served at least 30 days prior to the time fixed for hearing.

11. Petitioner offered no other proof that it served Respondent with the Notice of Hearing as required under the Rule.

For the forgoing reasons, the Commission finds it does not currently have jurisdiction over Respondent to consider the fines and penalties requested by Petitioner.

19IWCC0408

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petitioner for fines and penalties against Respondent for alleged violation of Section 4(a) of the Illinois Workers' Compensation Act, for failing to procure worker's compensation insurance, is dismissed.

DATED: AUG 2 - 2019

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/mcp
r-05-13-19
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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 no value change	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIMBERLY CURREY,

Petitioner,

vs. NO: 12 WC 33353

NEW ASHLEY STEWART, INC.,

Respondent.

19IWCC0409

DECISION AND OPINION ON REVIEW

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

Causal Relationship

Petitioner sustained an undisputed accident when she was attacked by an unknown assailant causing injury to her cervical spine and right upper extremity. T. 15. After a course of conservative care, on November 12, 2012, Petitioner underwent a cervical discectomy and fusion performed by Dr. Hyder; on April 5, 2013, an arthroscopic repair of her right shoulder rotator cuff performed by Dr. Schwartz; and on January 17, 2014, a right cubital tunnel release performed by Dr. Schwartz. T. 20-23; PX2. On June 18, 2014, Dr. Schwartz placed Petitioner at maximum medical improvement (MMI) and discharged her from care. *Id.*

On August 25, 2014, Petitioner sought treatment from Dr. Freedberg who is recommending additional surgery. PX11. On January 12, 2015, Dr. Lieber evaluated Petitioner pursuant to

Section 12 of the Act and is of the opinion additional surgery is not warranted.

The Arbitrator found Petitioner's current condition of ill-being not causally related to her accident. The Commission views the medical evidence differently. Petitioner sustained an undisputed accident leading to injury of both her cervical spine and right upper extremity which necessitated medical care. Despite being placed at MMI by her treating physician, Dr. Schwartz, Petitioner continues to voice complaints regarding her right shoulder. The Commission finds Petitioner's current conditions of ill-being causally related to her undisputed accident of June 29, 2012 which necessitated the surgeries as indicated above. Such finding of causal relationship does not automatically entitle Petitioner to ongoing medical treatment as such treatment must be reasonable and necessary. The Commission finds additional treatment as recommended by Dr. Freedberg is neither reasonable nor necessary pursuant to Section 8(a) of the Act.

Section 8(a) of the Act requires Respondent to pay for medical expenses which are "reasonably required to cure or relieve from the effects of the accidental injury..." *820 ILCS 305/8(a)* (West 2013). See *F & B Manufacturing Co. v. Industrial Commission of Illinois*, 325 Ill. App. 527, 534, 758 N.E.2d 18 (2001) ("Under Section 8(a) of the Act, the claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of claimant's injury").

Dr. Freedberg is recommending further surgery specifically to address Petitioner's biceps tendon based primarily upon Petitioner's ongoing subjective complaints of pain. PX15, p. 19-20. Dr. Freedberg opined this recommendation was based upon the objective testing specifically the EMG and MRI (*Id*), but neither of these tests evidence any actual pathology. The EMG performed on January 7, 2015 evidences absolutely no shoulder pathology but instead indicates bilateral carpal tunnel syndrome and right sided ulnar neuropathy. PX11. More importantly, the MRI performed on September 15, 2014 evidences no recurrent rotator cuff tear, and in fact, confirms an intact biceps tendon. *Id.*

Nonetheless, Dr. Freedberg is recommending surgery as it is his opinion "I find with shoulders, a lot of times, patients fail from other doctors because the biceps is not addressed." RX15, p. 25. Dr. Freedberg provides this recommendation despite the fact Petitioner recovered well from her prior surgery with Dr. Schwartz. Dr. Freedberg dismisses Dr. Schwartz' treatment and medical records stating:

> And sometimes doctors' records don't reflect the accuracy of how a patient portrays it because all surgeons have egos, and some surgeon's egos are really too grandiose for their own good; and, therefore, they are not willing to accept that the surgery they did, not a fault of their own, was unsuccessful. And my guess is that that could be playing a part with this. But my opinion is I don't think she ever did well. RX15, p. 31.

Dr. Freedberg offers this sweeping opinion despite his acknowledgement he neither possessed nor recalled the contents of Dr. Schwarz' records. RX15, p.24. As Dr. Freedberg stated he is guessing.

In contrast, Dr. Lieber testified he reviewed a complete set of Petitioner's medical records along with the MRI report and films. RX1, p. 9. Dr. Lieber opined the objective tests do not

19IWCC0409

evidence abnormal pathology. As such, surgical intervention is not warranted. RX1, p. 13-14. Consistent with the records of Dr. Schwartz, Dr. Lieber found Petitioner underwent a successful shoulder surgery resulting in residual complaints, but such complaints do not warrant additional surgical intervention. RX15, p. 18.

The Commission affords greater weight to the opinions of Dr. Lieber over those of Dr. Freedberg and finds the proposed prospective medical treatment is neither reasonable nor necessary and is denied. Based on the opinion of Dr. Lieber which is wholly consistent with those of Dr. Schwartz, the Commission finds Petitioner reached MMI on January 12, 2015.

Temporary Disability

The Arbitrator awarded Temporary Total Disability benefits from July 2, 2012 through January 1, 2013 and maintenance benefits of $53.00 per week from January 2, 2013 through January 12, 2015. The Commission affirms the TTD award but vacates the award of maintenance benefits. The benefits are temporary partial disability benefits pursuant to Section 8(a).

By its own terms, the Act grants maintenance benefits only while a claimant is engaged in a rehabilitation program; if the claimant is not engaged in some type of "rehabilitation" such as physical rehabilitation, formal job training, or a self-directed job search, there is no obligation to provide maintenance. *Greaney v. Industrial Commission*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331 (2005); see also, *W.B. Olson v. Illinois Workers' Compensation Commission*, 2012 IL App (1st) 113129WC, ¶39, 981 N.E.2d 25 (An employer is obligated to pay maintenance benefits only "while a claimant is engaged in" a rehabilitation program.)

It is uncontroverted that Petitioner has not and is not engaged in a vocational rehabilitation program; to the contrary, Petitioner testified she was granted social security disability benefits on December 19, 2014. T. 35. In an effort to supplement these benefits, Petitioner obtained employment at Triedstone Baptist Church daycare working approximately five hours per week earning $12 per hour. T. 37; 40. Petitioner testified she was limited by her social security disability award regarding the hours she could work. *Id.* Therefore, the Commission finds Petitioner is not entitled to maintenance under Section 8(a) and vacates the award of maintenance benefits. The Commission finds Petitioner is entitled to temporary partial disability benefits of $53 per week ($379.50 - $300 = $179.00(2/3)) through January 12, 2015, the date of MMI. See *Mechanical Devices v. Industrial Commission (Johnson)*, 344 Ill. App. 3d 752, 760, 800 N.E.2d 819 (2003) ("The factors to be considered in determining whether a claimant has reached maximum medical improvement include: (1) a release to return to work; (2) the medical testimony concerning the claimant's injury; (3) the extent of the injury; and (4) 'most importantly,' whether the injury has stabilized. [citations omitted]."). Respondent is entitled to a credit of $33,523.29 for temporary disability benefits previously paid.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 24, 2017 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

19IWCC0409

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 26-2/7 weeks, July 2, 2012 through January 1, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of maintenance is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $53.00 per week for a period of 105-6/7 weeks, January 2, 2013 through January 12, 2015, that being the period of temporary partial incapacity for work under §8(a) of the Act, and that as provided in §19(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that medical treatment and related expenses after January 12, 2015 are denied.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Respondent has paid $33,523.29 for temporary disability benefits.

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.

AUG 2 - 2019

DATED:
LEC/bsd
O052119
43

Elizabeth Coppoletti

Maria Portela

19IWCC0409

DISSENT

I believe the medical record in this case shows that Petitioner is in need of ongoing treatment as a result of her undisputed accident, and that the treatment recommended by Dr. Freedberg is both reasonable and necessary, as well as causally related to the accident on June 29, 2012. More to the point, I do not believe that Petitioner's condition has yet to stabilize, much less that she had reached MMI as of 1/12/15, and that the Commission's reliance on the opinion of hired gun Dr. Lieber to reach this conclusion is misplaced.

Along these lines, Petitioner continues to have significant complaints relative to her right shoulder. Dr. Freedberg testified persuasively that he disagreed with Dr. Lieber's conclusions that Petitioner's current condition was not related to the accident, that she was not in need of any further treatment and that she had reached MMI. (PX11, pp.16-18). Under the circumstances, Dr. Freedberg's recommendation for arthroscopic surgery to see what needs to be repaired seems imminently reasonable.

As a result, I would find that Petitioner's is entitled to ongoing medical care and treatment relative to her injury, and award benefits accordingly, including prospective medical expenses and ongoing temporary disability benefits.

For the foregoing reasons, I dissent.

Thomas J. Tyrrell

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

CURRY, KIMBERLY
Employee/Petitioner

Case# **12WC033353**

NEW ASHLEY STEWART INC
Employer/Respondent

19IWCC0409

On 9/28/2017, 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 1.17% shall accrue from the date listed above to the day before the 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:

1747 SEIDMAN MARGULIS & FAIRMAN LLP
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

2097 GRANT & FANNING
DANIEL SWANSON
300 S RIVERSIDE PLZ SUITE 2050
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)

Kimberly Currey,
Employee/Petitioner

v.

New Ashley Stewart, Inc.,
Employer/Respondent

Case # **12** WC **33353**

Consolidated cases: ____

19IWCC0409

An *Application for Adjustment 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 Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **August 24, 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? **(The parties stipulated and Respondent paid $161,537.15 in medical expenses)**

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, **June 29, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is not*** causally related to the accident. Petitioner has reached MMI for her injuries caused by the 6/26/12 accident.

In the year preceding the injury, Petitioner earned $**19,734.00**; the average weekly wage was $**379.50**.

On the date of accident, Petitioner was **42** 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 $**33,523.29** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**33,523.29**.

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

ORDER

Denial of Benefits

Because the Petitioner failed to prove that his current condition of ill-being is causally related to the injury after the January 18, 2015 IME date of Dr. Lieber, no TTD is owed after that date.

Medical Benefits

Because Petitioner failed to prove that a causal connection exists between the work accident of June 29, 2012 and any further necessity for medical treatment after June 18, 2014, medical treatment after that date is denied.

TTD Credit & Maintenance

The parties stipulated that Respondent paid 134-2/7 weeks of TTD or $33,523.29 from July 2, 2012 to January 18, 2015. Respondent shall be given a credit for TTD overpayment when it should have paid maintenance of $53.00 per week from the time in 2013 when she started working at Triedstone Baptist Church earning $12.00/hour for 20-25 hours per week until January 12, 2015. The Petitioner was paid $253.00 per week in TTD when she was entitled to maintenance of $53.00 creating an overpayment of $200.00 per week.

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

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

Kethi Shroff Steffen September 28, 2017

Signature of Arbitrator Date

ICArbDec19(b)

SEP 28 2017

FINDINGS OF FACT

Petitioner Kimberly Curry worked for Respondent as a sales associate and assistant manager for one year. (T 11; PX2, P0139, 51.) As part of her duties as an assistant manager, Petitioner was required to do deposits every day. (T 12.)

Petitioner was working for Respondent on June 29, 2012; on that date, she was an assistant manager. (T 11.) She was 42 years old. (PX2, P0139.) Petitioner is right-handed. (T 12; PX1, P0040.) Prior to June 29, 2012, Petitioner had never had any medical treatment for either her left or right shoulders or neck. (T 12-13.)

On June 29, 2012, Petitioner was called in to cover for the manager. (T 14.) She checked to ensure that they had the correct amount of money in the register, then got the deposits out and went on her way to the bank. (T 14-15.) On her way, out the door, as she was walking to her car, an assailant attacked petitioner from behind and snatched the purse off her right shoulder, running off with the store's money. (T 15.) The purse had a thick rubbery cording inside of it, and so the assailant pulled down extremely hard when he grabbed the purse. (T 17.) He then ran off. (T 17.)

Police came and Petitioner returned inside the store. (T 16.) As she wrote up a report, she noticed that her right arm had started hurting. (T 16.) About an hour after she finished up everything at the store, Petitioner noted that the pain kept getting more severe, so she went to the emergency room for treatment. (T 16.)

Petitioner sought treatment at the St. Margaret Mercy Hospital emergency room on June 29, 2012, where she was assessed with a shoulder strain and released with restrictions of no use of the right arm. (T 18.)

Petitioner returned to the St. Margaret Mercy Hospital emergency room on July 3, 2012, where she was seen by orthopedist Dr. Anthony Wilko. (PX1, P0039.) She related her history of injury: during a robbery at work on Friday, her purse was snatched off her right arm, jerking her right arm back. (PX1, P0039.) She reported that she was icing her arm and taking NSAIDs, but that she was still in pain; she further reported that she was experiencing periodic tingling in her right hand. (PX1, P0039.)

Dr. Wilko noted that Petitioner had no prior injuries to her right upper extremity. (PX1, P0040.) On examination, Petitioner was observed to have pain and decreased range of motion with external rotation. (PX1, P0041.) Dr. Wilko noted that Petitioner

may have a rotator cuff tear, and stressed to her the importance of following up with an orthopedist. (PX1, P0041.) Dr. Wilko stated: "The injury mechanism was a pulled limb. The injury was related to work." (PX1, P0039.)

On July 31, 2012, Petitioner presented to the St. Francis Health Services Orthopedic Clinic for follow-up; she reported that her pain had improved with rest, but complained of continued discomfort. (PX2, P0112.) On examination, Petitioner exhibited tenderness along the anterior right shoulder near the long head of the biceps tendon, with limited right arm range of motion, positive lift-off test, and decreased strength during internal rotation. (PX2, P0112.) She was assessed with a right shoulder strain and instructed to continue home exercises. (PX2, P0112-13.)

On August 20, 2012, Petitioner underwent an MRI of the cervical spine which disclosed a posterolateral disc herniation at C5-6 compressing the thecal sac and left lateral recess. (PX2, P0190.)

On September 5, 2012, Petitioner presented to Dr. Joseph Schwartz at Bone & Joint Specialists. (PX2, P0172.) Petitioner complained of right-sided shoulder and neck pain, with cramping and spasms progressing down her whole arm. (PX2, P0134, 39.) Petitioner also reported numbness progressing from her right elbow down into her pinky and ring finger. (PX2, P0134.) She reported that her problem began during a robbery, when her purse was snatched. (PX2, P0135.)

Petitioner related her history of injury; her right shoulder and neck pain began on June 29, 2012 when a thief grabbed her purse from behind and yanked it off her shoulder as she exited Respondent's store. (PX2, P0172.) She noticed arm pain an hour later while filling out paperwork, which gradually progressed up her whole arm; a couple of days later, she started noticing numbness extending from her elbow to her ring finger and pinky, occasioning her second ER visit. (PX2, P0172.)

On examination, Dr. Schwartz noted tenderness to palpation at the AC joint, along the anterior aspect of the humeral head and the right upper trapezius; right shoulder range of motion was "quite limited"; neck range of motion was somewhat limited, with a pulling sensation on the right side of the neck and right trapezius. (PX2, P0173.) Dr. Schwartz reviewed the MRIs, which revealed supraspinatus tendinosis at the insertion site with a possible partial-thickness tear, as well as disk herniation and thecal compression at C5-C6. (PX2, P0173.) He assessed Petitioner with neck and

right shoulder pain with rotator cuff tendinosis, and numbness in the ulnar nerve distribution with possible lower trunk brachial plexus injury or ulnar nerve injury. (PX2, P0173.) Dr. Schwartz performed an injection in the right subacromial space and AC joint, and referred Petitioner for nerve conduction studies. (PX2, P0173.)

On September 26, 2012, Petitioner returned to Dr. Schwartz. (PX2, P0170.) She reported that she had received no relief from the injection into her right subacromial space and AC joint. (PX2, P0170.) Dr. Schwartz stated that Petitioner's symptoms might be originating from brachial neuritis; he referred Petitioner to Dr. Zeshan Hydar for a neck evaluation. (PX2, P0171, 0200.) Dr. Hyder, in turn, referred Petitioner to Dr. Kondamuri at Midwest Interventional Spine Specialists for a selective nerve root block in order to determine if her symptoms were originating from her cervical spine.

On October 15, 2012, Petitioner presented to Dr. Kondamuri for the first time. (PX2, P0110.) He assessed Petitioner with cervical radiculopathy, a left-center cervical disc herniation at C5-C6, and "right upper extremity pain presumably related to the above." (PX2, P0111.) Dr. Kodamuri performed a nerve root block injection at C5-C6. (PX2, P0125.) Dr. Kodamuri noted that 15 to 30 minutes after the injection, Petitioner's pain had improved by 10%. (PX2, P0111.)

Petitioner returned to Dr. Hyder on October 23, 2012, reporting that her headaches were much better and that she had had improvement since undergoing the selective nerve root block. (PX2, P0081.) Dr. Hyder opined that Petitioner would benefit from an anterior cervical discectomy and fusion. (PX2, P0081.)

On November 20, 2012, Dr. Hyder performed a cervical discectomy and fusion at C5-C6 to address Petitioner's cervical radicular symptoms. (PX2, P0097.) Dr. Hyder stated that Petitioner had failed conservative management and had obtained good relief with a nerve root block, which meant that she was indicated for surgical intervention. (PX2, P0097.)

On November 27, 2012, Petitioner returned to Dr. Hyder; she reported that most of her numbness and tingling was gone, though she did have a little bit of cramping. (PX2, P0079.) Petitioner reported doing well on subsequent follow-up on January 8, 2013, but reported right shoulder pain on February 7, 2013 after "overdoing it" during physical therapy. (PX2, P0077-78.) Dr. Hyder opined that Petitioner had tendinitis

which was aggravated by physical therapy; he performed a steroid injection in her AC joint to address her symptoms. (PX2, P0077.)

On February 18, 2013, Petitioner underwent a CT scan of the cervical spine, which disclosed no foraminal compromise at C5-C6. (PX2, P0132.) The radiologist opined that the fusion "appears satisfactory." (PX2, P0132.)

On February 21, 2013, Petitioner underwent an EMG nerve conduction study which disclosed mild evidence of right sided mononeuropathy (carpal tunnel syndrome), as well as findings in the right C6 paraspinal muscle secondary to nerve root irritation. (PX2, P0117.)

Petitioner followed up with Dr. Hyder two more times; on February 28, 2013, he opined that Petitioner's symptoms were no longer originating from her neck, and referred her to an upper extremity specialist for further treatment. (PX2, P0075-76.)

On March 7, 2013, Petitioner returned to Dr. Schwartz for follow-up concerning her right arm symptoms. (PX2, P0169.) She reported that it had begun hurting her several weeks earlier, and that the pain had been continuous ever since, worse with activity and with a popping sensation during passive motion. (PX2, P0169.) Dr. Schwartz reviewed her MRI, which he opined showed rotator cuff tendinosis with partial-thickness tearing of the supraspinatus. (PX2, P0169.) Dr. Schwartz recommended right shoulder arthroscopic surgery to address the damage. (PX2, P0169.)

Petitioner underwent a right shoulder arthroscopic rotator cuff repair and subacromial decompression on April 5, 2013. (PX2, P0214.) Dr. Schwartz observed small tear in the anterior portion of the supraspinatus tendon, as well as a crescent-shaped tear in the subacromial space, which he sutured, as well as an anterior acromial spur, which he debrided. (PX2, P0214-15.)

Petitioner continued to treat with Dr. Schwartz over the next five months. (PX2, P0156-68.) During her June 6, 2013 follow-up with Dr. Schwartz, Petitioner reported that although her right shoulder pain had improved since the surgery, it still felt stiff. (PX2, P0163.) Petitioner reported that the numbness and spasms in her pinky and ring finger, which went away during the two months following her cervical fusion surgery, had returned; she reported that they were increasing in frequency and severity. (PX2, P0163.) Dr. Schwartz noted that Petitioner's nerve conduction studies had not shown

cubital tunnel syndrome; he opined that Petitioner might be suffering from electronegative cubital tunnel syndrome. (PX2, P0163.) He performed a right cubital tunnel injection to see if it would alleviate her paresthesias. (PX2, P0164.)

On June 19, 2013, Petitioner returned to Dr. Schwartz; she reported that the cubital tunnel injection had given her two weeks of relief. (PX2, P0162.) However, her symptoms of tingling from her elbow into her fourth and fifth digits returned thereafter; these would persist over the following months. (PX2, P0160-62.)

On October 16, 2013, Petitioner underwent a Section 12 examination with Dr. Mark Cohen. Petitioner complained of constant tingling and numbness in her pinky and ring finger. On examination, he noted tenderness over Petitioner's right ulnar nerve, with tingling and numbness into her pinky and ring finger with percussion. Dr. Cohen opined:

> One can certainly have tingling and numbness in the ring and small fingers from a stretch injury to the lower brachial plexus. Her tingling and numbness may certainly be multifactorial. I can only say that, given the time course of her symptoms relative to the initial event, one would have to conclude that in some way her current tingling and numbness is related to the June 2012 event. (PX2, P0145.)

Petitioner returned to Dr. Schwartz on January 8, 2014; she complained of right shoulder pain and occasional spasms, which rendered it difficult to write, type, and use a vacuum cleaner. (PX2, P0155.) Dr. Schwartz recommended that Petitioner undergo right cubital tunnel release; he cautioned her, however, that this may not relieve her symptoms, or that may do so only partially or temporarily. (PX2, P0155.) Petitioner elected to proceed with a right cubital tunnel release procedure. (PX2, P0155.)

On January 17, 2014, Petitioner underwent right cubital tunnel release surgery. (PX2, P0209.)

On February 3, 2014, Petitioner returned to Dr. Schwartz. (PX2, P0159.) She complained of occasional mild cramping in her fingers, but had experienced no tingling in her fingers since the surgery. (PX2, P0159.) On examination, however, Petitioner had some numbness over her posterior elbow. (PX2, P0159.)

Petitioner followed up once more on February 12, 2014, complaining numbness growing over her right elbow as the day progresses. (PX2, P0157.) On examination, Dr. Schwartz noted slight swelling over the incision site on Petitioner's elbow. (PX2,

P0157.) Dr. Schwartz put Petitioner on light clerical duty and instructed her to continue physical therapy. (PX2, P0157.)

On June 8, 2014, Petitioner returned to Dr. Schwartz, who put her at MMI and discharged her from care. On June 10, 2014, Petitioner underwent an FCE where she assessed as having light duty capabilities; she was given permanent restrictions of no lifting or carrying more than 13 pounds occasionally, no lifting or carrying more than 5 pounds constantly, and limited overhead use of the right arm. (T 24.) Petitioner was terminated by Respondent. (T 24.)

Petitioner presented to Dr. Freedberg on August 25, 2014. (PX15, P1024.) She complained of neck, right shoulder, right elbow, and right hand pain, as well as stiffness and difficulty driving. (PX11, P0773.) Petitioner reported that the pain in her shoulder was constant, with shooting pain from her elbow into her fourth and fifth fingers. (PX11, P0773.) She reported difficulty sleeping and difficulty driving using her right arm. (PX11, P0773.) Petitioner was taking Aleve to control her symptoms, but it was not helping. (PX11, P0773.)

Petitioner related her history of injury: she was in Respondent's store picking up a bank deposit. She was wearing a purse on her right shoulder. (PX11, P0773.) As she was walking out of the mall, a man grabbed her purse and began to pull on it, breaking the strap on her purse. (PX11, P0773.) She notified her employer and was sent home, at which point she visited the ER. (PX11, P0773.) She was assessed with a shoulder sprain and put in a sling. (PX11, P0773.) Over the following week, her shoulder pain started to increase. (PX11, P0773.) Petitioner returned to the ER on July 2, 2012, where she was referred to an orthopedist, Dr. Jeffrey Meier. (PX11, P0773.) Petitioner underwent cervical spine surgery on November 15, 2012; right shoulder surgery on April 13, 2013; and right elbow surgery in January 2014. (PX11, P0773.)

On examination, Dr. Freedberg noted tenderness in her cervical spinous process and cervical paraspinal region, with full cervical range of motion and pain in all directions. (PX11, P0774.) Petitioner was tender to palpation over the cubital tunnel in her right elbow, with diffuse tenderness in her right shoulder and reduced right shoulder range of motion. (PX11, P0774.) Petitioner exhibited no symptoms in her lumbar spine or in her left upper extremity. (PX11, P0774.)

Dr. Freedberg procured x-rays, which disclosed no bony abnormalities. (PX11, P0775.) He assessed Petitioner with cervical radiculitis, right shoulder pain status post arthroscopic RCR, and right elbow cubital tunnel syndrome. (PX11, P0775.) He ordered work-up via MRI arthrogram and EMG, and instructed Petitioner to return after testing was completed. (PX11, P0775.)

On September 7, 2014, Petitioner underwent an MRI arthrogram of the right shoulder at Suburban MRI, which disclosed undersurface thinning of the supraspinatus involving up to 50% of the tendon thickness without full-thickness tear. (PX11, P0751.)

On September 10, 2014, Petitioner returned to Dr. Freedberg. (PX11, P0738.) She complained of continued neck stiffness, pain in her right shoulder, and shooting pains from her right elbow into the 4th and 5th digits of her right hand with associated tingling and numbness. (PX11, P0738.) She remained the same upon examination. (PX11, P0739-40.) Dr. Freedberg reviewed Petitioner's MRI arthrograms. (PX11, P0740.) He reiterated his prior diagnosis, and performed a triamcinolone injection in the subacromial space of Petitioner's right shoulder. (PX11, P0740.) He maintained her at light duty and instructed her to follow up following a bilateral upper extremity EMG. (PX11, P0740-41.)

Petitioner next returned to Dr. Freedberg on November 19, 2014. (PX11, P0724.) She reported receiving 80% relief of her right shoulder symptoms for 3-4 weeks, beginning a couple of days after the injection. (PX11, P0724.) She reported neck cramping and pain radiating into her shoulder, as well as shoulder pain radiating down into her arm and fingertips. (PX11, P0724.)

On examination, Dr. Freedberg noted tenderness to palpation over Petitioner's cubital tunnel, tenderness to palpation over the cervical spinous process and paraspinal muscles, pain with right shoulder range of motion, and decreased sensation to light touch in Petitioner's 4th and 5th digits. (PX11, P0725-26.) Dr. Freedberg discussed surgery with the Petitioner, recommending a right shoulder arthroscopic rotator cuff repair, subacromial decompression, biceps tenotomy vs. tenodesis, and possible distal clavicle excision. (PX11, P0727.) Petitioner elected to proceed with surgery. (PX11, P0727.)

On January 12, 2015, Petitioner underwent a Section 12 examination with Dr. Lawrence Lieber. Petitioner related her history of injury, reporting that she had no prior right shoulder problems. On physical examination, Dr. Lieber noted decreased strength in Petitioner's right shoulder, tenderness to palpation in the right shoulder, right shoulder range of motion decreased secondary to pain, and positive O'Brien's, Reverse O'Brien's, speed, lift-off, and impingement tests on the right shoulder.

Dr. Lieber stated that "The petitioner did show evidence of some pre-existing degenerative abnormalities that may be symptomatic at this point," but opined that "there is no evidence of any significant aggravation of any pre-existing abnormalities that can be associated with the work event of June 29, 2012." Dr. Lieber opined that Petitioner's treatment to date had been reasonable and necessary; he opined that Petitioner required no further treatment, and that she reached maximum medical improvement as of her June 18, 2014 evaluation by Dr. Schwartz.

On May 1, 2015, Dr. Lieber authored an addendum to his Section 12 report of January 12, 2015, addressing the receipt of new medical records, including Petitioner's EMG of January 7, 2015 and right shoulder MRI arthrogram of September 7, 2014. He opined that the objective findings are consistent with a soft tissue injury to the cervical spine and left upper extremity, as well as a minor rotator cuff tear in her right shoulder, but that Petitioner's subjective complaints did not match this diagnosis. He opined that Petitioner's current need for medical treatment was not causally related to the accident, that no further treatment was indicated, and that Petitioner had a permanent restriction of no frequent overhead lifting or overhead lifting of greater than 20-25 pounds.

On February 17, 2016, Petitioner returned to Dr. Freedberg. (PX11, P0687.) She reported mild discomfort and achiness in her neck, neck pain when looking to the left, and inability to keep looking to the left. (PX11, P0687.) She reported constant, severe pain in her right shoulder and arm, with a burning sensation and radiation from the shoulder down the arm, as well as limited range of motion. (PX11, P0687.) Petitioner reported experiencing spasms in her arm that could get so bad that she would be unable to move her arm at all. (PX11, P0687.) Petitioner also reported constant, nagging pain and achiness in her elbow, with occasional sharp pains with movement and throbbing in her pinky and ring finger. (PX11, P0687.)

On examination, Petitioner continued to exhibit positive tenderness to palpation over the cervical spine and cubital tunnel of her elbow, with diffuse tenderness in the right shoulder and limited right arm range of motion. (PX11, P0688-89.) Dr. Freedberg recommended right shoulder arthroscopic surgery, and referred Petitioner to Dr. Novoseletsky for cervical injections. (PX11, P0690.)

On March 23, 2016, Petitioner returned to Dr. Freedberg. (PX11, P0675.) She continued to report stiffness and tightness in her neck, with difficulty looking to her left; right shoulder spasms; and nagging pain in her elbow, with constant throbbing in her pinky and ring finger and tingling at night that would wake her up. (PX11, P0675.) She remained essentially unchanged on examination. (PX11, P0676-77.)

Dr. Freedberg reviewed Dr. Lieber's January 12, 2015 Section 12 report and his subsequent addendum of May 1, 2015. (PX11, P0677-78.) Dr. Freedberg wrote:

> I absolutely disagree with him as there is no question of the injury when she was robbed and her purse was wrestled off her shoulder. So the need for treatment is without question. It is absolutely my opinion that her condition of ill being is causally connected to the accident in question. It is no surprise to me that Dr. Lieber denied the causation as in all my years and having read many reports from this doctor he has NEVER agreed with causation in any patient according to my experience. (PX11, P0679.)

On September 14, 2016, Dr. Freedberg authored a letter specifically addressing Dr. Lieber's Section 12 report. (PX11, P0658.) He wrote: "It is my opinion I absolutely disagree with the conclusions of Dr. Lieber. I feel that the treatment without question is necessitated from the accident in question." (PX11, P0658.) Addressing Dr. Lieber's statement that Petitioner's condition was not causally related and that she had reached maximum medical improvement, Dr. Freedberg wrote:

> There is no question from the time that I have reviewed and evaluated this patient that that is clearly not a true statement. That is clearly inaccurate information based off the patient's presentation. At this point, her prognosis is guarded because of the length of time. Clearly, at this time, she is in need for more treatment. There is no question in my mind within a reasonable degree of medical and orthopedic certainty that there is a positive causal relationship between the shoulder, elbow, cervical spine and shoulder complaints and the current conditions due to the work related injury as so described. I feel very strongly about that statement and I feel that she needs more further treatment in this particular matter in regards to her clinical condition.

(PX11, P0659.)

DEPOSITION TESTIMONY OF DR. HOWARD FREEDBERG

On November 8, 2016, Dr. Freedberg testified at an evidence deposition. (PX15.) Dr. Freedberg has been licensed to practice medicine in Illinois since 1982, and has been board certified in sports medicine since 1990, with recertifications in 2000 and 2010. (PX15, P1023.)

Dr. Freedberg testified that, based upon a reasonable degree of medical and surgical certainty, the incident of June 29, 2012 was a cause or contributing factor for Petitioner's conditions of ill-being in her cervical spine, right shoulder, elbow, and hand. (PX15, P1026.) He testified:

> She has documentation that is corroborated by both IME doctors of an accident that occurred that I believe the mechanism is applicable for the causation of the issues that she needed treatment for.
>
> She has continuity of care going from the date of the accident through my treatment until the last date of visit.
>
> And she does have pathology that has been elucidated from the MRIs as well as from the EMG test that was done on January 7th of 2015.

(PX15, P1026.) Asked to explain the role played by Petitioner's mechanism of injury, Dr. Freedberg testified that when Petitioner's purse was pulled off her shoulder, breaking the strap, her whole right upper extremity was tractioned: "And that, in itself, is a mechanism that's potentially a complete reason to cause the cervical[,] shoulder[,] elbow problems that she has experienced." (PX15, P1026.)

Dr. Freedberg testified that he disagrees with the conclusions of Dr. Lieber, and further testified that Dr. Lieber's Section 12 reports were "a little bit contradictory":

> Well initially, he says that she had a strain to the upper extremity. He says that she has problems of the upper extremity on his examination. He feels the treatment is reasonable and necessary.
>
> ...
>
> And then in the second report of May 1st, 2015, he then says that the patient's complaints are not consistent with the work injury and that, from an objective standpoint, no treatment is necessary, and that there's no causal connection between the current need for treatment and the work

injury. Because, simply, she's never gotten better. So I don't understand that part of his conclusion. (PX15, P1026-27.)

Dr. Freedberg testified that he recommended an arthroscopic procedure to evaluate the rotator cuff and see if it needs to be re-repaired, evaluate Petitioner's biceps, and resect about 8 millimeters in her acromioclavicular joint. (PX15, P1027.) He testified that he believed Petitioner had pain emanating from her rotator cuff, as well as from her biceps tendon; he testified that he would need an arthroscopy to determine how bad the damage is, as MRIs typically do not image these things very well. (PX15, P1027.) Dr. Freedberg testified that failure to address biceps tendon issues is a not-uncommon cause of failure in shoulder surgeries. (PX15, P1031.) He further testified that while cervical spine and shoulder pathologies can dovetail to some extent with overlapping symptoms, his physical examinations revealed both true shoulder problems and, independently, true neck problems. (PX15, P1029.) Dr. Freedberg testified that Petitioner could get better from this surgery, and that it would hopefully improve Petitioner's clinical condition, alleviate Petitioner's symptoms, and improve her quality of life. (PX15, P1027.)

On cross-examination Dr. Freedberg stated that he has a clinical suspicion based on Petitioner's examination that she does have rotator cuff pathology despite not being able to visualize it. Dr. Freedberg is recommending an arthroscopic procedure because the MRI does not image the bicep well, which makes him suspicious. (PX15 P1036). When asked whether symptom magnification or secondary gain can be ruled out, Dr. Freedberg replied *"everybody has a different pain tolerance. So if her pain tolerance is not good, which may be so, that's the cards you're dealt when you're playing poker".* (PX15 P1035)

TESTIMONY OF DR. LAWRENCE LIEBER

Dr. Lieber performed an Independent Medical Examination for Respondent on January 12, 2015. Dr. Lieber has been licensed in the State of Illinois since 1981 and is Board-certified in orthopedic surgery. Dr. Lieber opined that there is no causal connection between Petitioner's current need for medical treatment and the work injury of June 29, 2012. Further, any treatment after Dr. Schwartz' June 18, 2014 discharge and maximum medical improvement was not necessary or related to the June 29, 2012

work accident. Dr. Lieber found treatment prior to June 18, 2014 to be reasonable and necessary. However, Petitioner achieved maximum medical improvement on June 18, 2014. Moreover, Dr. Lieber opined Petitioner could return to work full duty as an assistant manager in clothing retail as long as she avoided lifting 20- 25 pounds overhead as a result of a prior rotator cuff repair. Dr. Lieber testified that he disagrees with Dr. Freedberg's opinion that Petitioner needs surgery as there is no objective evidence on any diagnostic studies to substantiate Dr. Freedberg's recommendation for an arthroscopic rotator cuff repair or any other surgery. Dr. Lieber stated that the Petitioner's subjective complaints are not related to the isolated event and associated surgery. Further, from an objective standpoint, there are no abnormalities noted that would require any further treatment that would be related to that event. (RX1, P 10)

PETITIONER'S ADDITIONAL TESTIMONY

Petitioner testified that if Dr. Freedberg's surgery were authorized, she would have the surgery. (T 28.) As of the date of hearing, Petitioner testified that she still has pain and tingling in her right shoulder and in the last two fingers on her right hand. (T 28-29.) Petitioner has problems resting, and cannot get out of her clothes at night without the assistance of her daughter or without cutting them off. (T 29.) She testified that she has problems writing, lifting things, and carrying things on her shoulder as well. (T 29.)

Petitioner testified that she looked for administrative work within her restrictions at schools and even tried retail. (Trial Transcript, Page 29). On cross-examination, Petitioner she acknowledged that she was currently working at Triedstone Baptist Church and started working there in 2013. (T 41) She testified that she works 4-5 hours a day or 20- 25 hours per week earning $12.00 per hour. She also stated that she applied for Social Security Disability after June 18, 2014 and was awarded Social Security Disability benefits on December 19, 2014. (Trial Transcript, Page 35)

Petitioner testified that she is currently looked for administrative work and retail work within her restrictions. (T 31.) The parties stipulated that Petitioner was 42 years old at the time of the accident. The parties stipulated that she earned $19,734.00

during the year prior to her accident, and that she had an average weekly wage of $379.50.

CONCLUSIONS OF LAW

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

The parties have stipulated that Petitioner suffered an accident arising out of and in the course and scope of her employment on June 29, 2012. Respondent accepted the accident and paid for TTD until 1/18/15 based on Dr. Lieber's IME findings. The Arbitrator agrees with Dr. Lieber's findings and concludes that Petitioner's current condition is not causally connected to the work accident and that Petitioner has reached MMI. In support, thereof the Arbitrator notes as follows:

The way the injury occurred is undisputed. Petitioner's purse was forcefully stolen from her causing her an injury to the right upper extremity. The accident and the pain from the injury is clearly reported and documents. There is no prior medical history relating to injury and pain in the right shoulder neck or hand. The manner of the injury largely supports Petitioner's reported pain complaints. In fact, during the initial years of treatment, there is agreement between all doctors that the Petitioner's current condition is causally connected.

Dr. Wilko of St. Margert Mercy Hospital noted that "the injury mechanism was a pulled limb. The injury was related to work." (PX1, P0039.) Dr. Mark Cohen, Respondent's first Section 12 examiner, concurred: "I can only say that, given the time course of her symptoms relative to the initial event, one would have to conclude that in some way her current tingling and numbness is related to the June 2012 event." (PX2, P0145.)

The causal connection issues become contested when Petitioner's treating physician, Dr. Schwartz, put her at MMI and Petitioner went to see Dr. Freedberg. He treats her conservatively with epidural injections and Petitioner reports 80% relief of her right shoulder symptoms for 3-4 weeks following this treatment. Petitioner continues to treat with him but reports new complaints of neck cramping and pain radiating into her shoulder, as well as shoulder pain radiating down into her arm and fingertips. (PX11, P0724.) Dr. Freedberg notes tenderness to palpation over Petitioner's cubital tunnel, tenderness to palpation over the cervical spinous process and paraspinal muscles, pain

with right shoulder range of motion, and decreased sensation to light touch in Petitioner's 4th and 5th digits. (PX11, P0725-26.)

On September 7, 2014, Petitioner underwent an MRI arthrogram of the right shoulder at Suburban MRI. Dr. Freedberg, recommends a right shoulder arthroscopic procedure to evaluate Petitioner's right rotator cuff and perform any necessary re-repairs, evaluate Petitioner's biceps, and resect about 8 millimeters in her acromioclavicular joint.

IME Dr. Lieber examined the Petition and reviewed the medical records. He disagreed with Dr. Freedberg findings and conclusion that more treatment/surgery is needed. Dr. Lieber agreed that the Petitioner has suffered a rotator cuff tear to her right shoulder. Based on his review and examination he opined that "The petitioner did show evidence of some pre-existing degenerative abnormalities that may be symptomatic at this point," but opined that "there is no evidence of any significant aggravation of any pre-existing abnormalities that can be associated with the work event of June 29, 2012." Dr. Lieber opined that Petitioner's treatment to date had been reasonable and necessary; he opined that Petitioner required no further treatment, and that she reached maximum medical improvement as of her June 18, 2014 evaluation by Dr. Schwartz.

In a May, 2015 addendum to his report, Dr. Lieber addressing the receipt of new medical records, including Petitioner's EMG of January 7, 2015 and right shoulder MRI arthrogram of September 7, 2014. He opined that the objective findings are consistent with a soft tissue injury to the cervical spine and left upper extremity, as well as a minor rotator cuff tear in her right shoulder, but that Petitioner's subjective complaints did not match this diagnosis. He opined that Petitioner's current need for medical treatment was not causally related to the accident, that no further treatment was indicated, and that Petitioner had a permanent restriction of no frequent overhead lifting or overhead lifting of greater than 20-25 pounds. He notes that overall, diagnostic studies show stabilization of her isolated injuries for a surgical standpoint, as well as an objective standpoint noted via EMG as well as MRI arthrogram of the shoulder in September, 2014. The stressed that the Petitioner should have full functional abilities of her right upper extremity, shoulder and arm area in association with the accident.

The Arbitrator has carefully considered both opinions and finds Dr. Lieber's opinion more persuasive. The mechanism of the injury supports the diagnosis and the treatment was appropriate for the Petitioner's conditions. After treatment, Dr. Schwartz placed Petitioner at MMI. Then Petitioner went to Dr. Freedberg for additional treatment. Although there is little break in treatment, Petitioner now reports new complaints of neck cramping. There is little by way of explanation why Petitioner changed physicians and there is no subjective evidence of a failed procedure other than Petitioner's continued symptoms. Over two years after the accident Petition see Dr. Freedberg upon a friend's recommendation after an MMI finding by Dr. Schwartz.

Under these unique circumstances with two qualified physicians in disagreement over causation, the Arbitrator looks at the subjective tests to find medical corroboration for continued symptomology. The Arbitrator also closely examines the credibility and motivations of ALL witnesses. The EMG and MRI arthrogram from September, 2014 do not support Dr. Freedberg's position. The EMG show normal nerve function for an individual that has cervical as well as cubital tunnel release surgery. There were no nerve abnormalities in her upper extremity or neck area. The MRI shows the indicia of prior rotator cuff surgery as well as an aging rotator cuff but not additional new damage. Dr. Lieber's opinion is therefore more persuasive. Dr. Freedberg's opines that the Petitioner's problems are likely caused by the bicep tendon. He discounts the lack of MRI findings by explaining that in his experience the MRIs do not typically image this (biceps tendon) very well. He stressed that his physical exam revealed both true shoulder problems and independently, true neck problems. Dr. Lieber explains that Petitioner's complains are disproportionate or 'inorganic'.

The Arbitrator finds Dr. Lieber's opinion more persuasive because it is based on objective tests. Furthermore, the length of time between accident and treatment with Dr. Freedberg as well as Dr. Schwartz's MMI finding adversely impact Petitioner's case. The Petitioner apparently failed to notify counsels that she had started employment with the Triedstone Baptist Church in 2013. This evidence was elicited during cross-examination and although the Arbitrator does not find this fatal to Petitioner's cause, it is a factor in consideration. In assessing the findings of Dr. Freedberg the Arbitrator notes that his opinions are extremely firm and without any reservations, whatsoever.

However, what is lacking, is a reasonable viable explanation of the objective MRI and EMG findings that do not affirmatively support his diagnosis.

Therefore, the Arbitrator finds that Petitioner's current condition is not causally related to her 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?

Most of the Petitioner's bills were paid by Respondent. At trial, Petitioner submitted additional outstanding bills. The bills were disputed based on liability. Based on the Arbitrator's above finding regarding causal connection, the claimed bills are denied after Dr. Lieber's January 12, 2015 Independent Medical Examination.

K. What temporary benefits are in dispute?

The parties agree that Petitioner is owed TTD, but disagree on the range of dates for which TTD is due. Petitioner contends that Petitioner is owed TTD from July 2, 2012 to the present representing 268- 4/7 weeks. Respondent contents that Petitioner is owed TTD from July 2, 2012 to January 18, 2015, the date at which Dr. Schwartz placed Petitioner at MMI. Respondent also correctly notes that the Petitioner started working at Triedstone Baptist Church in early 2013 and started collecting her Social Security Disability award on December 19, 2014. Petitioner worked at Triedstone Baptist Church since 2013 working 20-25 hours per week earning $12.00 per hour. Petitioner also acknowledged that working additional hours would limit her ability to get social security disability.

Initially, the Arbitrator notes that "A claimant's earning of occasional wages does not necessarily preclude a finding of temporary total disability." *Mech. Devices v. Indus. Comm'n*, 344 Ill.App.3d 752, 760, 800 N.E.2d 819, 826 (4th Dist. 2003) (claimant's part-time work averaged 3 hours per day, was not sufficient to cut off TTD benefits). However, the Arbitrator disagrees with Petitioner's contention that her wages were not continuous and substantial. Per her own testimony, the work has been steady and continuous since 2013. It is also noted that Petitioner did not front her employment until cross examination.

Regardless, the Arbitrator does find the Petitioner reached MMI and that TTD benefits terminate on 1/18/15 based on the IME findings of Dr. Lieber. The Arbitrator

also concludes that per Petitioner's own testimony her wages were not occasional. The parties stipulated that Respondent paid 134-2/7 weeks of TTD or $33,523.29 from July 2, 2012 to January 18, 2015. Respondent shall be given a credit for TTD overpayment when it should have paid only maintenance of $53.00 per week from the time in 2013 when she started working at Triedstone Baptist Church earning $12.00/hour for 20-25 hours per week until January 12, 2015. The Petitioner was paid $253.00 per week in TTD when she was entitled to maintenance of $53.00 creating an overpayment of $200.00 per week.

The Arbitrator finds that Respondent is entitled to a credit for the overpayment of $200/week from the start of Petitioner's employment in January, 2013 to 1/16/15. (No exact date of employment was presented at trial)

O. Prospective Medical

Based on the above findings that Petitioner has reached MMI, the Arbitrator denies Prospective medical in the form of the arthroscopic procedure recommended Dr. Freedberg.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SALAVATORE MESSINA,

Petitioner,

vs. NO: 15 WC 09502

NATIONAL TIRE & BATTERY,

Respondent.

19IWCC0410

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical including prospective care, temporary total disability benefits and permanent disability benefits and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with the below commentary.

Surgery has been recommended, but given Petitioner's BMI, such surgery is not feasible. As Dr. Wingate testified "It's not that surgery doesn't make sense. It – it's that I do not have a hospital or an operating room facility where I can – can get in there, and I can provide that surgical care for the patient. PX15, p. 24. Dr. Wehner, Respondent's expert physician testified "that in somebody of this degree of obesity that the primary recommendations should be weight loss and also some type of regular exercise program such as walking to promote future back health." RX2, p. 28. Petitioner testified he attempted to lose weight with a self-directed program but was unsuccessful. T. 53. It would appear a referral to a weight-loss specialist who would develop a comprehensive weight-loss program would be in order to allow Petitioner to undergo the surgical procedure and thereby increase his functionality.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2017 is hereby affirmed and adopted.

19IWCC0410

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 2 - 2019
LEC/mav
O:05/21/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MESSINA, SALVATORE
Employee/Petitioner

Case# **15WC009502**

15WC032461
15WC029808
16WC009942

NATIONAL TIRE & BATTERY
Employer/Respondent

19IWCC0410

On 8/25/2017, 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:

1927 HUGHES SOCOL PIERS RESNICK
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
TIMOTHY W ALBERTS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SALVATORE MESSINA
Employee/Petitioner

v.

NATIONAL TIRE & BATTERY
Employer/Respondent

Case # **15** WC **9502**

Consolidated cases: **15 WC 32461**
15 WC 29808
16 WC 9942

19IWCC0410

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **4/19/17**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

19IWCC0410

FINDINGS

On **3/7/15,** 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 $**66,202.76**; the average weekly wage was $**1,273.13**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **2** dependent children.

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

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

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

1. The Arbitrator finds that all treatment to date has been reasonable and necessary. Respondent shall pay the following outstanding charges, per the Fee Schedule:

ATI Physical Therapy	$3,715.36
Beloit Health System	$528.45
Illinois Orthopedic Network	$727.33
Metro Anesthesia Consultants	$2,052.78
Dr. Robert Wilson	$1,920.00

2. Permanent Total Disability: Respondent shall pay Petitioner permanent and total disability benefits of $848.75 per week for life, commencing 4/20/17, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund*, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

8/22/17
Date

AUG 25 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

19IWCC0410

SALVATORE MESSINA
Petitioner,

v.

Case No: **15 WC 9502**

consolidated with: 15 WC 32461
15 WC 29808
16 WC 9942

NATIONAL TIRE & BATTERY
Respondent.

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Four Applications for Adjustment of Claim were filed in this matter which proceeded to hearing on April 19, 2017 in Geneva, Illinois.

Separate decisions will be issued for each case. The case at bar concerns 15 WC 9502.

FINDINGS OF FACT

Petitioner testified he worked as a store manager for National Tire and Battery ("Respondent"). His duties included managing personnel, customer service, telephone service, technical service, inventory, vehicle repairs, and store accounting. Petitioner testified that Respondent sold a wide variety of automobile vehicle repairs which involved moving tires up to the front service counter on a regular basis. Petitioner also ordered parts, dealt with parts that were returned, conducted inventory and store counts and opened and closed the store.

15 WC 32461

The parties stipulated that Petitioner sustained an accidental injury arising out of and in the course of his employment on July 22, 2013. (AX1)

Petitioner testified that while dealing with a customer issue, his right foot became stuck on an orthopedic mat located behind the service desk of National Tire & Battery. (TX 18). As he turned, his right knee popped and he began to fall. (Id. pgs. 18-19). He caught himself before hitting the ground. (Id. pg. 19). At the time, Petitioner weighed around 330 pounds. (Id.) He testified his current weigh was approximately 368 pounds. (Id.).

After the accident, Petitioner sought treatment with Dr. Robert Wilson, his general practitioner who recommended a conservative treatment plan consisting of medication management and physical therapy. (PX1, pg. 02). Petitioner testified that he took some personal time off work following the accident but continued working his regular duties as the manager of National Tire & Battery thereafter. (TX. pg. 21). Petitioner testified his right knee hurt following the accident and that he had a difficult time climbing stairs. The records of Dr. Robert F. Wilson, Petitioner's family doctor, indicate that Petitioner presented on July 22, 2013, December 27, 2013 and June 4, 2014 with complaints of right knee pain for which the doctor prescribed pain medications. (PX1, pg., 2).

15 WC 9502

The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on March 7, 2015. (AX2). Petitioner testified that as he walked towards the front service desk at National Tire & Battery, he tripped on the same orthopedic floor mat involved in the above-described accident. Petitioner testified that as he was falling, it felt like someone had tied up his feet. He fell forward onto his right knee which landed on the orthopedic mat while his head hit the tile floor and the right side of his body hit a wall. Petitioner testified he laid on the ground for a few minutes. Petitioner testified his District Manager Matt Gearhardt would not allow him to leave the store to seek immediate medical treatment due to inventory duties that needed to be completed.

The next day, Petitioner presented to the Beloit Memorial Hospital ER with a history of tripping on a mat at work falling onto his right side and hitting his chin upward on a desk. Complaints of pain to his neck, upper and lower back as well as bilateral knee pain were noted. (PX8, pg. 84). Petitioner further complained of pain that radiated down his lumbar spine into his right leg. (Id. at pg. 08). A CT of the brain and cervical spine were performed, as well as a CT's of Petitioner's thoracic and lumbar spine. (PX3, pg. 05). Pain medications were administered to Petitioner upon discharge.

Petitioner presented to Beloit Health System Occupational Health Center on March 10, 2015. (PX 3, pg. 2). Advance Practice Registered Nurse ("APRN"), Brian Mulder noted Petitioner's complaints of neck, bilateral knee and low back pain since March 7, 2015 when he "got his left foot caught on a mat behind the cash register" causing him to fall, hitting his head on a tile floor with his right arm extended to catch his fall. (Id.). Petitioner complained of numbness and tingling in his left hand, numbness and tingling in his right leg which extended to his right heel and weakness and burning in his right leg. Petitioner also reported difficulty sleeping due to neck, bilateral knee and low back pain. Petitioner reported taking one Norco, twice a day for his neck, for pain. He further reported bilateral knee swelling with near "give away" sensation in his right knee at times. Petitioner reported a history of injuring his right knee one year prior but that his right knee pain had resolved prior to this injury. (Id.). APRN Mulder instituted work restrictions consisting of: no bending or twisting, no lifting more than five pounds, sitting or standing for pain relief as needed, no over shoulder activity and no more than eight hours a day, 40 hours a week of work. (Id. pg. 01). Pain medications were prescribed and Petitioner was to follow up in two week's time. (Id.).

On March 17, 2015 APRN Mulder noted Petitioner's complaints of bilateral knee as well as neck and low back pain. (Id. pg. 9). Petitioner further reported numbness, tingling and weakness in his right leg at times and sleeplessness due to knee, neck and back pain. He reported taking Vicoprofen four times a day and one Cyclopbenzaprine, three times a day for his pain. He reported these medications were prescribed by his family doctor. He reportedly was following work restrictions but experienced an increase in knee, neck and back pain when he performed work duties outside those restrictions. (Id.). Petitioner's work restrictions were continued and he was to follow up in two weeks. (Id.).
On April 8, 2015, an MRI of Petitioner's right knee revealed patellar tendinopathy and chondromalacia. (PX4, pgs. 01-02).

On April 22, 2015, an MRI of Petitioner's lumbar spine showed moderate central spinal stenosis at L2-L3, moderate to severe bilateral foraminal stenosis at L3-L4, mild central stenosis and moderate to severe foraminal stenosis at L4-L5 and moderate to severe foraminal stenosis at L5-S1. (Id., pgs. 03-04).

An MRI of Petitioner's cervical spine, on June 5, 2015, revealed mild disc bulging diffusely at C3-C4 and C5-C6 with mild marginal bony spurring along the vertebral endplates and mild narrowing along the neural foramen bilaterally. (Id., pgs. 05-06).

A left knee MRI performed on June 5, 2015, showed edema along the anterior aspect of the left knee with a more conspicuous fluid intense collection noted as possibly posttraumatic. (Id., pgs. 07-08).

On June 10, 2015 Petitioner presented for initial consult with Dr. Fred A. Sweet, an orthopedic surgeon at Rockford Spine Center at the request of APRN Brian Mulder. (PX5, pg. 12). Petitioner reported a history of a work-related slip and fall accident on March 5, 2015 followed by "some numbness in the left arm and pain in the right buttock area with posterolateral thigh". He was noted to have pain in his left knee. (Id.). The doctor noted Petitioner "has had x-rays and MRI of the lumbar and cervical spine done on open magnets that are of very poor quality." (Id.). The doctor recommended MRI on closed magnet of the lumbar and right hip to determine if Petitioner has an acute disc herniation causing his right lower extremity pain versus injury to the right hip.

On June 12, 2015, Petitioner followed up with APRN Mulder with complaints of neck, upper back and low back pain that radiated into both thighs, primarily in the right leg as well as pain in the right buttock and right posterolateral thigh and left arm numbness. (Id., pg. 10, 12, 34). Petitioner reported improvement in his bilateral knee pain but reported continued swelling. Petitioner reported being "fairly miserable with the pain" which was worse with standing, walking and any kind of activity. (Id.). He reported taking Vicoprofen 4 times a day and Flexeril twice a day for pain.

An MRI of Petitioner's right hip on June 24, 2015, was significant for mile tendinosis and fraying at the gluteus medius attachment to the greater trochanter with mild adjacent soft tissue edema. (PX6, pg. 01).

A June 24, 2015, MRI of Petitioner's lumbar spine noted a small central and slightly paracentral inferior disc extrusion at L2-L3 interpreted as not appearing to cause nerve root displacement,
a small left paracentral disc extrusion at L3-L4 causing mild displacement of the left L4 nerve root, a small to moderate central and left paracentral disc extrusion at L5-S1 displacing the left S1 nerve root extending into the left lateral recess and minimal lumbar curvature convex on the left. (Id., pg. 6).

On June 29, 2015, Dr. Sweet noted he reviewed MRI studies of Petitioner' right hip and low back that were significantly better imaging studies than those he reviewed on initial consult. (Id. pg. 11). The doctor recalled that Petitioner initially presented with right buttock area and posterolateral thigh pain, noting upon review of the recent lumbar MRI, "he has predominately left-sided pathology that could give him some of the numbness that he was describing in the left leg but really does not account for his right buttock and hip pain." (Id.). The doctor further noted "MRI of the right hip does show some tendinosis and fraying of the gluteus medius attachment near the greater trochanter as well as some soft tissue edema; therefore, I suspect that most of his symptoms are most likely coming from soft tissue and tendinosis injury to the right hip". (Id.). Dr. Sweet recommended conservative treatment and indicated that given his findings and Petitioner's body mass index, surgical intervention was not indicated. (Id.). The doctor indicated follow-up appointments could be obtained on an as needed basis. (Id.).

On June 30, 2015, Petitioner presented to APRN Mulder with neck, low back, upper back and bilateral knee pain. (Id. pg. 40). He reported continued numbness, tingling and weakness in both legs. His bilateral knee complaints were improving although he did report popping at times. (Id.). Petitioner continued to take Vicoprofen 4 times daily and Flexeril 1 time per day. (Id.). He was working within his restrictions but reported increased pain when he engaged in increased physical duties at work.

On July 14, 2015, Petitioner presented to APRN Mulder with complaints of persistent numbness and tingling in both legs when sitting for long periods of time that increased initially when standing. (Id. pg. 46). He further complained of shooting pain radiating down his legs with associated weakness. His bilateral knee pain was improving although he did report right knee swelling. Petitioner also reported shooting pain in his left arm two days prior, left arm numbness at times and increased neck pain. (Id.). Petitioner reported working within his restrictions with increased pain when he exceeded such. APRN Mulder continued Petitioner's work instructions and ordered physical therapy. (Id.).

Petitioner participated in physical therapy from July 21, 2015 through July 31, 2015. (PX3, pgs. 50-60).

On July 28, 2015 Petitioner presented to APRN Mulder with complaints of increased back pain that he related to the physical therapy he engaged in the day before. (Id. pg. 60). Petitioner further reported intermittent numbness and tingling in his left leg, bilateral leg weakness, and improving neck and bilateral knee pain. (Id.). APRN Mulder noted he would not need further care with respect to his bilateral knees and neck due to his continued improvement. Petitioner was instructed to return to work with restrictions related to his low back, follow-up with a neurosurgeon and return in two weeks

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The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 15, 2015. (AX3). Petitioner testified while working at the front service counter he heard some swearing. He walked towards the noise where he found an irate customer in bay area one. Petitioner asked the customer if he could help him but the belligerent customer continued his tirade. Petitioner asked the customer to curtail his behavior. The customer then clenched his fist and started swinging at Petitioner who swung his neck backward and physically moved his body backward at the same time. As Petitioner turned to call the police, he tripped over the leg of a vehicle lift rack and caught himself on the service desk. He then called 911. Petitioner testified he would have hit the ground had he not extended his hands outward to support himself.

Petitioner testified that following the incident, he experienced pain in his whole body: neck, shoulders, arm, back, legs and knees. He left work early that day and went home.

Petitioner did not seek medical attention until three days after the occurrence. (PX3, pgs. 65-68). He testified that he does not like to be a problem person and tried to push through and do the best he could.

On August 18, 2015, APRN Brian Mulder noted Petitioner presented with a history of a work-related altercation three days before when a customer appeared as if he were going to hit the Petitioner, at which time, Petitioner "jarred his low back pain and neck" to avoid being hit. (PX3, pg. 66). APRN Mulder noted Petitioner's complaints of intermittent numbness and tingling in his legs and feet, increased left leg pain radiating into his foot and increased left-sided neck pain radiating to his left hand along with intermittent numbness in his left pinky finger. Petitioner reported taking Vicoprofen four times and one Flexeril per day. APRN Mulder noted Petitioner was to obtain a cervical and lumbar MRI and continued his work restrictions. (Id. at 68).

On September 1, 2015, APRN Mulder noted Petitioner's complaints of neck pain radiating into his left arm with left arm numbness, tingling and weakness. He further complained of numbness, tingling and weakness in his left leg. (PX3, pg. 70) Petitioner was instructed to engage in desk work only with the ability to sit or stand as needed.

On September 4, 2015, Petitioner presented to Dr. Jerome Kolavo on referral from Dr. Wilson. (PX7, pgs. 01-04). Petitioner complained of constant low back pain "that at times travels into the lateral thigh and posterior calf down to the heel." The doctor also noted a "variety of complaints referable to his neck, back and left arm." Petitioner complained of pain in his left arm with numbness intermittently in an ulnar distribution of the forearm and fifth digit of the left hand as well as localized neck and left trapezius pain. On review of the June 24, 2015 lumbar MRI, the doctor noted a moderate left-sided L5-S1 disc herniation, a small left central bulging at L4-L5 and small central disc herniation at L2-L3, L3-L4 and to a lesser degree at L1-L2 which he noted as likely degenerative and chronic in nature. (Id.). Dr. Kolavo diagnosed intervertebral lumbar disc disorder with myelopathy, degeneration of lumbar or lumbosacral intervertebral disc, radiculitis of the left cervical region, and morbid obesity. Petitioner was instructed to perform light work only. (Id.).

The doctor noted Petitioner's report that new lumbar and cervical MRI's were ordered by another physician which Dr. Kolavo thought appropriate. The doctor further noted, "My initial impression is that his pain and disability is disproportionate to radiographic and objective physical findings." (Id., pg. 4)

On September 25, 2015, Dr. Wilson noted Petitioner's complaints of right knee pain. (Id., pg. 05).

On October 13, 2015, a cervical MRI indicated minimal disc bulging with a possible small left lateral disc protrusion at C5-6 on the left. (PX6, pg. 04-08)

On October 13, 2015, a lumbar MRI indicated multiple levels of disc desiccation, disc bulging, disc protrusion and extrusion, causing multiple levels of neural foraminal and spinal canal narrowing:

- At L1-2, a question of a small central/right paracentral disc protrusion was noted.
- At L2-3, disc desiccation with a disc osteophyte complex formation and possible small protrusion to the left was indicated.
- At L3-4, disc desiccation with a central disc protrusion causing indentation in the thecal sac was noted.
- At L5-S1, disc desiccation with prominent disc protrusion and extrusion centrally with associated indentation on the thecal sac was indicated. (PX6, pg. 06).

On October 13, 2015, APRN Mulder referred Petitioner to orthopedic surgeon, Dr. Jeffrey Wingate of the Illinois Orthopedic Network.

Petitioner presented for initial consult with Dr. Wingate on October 21, 2015. (PX8, pgs. 51, 65). At that visit, Mr. Messina complained of severe low back pain with numbness and weakness in the left leg. He complained, secondarily, of severe neck pain radiating into his left upper extremity, left shooting pains across the shoulder into the back of the elbow and down through the dorsal aspect of his radial forearm into the ulnar two digits of the left hand. (Id.). Petitioner further complained of right-sided pain in the low back and knee, and pain in his right upper thigh. Petitioner reported a throbbing pain with standing or walking. (Id.).

On exam, the doctor noted Petitioner ambulated with a notable limp, antalgia, positive SLR on the left and a partial left drop foot. (Id.).

Dr. Wingate reviewed the MRI study from June 24, 2015, noting:

> *A massively herniated foraminal and extra-foraminal herniation of disc material on the left side from his L5-S1 disc space that severely displaces and even obliterates the normal exiting space for the L5 nerve root, as well as the transitioning left S1 nerve root. The radiologist agrees the disc material extends into the left lateral recess and neural foramen with remarkable narrowing. Above it at L4-L5, he has significant triangulations around the thecal sac, with left greater than right neural foraminal narrowing. I disagree with the radiologist's interpretation that this is 'no significant mass effect or canal narrowing appearance'.*
>
> *Above that at L3-L4, there is a left paracentral disk extrusion with inferior migration of the fragment displacing the L4 nerve root on the left side. [T]he patient has an element of congenital stenosis with shortening of the pedicles that creates some level of pre-existent narrowing from the exiting nerve roots within all of the neural foramina of the lumbar spine. (Id.).*

The doctor also reviewed the October 13, 2015 cervical MRI scan noting disk dessication along the left central and paracentral herniation of disk material with narrowing of the central canal and left lateral recess and significant narrowing around the exiting C6 nerve root. No evidence of cervical myelopathy was noted

although the doctor did note a reversal of normal lordotic curvature. The doctor indicated Petitioner is straight or kyphotic through the cervical spine, significant for increasing the effect against the C6 nerve root. (Id.).

Dr. Wingate noted both MRI's are low/resolution open scans, and given Petitioner's 380 lb. body weight, higher resolution scans would better elucidate the neural pathology. (Id.).

The doctor diagnosed Petitioner with left C6 radiculopathy, severe left L5-S1 radiculopathy, left extruded foraminal and extra-foraminal herniation at L5-S1 and a central herniated nucleus pulposus with radiculopathy at L3-4 and L4-5 on the left side. (Id. pgs. 66-67).

Dr. Wingate noted a treatment plan as follows: that Petitioner be imaged with high resolution MRI scans of the neck and back; the placement steroid solution into left side of cervical epidural space around the free fragment disk herniation at C5-6; selectively blockading the L5-S1 nerve roots, both in terms of diagnostically evaluating the radiculopathy complaints, as well as placing steroid solution around the highly inflamed nerve roots. (Id.).

The doctor further indicated that long-term, after more appropriately imaging the spine, invasive spinal care may be indicated given the duration of complaints and symptoms along with the severity of foraminal narrowing in the cervical and lumbar spine. (Id.).

Dr. Wingate forbade Mr. Messina from working. (Id.).

On October 30, 2015, Petitioner consulted with Dr. Thomas Poepping, an orthopedic surgeon at G & T Orthopaedics who noted a history of a March 7, 2015 work injury where Petitioner fell onto his right side. (PX9, pg. 1). Petitioner reported developing low back, right hip, and bilateral leg pain consequently. (Id.). Petitioner reported occasional right leg pain but his primary complaint concerned his numbness and pain radiating down the left leg. Petitioner further complained of some right knee pain. (Id.). On exam, the doctor noted right hip tenderness over the trochanteric bursa and severe midline and paraspinal tenderness of the lumbar region with positive SLR bilaterally. The doctor reviewed MRI of Petitioner's right hip noting some mild trochanteric bursitis. On review of a lumbar spine MRI, the doctor noted "severe L5-S1 degenerative disc disease with bulging of the disc at this level and severe bilateral neural foraminal narrowing." (Id., pg. 2). Dr. Poepping's noted an impression of lumbar radiculopathy and right hip trochanteric bursitis. The doctor further noted, "I think the majority of his symptomology is certainly coming from his back. I think his hip is fairly minimal at this point." (Id.). The doctor referred Petitioner to pain management for a trial injection and for a neuro surgery consult. He further noted Petitioner could return to seated work with position change as needed. (Id.).

On November 5, 2015, Dr. Sajjad Murtaza administered an epidural steroid injection to Petitioner's low back. (Id. pg. 126).

Cervical and Lumbar MRI's were performed on November 9, 2015. (Id., pgs. 138-139).

Petitioner next saw Dr. Wingate on December 2, 2015 at which time the doctor noted leftward free fragments at L5-S1 and a left paracentral disk extrusion with inferior migration at L3-4. (PX8, pgs. 94-95). Dr. Wingate again noted that Petitioner not return to work. The doctor further noted that on a recent Saturday night, upon returning home after a 12- hour work day, Petitioner had the onset of a sudden feeling of warmth in his buttocks, and sustained an episode of encopresis in which he soiled his underwear. (Id.).

A CT lumbar myelogram with contrast on December 21, 2015 noted a clinical history of a herniated disk at L3-S1 and encopresis along with complaints of low back pain and pain extending into the lower extremities, left greater than right. (PX11, pgs. 01-04).

The lumbar CT was interpreted by Dr. Wingate on January 20, 2016, at which time he noted an "extruded left L5-S1 herniated nucleus pulposus completely filling/obliterating the left L5 neural foramen". (PX8, pg. 52). The doctor noted the study confirmed Petitioner had severe left L5 neural foraminal narrowing. The doctor further noted a "global level of spinal pathology" noting "severe retrolisthesis at multiple levels" and "moderate neural foraminal narrowing at L2-L3 where retrolisthesis exists" and degenerative scoliosis. (Id.). Dr. Wingate indicated "there is nothing normal anywhere in his lumbosacral spine" and that in order to "fix" or "directly address" Petitioner's severe degree of neural foraminal narrowing at L5, the severe level of retrolisthesis across the disc space and the end plate osteophyte spurring a combination of interbody and posterolateral fusion would be required. (Id.).

At the January 20, 2016 visit with Dr. Wingate, Petitioner complained of lower back, upper back, neck pain, numbness in the left arm and bilateral knee pain with numbness and tingling in the left knee (PX 8, pg. 55). He reported that laying down was extremely painful. (Id.).

At this visit Petitioner indicated he was working 55 hours a week. Dr. Wingate noted Petitioner's current duties at work where he was constantly on his feet and moving continuously, is more than Petitioner's body can physiologically support. (PX8, pgs. 52-53).

Dr. Wingate indicated he reviewed "several IMEs to date", that all of Petitioner's benefits had been terminated and that his employer was requiring him to work a 55-hour work week because he manages the facility. Petitioner reported when he first returned to this work schedule, after working two consecutive days on his feet for more than 13 hours per day, he experienced two episodes of encopresis. Petitioner further reported neck pain that has caused severe headaches and his left arm to go numb.

Dr. Wingate noted he disagreed with the IME opinion that Petitioner has been a long time opioid dependent. The doctor noted Petitioner had brought in 16 years of medical records dating back to October, 1999 and that his first prescription for opioid medication was for ankle pain in 2000 while the next prescription was not until the Petitioner's first July 2013 work accident. (Id.).

Dr. Wingate testified that the recent CT supported why Petitioner could potentially be losing control of his bowel and bladder function. (Id. pg. 23).

With respect to the doctor's actual recommendations regarding Petitioner's low back pain and left leg symptoms, the doctor did not recommend surgery, noting he did not have the "ability to provide care surgically for a patient" with a BMI of 52. (Id.).

Dr. Wingate recommended continued interventional pain management with application of steroids around the severely stenosed lumbosacral junction and cessation of all work. (Id.).

On February 18, 2016, Petitioner presented to Dr. Sajjad Murtaza with complaints of lower lumbar pain radiating "down his leg". The doctor noted significant pathology at L4-L5 with disk extrusions and nerve impingements at these levels. The doctor administered a lumbar transforaminal ESI on the left using fluoroscopic needle localization and epiroprim at L4-5 and L5-S1. (Id., pg. 125.

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The parties stipulated that on March 25, 2016, Petitioner sustained accidental injuries arising out of and in the course of his employment. (AX4). Petitioner testified he was servicing a client, gathering and writing down vehicle information onto a clipboard. As he was returning to the building from the parking lot, he slipped on ice, fell forward and hit his head on the cement pavement.

Beloit Fire Department records indicate that upon arrival, Petitioner was found lying prone in the walkway of a place of business. (PX2, pg. 16) A small head contusion was noted as well as complaints of back and neck pain. A C-collar was place on Petitioner and he was transported to Beloit Memorial Hospital whose records indicate Petitioner was then transferred to Mercy Hospital in Janesville, Wisconsin, after a determination that the 390-lb. patient was above the weight limit for the hospital's CT scanner. (PX2, pgs. 01-16)

Records from Mercy Hospital note Petitioner's complaints of headache, posterior neck pain, left sided back pain, right wrist pain, amongst other complaints. Multiple x-rays of Petitioner's bilateral knees, pelvis and right wrist were taken as well as CT of Petitioner's head, neck, mid and low back. (PX13) Petitioner reported a history of chronic neck and low back pain with occasional paresthesia in the left lower extremity. (Id. p. 3).

The hospital ER opined that Petitioner exacerbated his chronic pain during the fall. (Id.). Petitioner was nauseous and light-headed after ambulating. (Id.). He was prescribed a wheeled walker for one month. (Id.).

Three days later, Petitioner followed up with Dr. Wingate, at which time, the doctor again instructed Petitioner to stay off work. (PX8, pg. 75).

Petitioner did not return to work and has not since the March 25, 2016 work accident.

Petitioner on March 31, 2016, presented to Dr. Murtaza who noted a history of the March 25, 2016 work-related fall. (Id., pgs. 23). Petitioner complained of significant neck pain and lower back pain radiating into his bilateral lower extremities, left greater than right, along with numbness and pins-and-needles sensation. (Id.). Petitioner further complained of right knee swelling that was visible on exam. Petitioner was wearing a C-collar. Dr. Murtaza recommended a bilateral TFESI with orthopedic follow-up for his right knee. The doctor dispensed Meloxicam, Pantaprazole, Cyclobenzaprine, and Vicoprofen. Lidoderm patches were prescribed. Petitioner was restricted from working. (Id.).

On April 7, 2016, Dr. Murtaza administered an L5-S1 lumbar transforaminal ESI. (Id., pg. 25).

Dr. Murtaza's May 5, 2016 records indicate Petitioner had been administered three lumbar injections to date with 5% relief. (Id. pg. 112). Petitioner continued to complain of significant low back pain with radiation to his bilateral lower extremities, left greater than right at a 9/10. (Id.). He further complained of bilateral knee pain, worse on the right. Petitioner had yet to see an orthopedist. He also complained of significant neck pain with radiation to the left upper extremity as well as constant headaches. Petitioner reportedly was applying for disability. Dr. Murtaza noted Petitioner was not a surgical candidate due to his weight and pathology in his spine. The doctor recommended re-starting physical therapy 2-3 times per week for 4 weeks, followed by a home exercise program. The doctor noted Petitioner "may not return to work". (Id.). Gabapentin was prescribed for neuropathic pain and a refill for Vicoprofen was noted. (Id.).

On July 7, 2016, Dr. Murtaza administered a cervical epidural injection at C5-6. (Id., pg. 26).

Petitioner went to ATI physical therapy on July 11, 2016 for an initial evaluation. (PX14, pgs. 19-20). The therapist noted that Petitioner presented with signs and symptoms consistent with cervicalgia and right knee pain. (Id., pg. 19). Petitioner was notably ambulating with a quad cane and a walker. (Id., pgs. 05, 19).

Petitioner began physical therapy on July 13, 2016, and attended eight sessions, through July 29, 2016. (Id., pgs. 04-11). Petitioner was noted to have suffered paralysis on July 28, 2016. (Id., pg. 02).

Petitioner, at the July 29, 2016 visit, felt worse, coughed, lost control of his muscles and fell. (Id., pg. 02).

At Petitioner's visit with Dr. Murtaza on August 4, 2016, Petitioner stated he experiences intermittent paralysis in the right arm which last for one to three minutes. (PX8, pg. 120). Petitioner also reported a 15% pain relief with the last cervical epidural injection on July 7, 2016. (Id.).

Dr. Murtaza, at the August 4, 2016 visit, noted Petitioner's complaints of headaches, neck pain, low back pain, upper extremity radiculitis, bilateral lower extremity radiculitis and right knee pain. The doctor opined that Petitioner is not a surgical candidate nor a good candidate for therapy as the therapy has only exacerbated his symptoms. No further treatment was recommended aside from long-term pain management. (Id. pg. 120). Petitioner consulted with Dr. Edward Herba, a neurologist, on August 30, 2016. (PX8, pg. 34). Dr. Herba stated that Petitioner demonstrates a personal loss of sensation in both legs and both arms. (Id.) The doctor further stated he did not believe Petitioner had arthritic changes involving the spine. (Id.).

Petitioner presented to Dr. Murtaza on October 18, 2016 and November 8, 2016 at which time he noted no change in Petitioner's condition. (Id. pgs. 37, 39).

At Petitioner's visit with Dr. Murtaza on December 6, 2016, the doctor noted that Petitioner's wife helps him bathe and dress. (Id. pg. 02).

At Petitioner's visit with Dr. Murtaza on January 31, 2017, it was reported that Petitioner had another episode one week ago where his entire body became numb and tingly with paralysis for about one minute. (Id. pg. 05).

Petitioner saw Dr. Murtaza on February 28, 2017 and March 21, 2017 with no change, the doctor indicated Petitioner could not work. (Id. pg. 06).

At the hearing, Petitioner testified he last saw Dr. Murtaza a few weeks before the hearing.

CONCLUSIONS OF LAW

C) The Arbitrator find that Petitioner's current condition of ill-being is causally related to the work accident of March 7, 2015.

It is undisputed that Petitioner was involved in a traumatic slip and fall accident that arose out of and in the course of his employment with Respondent on March 7, 2015 when he fell forward onto his right knee while his head hit a tile floor and the right side of his body hit a wall. (AX2).

Petitioner's treatment began the following day when complaints of low back, neck, and bilateral knees as well as numbness and tingling in his left hand and right leg were noted. His ongoing treatment and complaints are well documented in the records submitted into evidence.

His treating physician, Dr. Wingate testified that he reviewed 17 years of medical records from Petitioner's primary physician and other than one self-limited episode of back pain with no subsequent references, he saw no evidence of a prior-existing back condition before March of 2015. (PX15, pg. 29).

At his deposition Dr. Wingate testified that Petitioner's underlying problems began with the March 7, 2015 work accident, opining that Petitioner's symptoms in his low back, legs, neck and left arm are causally related to that work-related accident. (PX15, pg. 29, 31).

The doctor further testified the subsequent injury of August 15, 2015, "did not do him any favors" in that "it certainly didn't lessen anything that was going on". (Id. pg. 31).

All IME doctors concede that Petitioner was injured on the date of the work accident although they conclude that Petitioner should have no continuing physical problems. All IME doctors opine that if Petitioner does have any current condition of ill-being, any such condition is simply degenerative in nature with no causal connection to any of the four work accidents. The Arbitrator finds this an untenable position given the preponderance of evidence contained in the record.

The Arbitrator notes Dr. Wehner acknowledged that Petitioner failed to achieve any relief of a lasting nature from the epidural steroid injections and transforaminal epidural injections that were performed.
In his December 21, 2015 note, Dr. Wingate noted disagreements with Dr. Wehner's opinions that Petitioner had centralized leg pain and stabilized low back pain. Dr. Wingate also noted disagreement with Dr. Wehner's opinion that disc extrusions would be considered degenerative in nature, and of a mild degree in a patient without previous history of radiating pain from the low back to the leg. (PX8 pg. 94).

The Arbitrator notes Dr. Wehner's opinion that three lumbar spine MRIs dated April 22, 2015, June 24, 2015 and October 13, 2015 demonstrated only degenerative changes or "chronic findings." (RX2., deposition ex. 2, p.5). Dr. Wehner stated the first MRI was "somewhat compromised" and "would not be considered a diagnostic study and therefore the report is really invalid". With respect to the subsequent lumbar MRI's, Dr. Wehner noted "bulging and extrusions" which she believed were mild and of a degenerative nature. (Id.).

Dr. Wingate acknowledged the suboptimal imaging on the June 24, 2015 lumbar MRI, nonetheless, the doctor testified the study was "good enough to show" that Petitioner has "severely compressed" set of nerves along the left side of his spine, a "central and left-sided disk herniation at – L5-s1", a herniation at L4-L5 with "significant stenotic changes" along with degenerative change at L2-L3. (PX15, pg. 9)

With respect to the lumbar MRI taken on October 13, 2015, Dr. Wingate testified it was a better imaging study with findings that were "a little more extensive". (Id.). With better imaging, Dr. Wingate noted extruded disk material "not only centrally into the spinal canal at L5 S1, but also out into the neural foreman along the course of the exiting L5 nerve root". (Id.). The doctor testified this MRI confirmed Petitioner suffered from severe retrolisthesis and stenosis around the left L5 and S1 nerve roots. The study also confirmed the presence of a fragment of disk material at the L4-L5 segment. (Id., pg. 23) The doctor further noted the study supported why and how Petitioner could be losing control of his bowel and bladder. (Id.).
Dr. Wingate opined in his December 21, 2015 note that the "leftward disk herniation with free fragment at L5-S1, and the left paracentral disk extrusion with inferior migration at L3-L4" with associated lumbar radiculopathy and severe neuroforaminal stenosis "are not chronic degenerative findings" but "indeed represent acute injuries as relatable to the work-described injuries". (Id., pg. 95)

Dr. Wingate testified that Petitioner presented on December 2, 2015 with a recent history of encopresis which is an involuntary bowel movement. (PX15, pg. 20-21) The doctor explained that Petitioner had "no sense of rectal fullness or appreciation that he might need to go to the bathroom." (Id. pg. 21) Dr. Wingate testified such an episode can be an ominous sign for a person with severely pinched nerves in the lower spine. (Id.).
Dr. Wingate testified that "instead of waiting around to try to get a high-resolution MRI scan, I felt the –the need to – the urgency to get a CT myelogram at this point" which would give a picture of the nerves, the bone, bone spurs, arthritic changes as well as some read on inflammation. (Id.).

The CT lumbar myelogram with contrast was performed on December 21, 2015. (PX11, pgs. 01-04). The doctor testified the test most importantly, confirmed his October 21, 2015 note regarding compromised space for the left L5 nerve root. The study also confirmed a "severe degree of retrolisthesis, 3 millimeters of retrolisthesis at L5 and S1" as well as the fragment of disk material at L4-L5. (PX15, pg. 22). With respect to Petitioner's reported loss of bowel function, the doctor testified that the myelogram supported why and how he could be losing bowel and bladder function. (Id.).
With respect to Petitioner's cervical spine, Dr. Wingate disagreed with Dr. Wehner's opinion that Petitioner's cervical pathology is consistent with minimal bulging at C3-C4, C4-C5 and C5-C6. Dr. Wingate's October 21,

2015 report notes the October 13, 2015 cervical MRI scan was significant for "disk dessication along with a left central and paracentral herniation of disk material" as well as narrowing of the central canal space and significant narrowing around the exiting C6 nerve root. (Id., pg. 97). With respect to these findings, Dr. Wingate testified that Petitioner has "a small but distinct extruded disk fragment at C-5 – C6 that's in contact with the left C6 nerve root" which "can be a very bad problem particularly when combined with the fact that that MRI scan clearly shows that he does not have normal lordosis". (PX15, pg. 11) Dr. Wingate further testified that reversal of normal lordotic curvature means that Petitioner's neck is "extremely flattened" or kyphotic through the cervical spine which stretches and elongates the exit pathway for the nerves particularly at the C5-C6 level increasing vulnerability for a small disk herniation. (Id., pg. 12)

Based on the totality of evidence contained in the record, including the opinions of Dr. Wingate and the treating medical records, the Arbitrator finds the preponderance of evidence contained in the record supports a finding that Petitioner's injuries to his low back, neck, bilateral knees, left arm and right hip are causally related to the March 7, 2015 work-related accident. The Arbitrator further finds that Petitioner aggravated and accelerated a pre-existing condition in his right knee caused by the accidental injury he sustained on July 22, 2013. (See 15 WC 32462 addendum and decision).

The Arbitrator finds that respondent has not paid all appropriate charges for all reasonable and necessary medical services and is liable for five medical bills that are currently in dispute.

The Arbitrator finds that all treatment to date has been reasonable and necessary. Respondent shall pay the following outstanding charges, per the Fee Schedule:

ATI Physical Therapy	$3,715.36
Beloit Health System	$528.45
Illinois Orthopedic Network	$727.33
Metro Anesthesia Consultants	$2,052.78
Dr. Robert Wilson	$1,920.00

What is the nature and extent of Petitioner's injuries?

Dr. Wingate testified that although Petitioner would benefit from a lumbar decompression and fusion, no hospital or surgery center in Illinois would allow such a procedure because of the risks involved in administering anesthesia to anyone with a BMI over 40.. (PX15, pg. 24, 25).

Dr. Wingate further testified that if a fusion was performed on Petitioner, "we are not so much as fixing the problem as we are changing the problem". (Id., pg. 26). The doctor explained:

> *Unfortunately, that is a surgical procedure that carries a huge morbidity.*
> *There is probably at least an 80 or 85% chance that Mr. Messina would have some type of medical complication during that surgical procedure,*
> *or more importantly, in the first few days after that surgical procedure.*
> *And there is a huge problem that within two to four years after that operation that Mr. Messina would then have a surgically treatable lesion immediately above it at L3-4 and L2-3.* (Id., pg. 26).

Dr. Wingate testified Petitioner is medically unable to obtain gainful employment and that he should be considered completely and totally disabled. (Id. pg. 30). He further testified that "the most humane option" is to keep the inflammation down around the involved nerve roots and to lessen the stresses that go across that segment of the spine, even if it means taking the "unreconstructable patient completely out of work, completely

removing him from the day to day stresses" and essentially putting him in a position where he can rest and "get rid of the inflammation" in these segments of the spine. (Id., pgs. 26-27).

Dr. Wingate testified that Petitioner's condition with respect to his left L5 and S1 nerve roots puts Petitioner at an increased risk for falls:

> *Indeed, this has already started to come true. He has now had several falls. I believe most recently he slipped on ice and was unable to recover his upright posture. There's no way that a patient of his stature with improperly functioning L5 and S1 nerve roots can possibly stay upright and keep themselves safe. (Id. pg. 29).*

When asked by Respondent if he considered referring Petitioner to physical therapy, work conditioning or vocational rehabilitation prior to concluding that Petitioner was medically unable to work, the doctor responded:

> *Physical therapy in this clinical scenario, in -- in my professional opinion, is -- is not warranted. With the degree of nerve root compression, with documented EMG and nerve conduction study findings of radiculopathy involving those nerve roots, and with severe stenosis around the nerve roots and, now, clinical episodes of encopresis, in my opinion it would be not warranted to pursue physical therapy per se.*
>
> *Pain management with steroid injections that could help to decrease the inflammation in those tissues as invasive forms of helping to manage the situation could be beneficial. And if there is a positive response to those injections then absolutely... would be warranted but to continue beating up severely constrained compressed nerve roots with further activity and further motion is not beneficial in this situation. (Id.).*

After questioning by Respondent's attorney, Dr. Wingate testified that he thought it was *possible* that Petitioner could perform sedentary work, but the following issues will arise:

> *[T]he sedentary position would have to accommodate to the fact that with his severe neurologic impingement and compression of those nerve roots he cannot maintain a seated position for probably more than 15 or 20 minutes he cannot maintain a standing position for more than 15 or 20 minutes he certainly cannot go out and walk any distances. (Id. pg. 37-38).*

Dr. Wingate agreed with Respondent that if a hypothetical position that was sedentary in nature that could accommodate the switching from sitting to standing, then it would be a "win-win" for Petitioner. (Id. pg. 39).

At Petitioner's request, Thomas Grzesik, a certified rehabilitation counselor and licensed clinical professional counselor, met with Petitioner on November 30, 2016, reviewed treating medical records and conducted a battery of vocational tests. (PX17)

Mr. Grzesik opined, based on the opinions of Dr. Wingate and Dr. Murtaza, that Petitioner is unable to perform the responsibilities and duties of his former position for Respondent as a Store Manager. (PX15, dep. Ex. 2, pg. 26)

In determining that Petitioner was not an appropriate candidate for further vocational rehabilitation services, Mr. Grzesik considered Petitioner's post-work injury vocational profile (44 years old, 12 grade education, lack

of transferable skills, work restrictions and learning and academic ability as tested) and applied the factors established in *National Tea Company v. IIC*, 73 Ill.Dec. 575 (1983).

He further testified that Petitioner is not qualified to do any at home, telecommuting-type of employment. There was nothing in the interview with Petitioner or in the records that would indicate Petitioner has a background for a home-based job. (PX17, pg. 27).

It was Mr. Grzesik's opinion that Petitioner is permanently and totally disabled under the guidelines set forth by the Illinois Workers' Compensation Commission. (PX17, dep. Ex. 2, pg. 26).

Based on the record as a whole, with particular reliance on the opinions of Dr. Wingate coupled and Mr. Grzesik, the Arbitrator finds Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act.

Respondent shall pay Petitioner $848.75/week for life, commencing April 19, 2017, as provided in Section 8(f) 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

SALAVATORE MESSINA,

Petitioner,

vs. NO: 16 WC 009942

NATIONAL TIRE & BATTERY,

Respondent.

19IWCC0411

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, TTD, and PPD 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 25, 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.

19IWCC0411

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 2 - 2019
LEC/mav
O: 5/21/19
43

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Thomas J. Tyrrell
Thomas J. Tyrrell

Maria Elena Portela
Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MESSINA, SALVATORE
Employee/Petitioner

Case# **16WC009942**

15WC009502
15WC032461
15WC029808

NATIONAL TIRE & BATTERY
Employer/Respondent

19IWCC0411

On 8/25/2017, 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:

1927 HUGHES SOCOL PIERS RESNICK
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
TIMOTHY W ALBERTS
200 N LASALLE ST SUITE 2700
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

SALVATORE MESSINA
Employee/Petitioner

v.

NATIONAL TIRE & BATTERY
Employer/Respondent

Case # **16** WC **9942**

Consolidated cases: **15 WC 9502**
15 WC 32461
15 WC 29808

19IWCC0411

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **4/19/17**. 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 **3/25/16,** 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 $**66,202.76**; the average weekly wage was $**1,273.13**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent children.

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

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

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

1. The Arbitrator finds that all treatment to date has been reasonable and necessary. Respondent shall pay the following outstanding charges, per the Fee Schedule:

ATI Physical Therapy	$3,715.36
Beloit Health System	$528.45
Illinois Orthopedic Network	$727.33
Metro Anesthesia Consultants	$2,052.78
Dr. Robert Wilson	$1,920.00

2. Respondent is ordered to pay Petitioner TTD benefits commencing *7/6/16* through *4/19/17*, as provided in Section 8(a) of the Act.

3. Permanent Total Disability: Respondent shall pay Petitioner permanent and total disability benefits of $848.75 per week for life, commencing 4/20/17, as provided in Section 8(f) of the Act.

4. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund*, as provided in Section 8(g) of the Act.

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

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

Jason C. Hyatt

Signature of Arbitrator

8/22/17

Date

ICArbDec p. 2

AUG 25 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SALVATORE MESSINA
Petitioner,

v.

Case No: **16 WC 9942**

consolidated with: 15 WC 9502
15 WC 32461
15 WC 29808

NATIONAL TIRE & BATTERY
Respondent.

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Four Applications for Adjustment of Claim were filed in this matter which proceeded to hearing on April 19, 2017 in Geneva, Illinois.

Separate decisions will be issued for each case. The case at bar concerns 16 WC 9942.

FINDINGS OF FACT

Petitioner testified he worked as a store manager for National Tire and Battery ("Respondent"). His duties included managing personnel, customer service, telephone service, technical service, inventory, vehicle repairs, and store accounting. Petitioner testified that Respondent sold a wide variety of automobile vehicle repairs which involved moving tires up to the front service counter on a regular basis. Petitioner also ordered parts, dealt with parts that were returned, conducted inventory and store counts and opened and closed the store.

Petitioner's Prior Accidents
15 WC 32461

The parties stipulated that Petitioner sustained an accidental injury arising out of and in the course of his employment on July 22, 2013. (AX1)

Petitioner testified that while dealing with a customer issue, his right foot became stuck on an orthopedic mat located behind the service desk of National Tire & Battery. (TX 18). As he turned, his right knee popped and he began to fall. (Id. pgs. 18-19). He caught himself before hitting the ground. (Id. pg. 19). At the time, Petitioner weighed around 330 pounds. (Id.) He testified his current weigh was approximately 368 pounds. (Id.).

After the accident, Petitioner sought treatment with Dr. Robert Wilson, his general practitioner who recommended a conservative treatment plan consisting of medication management and physical therapy. (PX1, pg. 02). Petitioner testified that he took some personal time off work following the accident but continued working his regular duties as the manager of National Tire & Battery thereafter. (TX. pg. 21). Petitioner testified his right knee hurt following the accident and that he had a difficult time climbing stairs.

The records of Dr. Robert F. Wilson, Petitioner's family doctor, indicate that Petitioner presented on July 22, 2013, December 27, 2013 and June 4, 2014 with complaints of right knee pain for which the doctor prescribed pain medications.
(PX1, pg., 2).

15 WC 9502

The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on March 7, 2015. (AX2). Petitioner testified that as he walked towards the front service desk at National Tire & Battery, he tripped on the same orthopedic floor mat involved in the above-described accident. Petitioner testified that as he was falling, it felt like someone had tied up his feet. He fell forward onto his right knee which landed on the orthopedic mat while his head hit the tile floor and the right side of his body hit a wall. Petitioner testified he laid on the ground for a few minutes. Petitioner testified his District Manager Matt Gearhardt would not allow him to leave the store to seek immediate medical treatment due to inventory duties that needed to be completed.

The next day, Petitioner presented to the Beloit Memorial Hospital ER with a history of tripping on a mat at work falling onto his right side and hitting his chin upward on a desk. Complaints of pain to his neck, upper and lower back as well as bilateral knee pain were noted. (PX8, pg. 84). Petitioner further complained of pain that radiated down his lumbar spine into his right leg. (Id. at pg. 08). A CT of the brain and cervical spine were performed, as well as a CT's of Petitioner's thoracic and lumbar spine. (PX3, pg. 05). Pain medications were administered to Petitioner upon discharge.

Petitioner presented to Beloit Health System Occupational Health Center on March 10, 2015. (PX 3, pg. 2). Advance Practice Registered Nurse ("APRN"), Brian Mulder noted Petitioner's complaints of neck, bilateral knee and low back pain since March 7, 2015 when he "got his left foot caught on a mat behind the cash register" causing him to fall, hitting his head on a tile floor with his right arm extended to catch his fall. (Id.). Petitioner complained of numbness and tingling in his left hand, numbness and tingling in his right leg which extended to his right heel and weakness and burning in his right leg. Petitioner also reported difficulty sleeping due to neck, bilateral knee and low back pain. Petitioner reported taking one Norco, twice a day for his neck, for pain. He further reported bilateral knee swelling with near "give away" sensation in his right knee at times. Petitioner reported a history of injuring his right knee one year prior but that his right knee pain had resolved prior to this injury. (Id.). APRN Mulder instituted work restrictions consisting of: no bending or twisting, no lifting more than five pounds, sitting or standing for pain relief as needed, no over shoulder activity and no more than eight hours a day, 40 hours a week of work. (Id. pg. 01). Pain medications were prescribed and Petitioner was to follow up in two week's time. (Id.).

On March 17, 2015 APRN Mulder noted Petitioner's complaints of bilateral knee as well as neck and low back pain. (Id. pg. 9). Petitioner further reported numbness, tingling and weakness in his right leg at times and sleeplessness due to knee, neck and back pain. He reported taking Vicoprofen four times a day and one Cyclopbenzaprine, three times a day for his pain. He reported these medications were prescribed by his family doctor. He reportedly was following work restrictions but experienced an increase in knee, neck and back pain when he performed work duties outside those restrictions. (Id.). Petitioner's work restrictions were continued and he was to follow up in two weeks. (Id.).
On April 8, 2015, an MRI of Petitioner's right knee revealed patellar tendinopathy and chondromalacia. (PX4, pgs. 01-02).

On April 22, 2015, an MRI of Petitioner's lumbar spine showed moderate central spinal stenosis at L2-L3, moderate to severe bilateral foraminal stenosis at L3-L4, mild central stenosis and moderate to severe foraminal stenosis at L4-L5 and moderate to severe foraminal stenosis at L5-S1. (Id., pgs. 03-04).

An MRI of Petitioner's cervical spine, on June 5, 2015, revealed mild disc bulging diffusely at C3-C4 and C5-C6 with mild marginal bony spurring along the vertebral endplates and mild narrowing along the neural foramen bilaterally. (Id., pgs. 05-06).

A left knee MRI performed on June 5, 2015, showed edema along the anterior aspect of the left knee with a more conspicuous fluid intense collection noted as possibly posttraumatic. (Id., pgs. 07-08).

On June 10, 2015 Petitioner presented for initial consult with Dr. Fred A. Sweet, an orthopedic surgeon at Rockford Spine Center at the request of APRN Brian Mulder. (PX5, pg. 12). Petitioner reported a history of a work-related slip and fall accident on March 5, 2015 followed by "some numbness in the left arm and pain in the right buttock area with posterolateral thigh". He was noted to have pain in his left knee. (Id.). The doctor noted Petitioner "has had x-rays and MRI of the lumbar and cervical spine done on open magnets that are of very poor quality." (Id.). The doctor recommended MRI on closed magnet of the lumbar and right hip to determine if Petitioner has an acute disc herniation causing his right lower extremity pain versus injury to the right hip.

On June 12, 2015, Petitioner followed up with APRN Mulder with complaints of neck, upper back and low back pain that radiated into both thighs, primarily in the right leg as well as pain in the right buttock and right posterolateral thigh and left arm numbness. (Id., pg. 10, 12, 34). Petitioner reported improvement in his bilateral knee pain but reported continued swelling. Petitioner reported being "fairly miserable with the pain" which was worse with standing, walking and any kind of activity. (Id.). He reported taking Vicoprofen 4 times a day and Flexeril twice a day for pain.

An MRI of Petitioner's right hip on June 24, 2015, was significant for mile tendinosis and fraying at the gluteus medius attachment to the greater trochanter with mild adjacent soft tissue edema. (PX6, pg. 01).

A June 24, 2015, MRI of Petitioner's lumbar spine noted a small central and slightly paracentral inferior disc extrusion at L2-L3 interpreted as not appearing to cause nerve root displacement,
a small left paracentral disc extrusion at L3-L4 causing mild displacement of the left L4 nerve root, a small to moderate central and left paracentral disc extrusion at L5-S1 displacing the left S1 nerve root extending into the left lateral recess and minimal lumbar curvature convex on the left. (Id., pg. 6).

On June 29, 2015, Dr. Sweet noted he reviewed MRI studies of Petitioner' right hip and low back that were significantly better imaging studies than those he reviewed on initial consult. (Id. pg. 11). The doctor recalled that Petitioner initially presented with right buttock area and posterolateral thigh pain, noting upon review of the recent lumbar MRI, "he has predominately left-sided pathology that could give him some of the numbness that he was describing in the left leg but really does not account for his right buttock and hip pain." (Id.). The doctor further noted "MRI of the right hip does show some tendinosis and fraying of the gluteus medius attachment near the greater trochanter as well as some soft tissue edema; therefore, I suspect that most of his symptoms are most likely coming from soft tissue and tendinosis injury to the right hip". (Id.). Dr. Sweet recommended conservative treatment and indicated that given his findings and Petitioner's body mass index, surgical intervention was not indicated. (Id.). The doctor indicated follow-up appointments could be obtained on an as needed basis. (Id.).

On June 30, 2015, Petitioner presented to APRN Mulder with neck, low back, upper back and bilateral knee pain. (Id. pg. 40). He reported continued numbness, tingling and weakness in both legs. His bilateral knee complaints were improving although he did report popping at times. (Id.). Petitioner continued to take Vicoprofen 4 times daily and Flexeril 1 time per day. (Id.). He was working within his restrictions but reported increased pain when he engaged in increased physical duties at work.

On July 14, 2015, Petitioner presented to APRN Mulder with complaints of persistent numbness and tingling in both legs when sitting for long periods of time that increased initially when standing. (Id. pg. 46). He

further complained of shooting pain radiating down his legs with associated weakness. His bilateral knee pain was improving although he did report right knee swelling. Petitioner also reported shooting pain in his left arm two days prior, left arm numbness at times and increased neck pain. (Id.). Petitioner reported working within his restrictions with increased pain when he exceeded such. APRN Mulder continued Petitioner's work instructions and ordered physical therapy. (Id.).

Petitioner participated in physical therapy from July 21, 2015 through July 31, 2015. (PX3, pgs. 50-60).

On July 28, 2015 Petitioner presented to APRN Mulder with complaints of increased back pain that he related to the physical therapy he engaged in the day before. (Id. pg. 60). Petitioner further reported intermittent numbness and tingling in his left leg, bilateral leg weakness, and improving neck and bilateral knee pain. (Id.). APRN Mulder noted he would not need further care with respect to his bilateral knees and neck due to his continued improvement. Petitioner was instructed to return to work with restrictions related to his low back, follow-up with a neurosurgeon and return in two weeks

15 WC 29808

The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 15, 2015. (AX3). Petitioner testified while working at the front service counter he heard some swearing. He walked towards the noise where he found an irate customer in bay area one. Petitioner asked the customer if he could help him but the belligerent customer continued his tirade. Petitioner asked the customer to curtail his behavior. The customer then clenched his fist and started swinging at Petitioner who swung his neck backward and physically moved his body backward at the same time. As Petitioner turned to call the police, he tripped over the leg of a vehicle lift rack and caught himself on the service desk. He then called 911. Petitioner testified he would have hit the ground had he not extended his hands outward to support himself.

Petitioner testified that following the incident, he experienced pain in his whole body: neck, shoulders, arm, back, legs and knees. He left work early that day and went home.

Petitioner did not seek medical attention until three days after the occurrence. (PX3, pgs. 65-68). He testified that he does not like to be a problem person and tried to push through and do the best he could.

On August 18, 2015, APRN Brian Mulder noted Petitioner presented with a history of a work-related altercation three days before when a customer appeared as if he were going to hit the Petitioner, at which time, Petitioner "jarred his low back pain and neck" to avoid being hit. (PX3, pg. 66). APRN Mulder noted Petitioner's complaints of intermittent numbness and tingling in his legs and feet, increased left leg pain radiating into his foot and increased left-sided neck pain radiating to his left hand along with intermittent numbness in his left pinky finger. Petitioner reported taking Vicoprofen four times and one Flexeril per day. APRN Mulder noted Petitioner was to obtain a cervical and lumbar MRI and continued his work restrictions. (Id. at 68).

On September 1, 2015, APRN Mulder noted Petitioner's complaints of neck pain radiating into his left arm with left arm numbness, tingling and weakness. He further complained of numbness, tingling and weakness in his left leg. (PX3, pg. 70) Petitioner was instructed to engage in desk work only with the ability to sit or stand as needed.

On September 4, 2015, Petitioner presented to Dr. Jerome Kolavo on referral from Dr. Wilson. (PX7, pgs. 01-04). Petitioner complained of constant low back pain "that at times travels into the lateral thigh and posterior calf down to the heel." The doctor also noted a "variety of complaints referable to his neck, back and left arm." Petitioner complained of pain in his left arm with numbness intermittently in an ulnar distribution of the

forearm and fifth digit of the left hand as well as localized neck and left trapezius pain. On review of the June 24, 2015 lumbar MRI, the doctor noted a moderate left-sided L5-S1 disc herniation, a small left central bulging at L4-L5 and small central disc herniation at L2-L3, L3-L4 and to a lesser degree at L1-L2 which he noted as likely degenerative and chronic in nature. (Id.). Dr. Kolavo diagnosed intervertebral lumbar disc disorder with myelopathy, degeneration of lumbar or lumbosacral intervertebral disc, radiculitis of the left cervical region, and morbid obesity. Petitioner was instructed to perform light work only. (Id.). The doctor noted Petitioner's report that new lumbar and cervical MRI's were ordered by another physician which Dr. Kolavo thought appropriate. The doctor further noted, "My initial impression is that his pain and disability is disproportionate to radiographic and objective physical findings." (Id., pg. 4)

On September 25, 2015, Dr. Wilson noted Petitioner's complaints of right knee pain. (Id., pg. 05).

On October 13, 2015, a cervical MRI indicated minimal disc bulging with a possible small left lateral disc protrusion at C5-6 on the left. (PX6, pg. 04-08)

On October 13, 2015, a lumbar MRI indicated multiple levels of disc desiccation, disc bulging, disc protrusion and extrusion, causing multiple levels of neural foraminal and spinal canal narrowing:

- At L1-2, a question of a small central/right paracentral disc protrusion was noted.
- At L2-3, disc desiccation with a disc osteophyte complex formation and possible small protrusion to the left was indicated.
- At L3-4, disc desiccation with a central disc protrusion causing indentation in the thecal sac was noted.
- At L5-S1, disc desiccation with prominent disc protrusion and extrusion centrally with associated indentation on the thecal sac was indicated. (PX6, pg. 06).

On October 13, 2015, APRN Mulder referred Petitioner to orthopedic surgeon, Dr. Jeffrey Wingate of the Illinois Orthopedic Network.

Petitioner presented for initial consult with Dr. Wingate on October 21, 2015. (PX8, pgs. 51, 65). At that visit, Mr. Messina complained of severe low back pain with numbness and weakness in the left leg. He complained, secondarily, of severe neck pain radiating into his left upper extremity, left shooting pains across the shoulder into the back of the elbow and down through the dorsal aspect of his radial forearm into the ulnar two digits of the left hand. (Id.). Petitioner further complained of right-sided pain in the low back and knee, and pain in his right upper thigh. Petitioner reported a throbbing pain with standing or walking. (Id.).

On exam, the doctor noted Petitioner ambulated with a notable limp, antalgia, positive SLR on the left and a partial left drop foot. (Id.).

Dr. Wingate reviewed the MRI study from June 24, 2015, noting:

> *A massively herniated foraminal and extra-foraminal herniation of disc material on the left side from his L5-S1 disc space that severely displaces and even obliterates the normal exiting space for the L5 nerve root, as well as the transitioning left S1 nerve root. The radiologist agrees the disc material extends into the left lateral recess and neural foramen with remarkable narrowing. Above it at L4-L5, he has significant triangulations around the thecal sac, with left greater than right neural foraminal narrowing. I disagree with the radiologist's interpretation that this is 'no significant mass effect or canal narrowing appearance'.*
>
> *Above that at L3-L4, there is a left paracentral disk extrusion with inferior migration of the fragment displacing the L4 nerve root on the left side. [T]he patient has an element of congenital stenosis with*

shortening of the pedicles that creates some level of pre-existent narrowing from the exiting nerve roots within all of the neural foramina of the lumbar spine. (Id.).

The doctor also reviewed the October 13, 2015 cervical MRI scan noting disk dessication along the left central and paracentral herniation of disk material with narrowing of the central canal and left lateral recess and significant narrowing around the exiting C6 nerve root. No evidence of cervical myelopathy was noted although the doctor did note a reversal of normal lordotic curvature. The doctor indicated Petitioner is straight or kyphotic through the cervical spine, significant for increasing the effect against the C6 nerve root. (Id.).

Dr. Wingate noted both MRI's are low/resolution open scans, and given Petitioner's 380 lb. body weight, higher resolution scans would better elucidate the neural pathology. (Id.).

The doctor diagnosed Petitioner with left C6 radiculopathy, severe left L5-S1 radiculopathy, left extruded foraminal and extra-foraminal herniation at L5-S1 and a central herniated nucleus pulposus with radiculopathy at L3-4 and L4-5 on the left side. (Id. pgs. 66-67).

Dr. Wingate noted a treatment plan as follows: that Petitioner be imaged with high resolution MRI scans of the neck and back; the placement steroid solution into left side of cervical epidural space around the free fragment disk herniation at C5-6; selectively blockading the L5-S1 nerve roots, both in terms of diagnostically evaluating the radiculopathy complaints, as well as placing steroid solution around the highly inflamed nerve roots. (Id.).

The doctor further indicated that long-term, after more appropriately imaging the spine, invasive spinal care may be indicated given the duration of complaints and symptoms along with the severity of foraminal narrowing in the cervical and lumbar spine. (Id.).

Dr. Wingate forbade Mr. Messina from working. (Id.).

On October 30, 2015, Petitioner consulted with Dr. Thomas Poepping, an orthopedic surgeon at G & T Orthopaedics who noted a history of a March 7, 2015 work injury where Petitioner fell onto his right side. (PX9, pg. 1). Petitioner reported developing low back, right hip, and bilateral leg pain consequently. (Id.). Petitioner reported occasional right leg pain but his primary complaint concerned his numbness and pain radiating down the left leg. Petitioner further complained of some right knee pain. (Id.). On exam, the doctor noted right hip tenderness over the trochanteric bursa and severe midline and paraspinal tenderness of the lumbar region with positive SLR bilaterally. The doctor reviewed MRI of Petitioner's right hip noting some mild trochanteric bursitis. On review of a lumbar spine MRI, the doctor noted "severe L5-S1 degenerative disc disease with bulging of the disc at this level and severe bilateral neural foraminal narrowing." (Id., pg. 2). Dr. Poepping's noted an impression of lumbar radiculopathy and right hip trochanteric bursitis. The doctor further noted, "I think the majority of his symptomology is certainly coming from his back. I think his hip is fairly minimal at this point." (Id.). The doctor referred Petitioner to pain management for a trial injection and for a neuro surgery consult. He further noted Petitioner could return to seated work with position change as needed. (Id.).

On November 5, 2015, Dr. Sajjad Murtaza administered an epidural steroid injection to Petitioner's low back. (Id. pg. 126).

Cervical and Lumbar MRI's were performed on November 9, 2015. (Id., pgs. 138-139).

Petitioner next saw Dr. Wingate on December 2, 2015 at which time the doctor noted leftward free fragments at L5-S1 and a left paracentral disk extrusion with inferior migration at L3-4. (PX8, pgs. 94-95). Dr. Wingate again noted that Petitioner not return to work. The doctor further noted that on a recent Saturday night, upon

returning home after a 12- hour work day, Petitioner had the onset of a sudden feeling of warmth in his buttocks, and sustained an episode of encopresis in which he soiled his underwear. (Id.).

A CT lumbar myelogram with contrast on December 21, 2015 noted a clinical history of a herniated disk at L3-S1 and encopresis along with complaints of low back pain and pain extending into the lower extremities, left greater than right. (PX11, pgs. 01-04).

The lumbar CT was interpreted by Dr. Wingate on January 20, 2016, at which time he noted an "extruded left L5-S1 herniated nucleus pulposus completely filling/obliterating the left L5 neural foramen". (PX8, pg. 52). The doctor noted the study confirmed Petitioner had severe left L5 neural foraminal narrowing. The doctor further noted a "global level of spinal pathology" noting "severe retrolisthesis at multiple levels" and "moderate neural foraminal narrowing at L2-L3 where retrolisthesis exists" and degenerative scoliosis. (Id.). Dr. Wingate indicated "there is nothing normal anywhere in his lumbosacral spine" and that in order to "fix" or "directly address" Petitioner's severe degree of neural foraminal narrowing at L5, the severe level of retrolisthesis across the disc space and the end plate osteophyte spurring a combination of interbody and posterolateral fusion would be required. (Id.).

At the January 20, 2016 visit with Dr. Wingate, Petitioner complained of lower back, upper back, neck pain, numbness in the left arm and bilateral knee pain with numbness and tingling in the left knee (PX 8, pg. 55). He reported that laying down was extremely painful. (Id.).

At this visit Petitioner indicated he was working 55 hours a week. Dr. Wingate noted Petitioner's current duties at work where he was constantly on his feet and moving continuously, is more than Petitioner's body can physiologically support. (PX8, pgs. 52-53).

Dr. Wingate indicated he reviewed "several IMEs to date", that all of Petitioner's benefits had been terminated and that his employer was requiring him to work a 55-hour work week because he manages the facility. Petitioner reported when he first returned to this work schedule, after working two consecutive days on his feet for more than 13 hours per day, he experienced two episodes of encopresis. Petitioner further reported neck pain that has caused severe headaches and his left arm to go numb.

Dr. Wingate noted he disagreed with the IME opinion that Petitioner has been a long time opioid dependent. The doctor noted Petitioner had brought in 16 years of medical records dating back to October, 1999 and that his first prescription for opioid medication was for ankle pain in 2000 while the next prescription was not until the Petitioner's first July 2013 work accident. (Id.).

Dr. Wingate testified that the recent CT supported why Petitioner could potentially be losing control of his bowel and bladder function. (Id. pg. 23).

With respect to the doctor's actual recommendations regarding Petitioner's low back pain and left leg symptoms, the doctor did not recommend surgery, noting he did not have the "ability to provide care surgically for a patient" with a BMI of 52. (Id.).

Dr. Wingate recommended continued interventional pain management with application of steroids around the severely stenosed lumbosacral junction and cessation of all work. (Id.).

On February 18, 2016, Petitioner presented to Dr. Sajjad Murtaza with complaints of lower lumbar pain radiating "down his leg". The doctor noted significant pathology at L4-L5 with disk extrusions and nerve impingements at these levels. The doctor administered a lumbar transforaminal ESI on the left using fluoroscopic needle localization and epiroprim at L4-5 and L5-S1. (Id., pg. 125.

The Case at Issue
16 WC 9942

The parties stipulated that on March 25, 2016, Petitioner sustained accidental injuries arising out of and in the course of his employment. (AX4). Petitioner testified he was servicing a client, gathering and writing down vehicle information onto a clipboard. As he was returning to the building from the parking lot, he slipped on ice, fell forward and hit his head on the cement pavement.

Beloit Fire Department records indicate that upon arrival, Petitioner was found lying prone in the walkway of a place of business. (PX2, pg. 16) A small head contusion was noted as well as complaints of back and neck pain. A C-collar was place on Petitioner and he was transported to Beloit Memorial Hospital whose records indicate Petitioner was then transferred to Mercy Hospital in Janesville, Wisconsin, after a determination that the 390-lb. patient was above the weight limit for the hospital's CT scanner. (PX2, pgs. 01-16)

Records from Mercy Hospital note Petitioner's complaints of headache, posterior neck pain, left sided back pain, right wrist pain, amongst other complaints. Multiple x-rays of Petitioner's bilateral knees, pelvis and right wrist were taken as well as CT of Petitioner's head, neck, mid and low back. (PX13) Petitioner reported a history of chronic neck and low back pain with occasional paresthesia in the left lower extremity. (Id. p. 3).

The hospital ER opined that Petitioner exacerbated his chronic pain during the fall. (Id.). Petitioner was nauseous and light-headed after ambulating. (Id.). He was prescribed a wheeled walker for one month. (Id.).

Three days later, Petitioner followed up with Dr. Wingate, at which time, the doctor again instructed Petitioner to stay off work. (PX8, pg. 75).

Petitioner on March 31, 2016, presented to Dr. Murtaza who noted a history of the March 25, 2016 work-related fall. (Id., pgs. 23). Petitioner complained of significant neck pain and lower back pain radiating into his bilateral lower extremities, left greater than right, along with numbness and pins-and-needles sensation. (Id.). Petitioner further complained of right knee swelling that was visible on exam. Petitioner was wearing a C-collar. Dr. Murtaza recommended a bilateral TFESI with orthopedic follow-up for his right knee. The doctor dispensed Meloxicam, Pantaprazole, Cyclobenzaprine, and Vicoprofen. Lidoderm patches were prescribed. Petitioner was restricted from working. (Id.).

On April 7, 2016, Dr. Murtaza administered an L5-S1 lumbar transforaminal ESI. (Id., pg. 25).

Dr. Murtaza's May 5, 2016 records indicate Petitioner had been administered three lumbar injections to date with 5% relief. (Id. pg. 112). Petitioner continued to complain of significant low back pain with radiation to his bilateral lower extremities, left greater than right at a 9/10. (Id.). He further complained of bilateral knee pain, worse on the right. Petitioner had yet to see an orthopedist. He also complained of significant neck pain with radiation to the left upper extremity as well as constant headaches. Petitioner reportedly was applying for disability. Dr. Murtaza noted Petitioner was not a surgical candidate due to his weight and pathology in his spine. The doctor recommended re-starting physical therapy 2-3 times per week for 4 weeks, followed by a home exercise program. The doctor noted Petitioner "may not return to work". (Id.). Gabapentin was prescribed for neuropathic pain and a refill for Vicoprofen was noted. (Id.).

On July 7, 2016, Dr. Murtaza administered a cervical epidural injection at C5-6. (Id., pg. 26).

Petitioner went to ATI physical therapy on July 11, 2016 for an initial evaluation. (PX14, pgs. 19-20). The therapist noted that Petitioner presented with signs and symptoms consistent with cervicalgia and right knee pain. (Id., pg. 19). Petitioner was notably ambulating with a quad cane and a walker. (Id., pgs. 05, 19).

Petitioner began physical therapy on July 13, 2016, and attended eight sessions, through July 29, 2016. (Id., pgs. 04-11). Petitioner was noted to have suffered paralysis on July 28, 2016. (Id., pg. 02).

Petitioner, at the July 29, 2016 visit, felt worse, coughed, lost control of his muscles and fell. (Id., pg. 02).

At Petitioner's visit with Dr. Murtaza on August 4, 2016, Petitioner stated he experiences intermittent paralysis in the right arm which last for one to three minutes. (PX8, pg. 120). Petitioner also reported a 15% pain relief with the last cervical epidural injection on July 7, 2016. (Id.).

Dr. Murtaza, at the August 4, 2016 visit, noted Petitioner's complaints of headaches, neck pain, low back pain, upper extremity radiculitis, bilateral lower extremity radiculitis and right knee pain. The doctor opined that Petitioner is not a surgical candidate nor a good candidate for therapy as the therapy has only exacerbated his symptoms. No further treatment was recommended aside from long-term pain management. (Id. pg. 120).

Petitioner consulted with Dr. Edward Herba, a neurologist, on August 30, 2016. (PX8, pg. 34). Dr. Herba stated that Petitioner demonstrates a personal loss of sensation in both legs and both arms. (Id.) The doctor further stated he did not believe Petitioner had arthritic changes involving the spine. (Id.).

Petitioner presented to Dr. Murtaza on October 18, 2016 and November 8, 2016 at which time he noted no change in Petitioner's condition. (Id. pgs. 37, 39).

At Petitioner's visit with Dr. Murtaza on December 6, 2016, the doctor noted that Petitioner's wife helps him bathe and dress. (Id. pg. 02).

At Petitioner's visit with Dr. Murtaza on January 31, 2017, it was reported that Petitioner had another episode one week ago where his entire body became numb and tingly with paralysis for about one minute. (Id. pg. 05).

Petitioner saw Dr. Murtaza on February 28, 2017 and March 21, 2017 with no change, the doctor indicated Petitioner could not work. (Id. pg. 06).

At the hearing, Petitioner testified he last saw Dr. Murtaza a few weeks before the hearing.

CONCLUSIONS OF LAW

C) The Arbitrator find that Petitioner's current condition of ill-being is causally related to the work accident of August 15, 2015.

The Arbitrator has already found that Petitioner's accident of March 7, 2015 and August 15, 2015 are causally related to his current condition of ill-being in his low back, neck, bilateral knees, left arm and right hip. (See decision and addendum, 15 WC 9502; 15 WC 29808).

The parties stipulated that on March 25, 2016, Petitioner sustained accidental injuries arising out of and in the course of his employment. (AX4). Petitioner testified he was servicing a client, gathering and writing down vehicle information onto a clipboard. As he was returning to the building from the parking lot, he slipped on ice, fell forward and hit his head on the cement pavement.

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Petitioner was then transferred to Mercy Hospital in Janesville, Wisconsin, after a determination that the 390-lb. patient was above the weight limit for the hospital's CT scanner. (PX2, pgs. 01-16)

Records from Mercy Hospital note Petitioner's complaints of headache, posterior neck pain, left sided back pain, right wrist pain, amongst other complaints. Multiple x-rays of Petitioner's bilateral knees, pelvis and right wrist were taken as well as CT of Petitioner's head, neck, mid and low back. (PX13) Petitioner reported a history of chronic neck and low back pain with occasional paresthesia in the left lower extremity. (Id. p. 3).

The hospital ER opined that Petitioner exacerbated his chronic pain during the fall. (Id.). Petitioner was nauseous and light-headed after ambulating. (Id.). He was prescribed a wheeled walker for one month. (Id.).

Three days later, Petitioner followed up with Dr. Wingate, at which time, the doctor again instructed Petitioner to stay off work. (PX8, pg. 75).

Petitioner on March 31, 2016, presented to Dr. Murtaza who noted a history of the March 25, 2016 work-related fall. (Id., pgs. 23). Petitioner complained of significant neck pain and lower back pain radiating into his bilateral lower extremities, left greater than right, along with numbness and pins-and-needles sensation. (Id.). Petitioner further complained of right knee swelling that was visible on exam. Petitioner was wearing a C-collar. Dr. Murtaza recommended a bilateral TFESI with orthopedic follow-up for his right knee. The doctor dispensed Meloxicam, Pantaprazole, Cyclobenzaprine, and Vicoprofen. Lidoderm patches were prescribed. Petitioner was restricted from working. (Id.).

All IME doctors concede that Petitioner was injured on the date of all four work accidents although they conclude that Petitioner should have no continuing physical problems. All IME doctors opine that if Petitioner does have any current condition of ill-being, any such condition is simply degenerative in nature with no causal connection to any of the four work accidents. The Arbitrator finds this an untenable position given the preponderance of evidence contained in the record. (See Arbitrator's Addendum, 15 WC 9502).

Based on the opinions of Dr. Wingate and the treating medical records, the Arbitrator finds the preponderance of evidence contained in the record supports a finding that Petitioner aggravated and accelerated his conditions of ill-being with respect to his low back, neck, bilateral knees, left arm and right hip and that his current condition of ill-being with respect to those body parts is causally related to the March 25, 2016 work related accident.

The Arbitrator finds that respondent has not paid all appropriate charges for all reasonable and necessary medical services and is liable for five medical bills that are currently in dispute.

The Arbitrator finds that all treatment to date has been reasonable and necessary. Respondent shall pay the following outstanding charges, per the Fee Schedule:

ATI Physical Therapy	$3,715.36
Beloit Health System	$528.45
Illinois Orthopedic Network	$727.33
Metro Anesthesia Consultants	$2,052.78
Dr. Robert Wilson	$1,920.00

TTD

Petitioner testified that his last day of work for Respondent was March 25, 2016. (TX pg. 66). The Arbitrator notes Petitioner is seeking TTD benefits from July 6, 2016 through April 19, 2017, the date of the hearing. (Arb.

Ex. 4). Based on the evidence considered as a whole, the Arbitrator finds that Petitioner was unable to work during the claimed time period and awards Petitioner TTD benefits from July 6, 2016 through April 19, 2017.

What is the nature and extent of Petitioner's injuries?

Dr. Wingate testified that although Petitioner would benefit from a lumbar decompression and fusion, no hospital or surgery center in Illinois would allow such a procedure because of the risks involved in administering anesthesia to anyone with a BMI over 40. (PX15, pg. 24, 25).

Dr. Wingate further testified that if a fusion was performed on Petitioner, "we are not so much as fixing the problem as we are changing the problem". (Id., pg. 26). The doctor explained:

> *Unfortunately, that is a surgical procedure that carries a huge morbidity. There is probably at least an 80 or 85% chance that Mr. Messina would have some type of medical complication during that surgical procedure, or more importantly, in the first few days after that surgical procedure. And there is a huge problem that within two to four years after that operation that Mr. Messina would then have a surgically treatable lesion immediately above it at L3-4 and L2-3.* (Id., pg. 26).

Dr. Wingate testified Petitioner is medically unable to obtain gainful employment and that he should be considered completely and totally disabled. (Id. pg. 30). He further testified that "the most humane option" is to keep the inflammation down around the involved nerve roots and to lessen the stresses that go across that segment of the spine, even if it means taking the "unreconstructable patient completely out of work, completely removing him from the day to day stresses" and essentially putting him in a position where he can rest and "get rid of the inflammation" in these segments of the spine. (Id., pgs. 26-27).

Dr. Wingate testified that Petitioner's condition with respect to his left L5 and S1 nerve roots puts Petitioner at an increased risk for falls:

> *Indeed, this has already started to come true. He has now had several falls. I believe most recently he slipped on ice and was unable to recover his upright posture. There's no way that a patient of his stature with improperly functioning L5 and S1 nerve roots can possibly stay upright and keep themselves safe. (Id. pg. 29).*

When asked by Respondent if he considered referring Petitioner to physical therapy, work conditioning or vocational rehabilitation prior to concluding that Petitioner was medically unable to work, the doctor responded:

> *Physical therapy in this clinical scenario, in -- in my professional opinion, is -- is not warranted. With the degree of nerve root compression, with documented EMG and nerve conduction study findings of radiculopathy involving those nerve roots, and with severe stenosis around the nerve roots and, now, clinical episodes of encopresis, in my opinion it would be not warranted to pursue physical therapy per se.*
>
> *Pain management with steroid injections that could help to decrease the inflammation in those tissues as invasive forms of helping to manage the situation could be beneficial. And if there is a positive response to those injections then absolutely... would be warranted but to continue beating up severely constrained compressed nerve roots with further activity and further motion is not beneficial in this situation. (Id.).*

After questioning by Respondent's attorney, Dr. Wingate testified that he thought it was *possible* that Petitioner could perform sedentary work, but the following issues will arise:

> *[T]he sedentary position would have to accommodate to the fact that with his severe neurologic impingement and compression of those nerve roots he cannot maintain a seated position for probably more than 15 or 20 minutes he cannot maintain a standing position for more than 15 or 20 minutes he certainly cannot go out and walk any distances. (Id. pg. 37-38).*

Dr. Wingate agreed with Respondent that if a hypothetical position that was sedentary in nature that could accommodate the switching from sitting to standing, then it would be a "win-win" for Petitioner. (Id. pg. 39).

At Petitioner's request, Thomas Grzesik, a certified rehabilitation counselor and licensed clinical professional counselor, met with Petitioner on November 30, 2016, reviewed treating medical records and conducted a battery of vocational tests. (PX17)

Mr. Grzesik opined, based on the opinions of Dr. Wingate and Dr. Murtaza, that Petitioner is unable to perform the responsibilities and duties of his former position for Respondent as a Store Manager. (PX15, dep. Ex. 2, pg. 26)

In determining that Petitioner was not an appropriate candidate for further vocational rehabilitation services, Mr. Grzesik considered Petitioner's post-work injury vocational profile (44 years old, 12 grade education, lack of transferable skills, work restrictions and learning and academic ability as tested) and applied the factors established in *National Tea Company v. IIC*, 73 Ill.Dec. 575 (1983).

He further testified that Petitioner is not qualified to do any at home, telecommuting-type of employment. There was nothing in the interview with Petitioner or in the records that would indicate Petitioner has a background for a home-based job. (PX17, pg. 27).

It was Mr. Grzesik's opinion that Petitioner is permanently and totally disabled under the guidelines set forth by the Illinois Workers' Compensation Commission. (PX17, dep. Ex. 2, pg. 26).

Based on the record as a whole, with particular reliance on the opinions of Dr. Wingate coupled and Mr. Grzesik, the Arbitrator finds Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act.

Respondent shall pay Petitioner $848.75/week for life, commencing April 19, 2017, as provided in Section 8(f) 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

SALAVATORE MESSINA,

Petitioner,

vs. NO: 15 WC 032461

NATIONAL TIRE & BATTERY,

Respondent.

19IWCC0412

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, TTD, and PPD 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 25, 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.

19IWCC0412

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 2 - 2019
LEC/mav
O: 5/21/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MESSINA, SALVATORE
Employee/Petitioner

Case# **15WC032461**

15WC009502
15WC029808
16WC009942

NATIONAL TIRE & BATTERY
Employer/Respondent

19IWCC0412

On 8/25/2017, 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:

1927 HUGHES SOCOL PIERS RESNICK
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKON LLC
TIMOTHY W ALBERTS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SALVATORE MESSINA
Employee/Petitioner

v.

NATIONAL TIRE & BATTERY
Employer/Respondent

Case # **15** WC **32461**

Consolidated cases: **15 WC 9502**
15 WC 29808
16 WC 9942

19IWCC0412

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **4/19/17**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

19IWCC0412

FINDINGS

On **7/22/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,202.76**; the average weekly wage was **$1,273.13**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$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 Arbitrator finds that Petitioner's right knee condition caused by the July 22, 2013 accident was aggravated and accelerated by his subsequent work accident on March 7, 2015 (15 WC 9502), August 15, 2015 (15 WC 29808) and March 25, 2016 (16 WC 9942) and that Petitioner's current condition of ill being in his right knee is causally connected to those accidents.

The remaining disputed issues will be considered in the companion cases: 15 WC 9502, 15 WC 29808, 16 WC 9942.

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

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

Jason C. Hyatt

Signature of Arbitrator

8/22/17

Date

ICArbDec p. 2

AUG 25 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SALVATORE MESSINA
Petitioner,

v.

Case No: **15 WC 32461**

consolidated with: 15 WC 9502
15 WC 29808
16 WC 9942

NATIONAL TIRE & BATTERY
Respondent.

19IWCC0412

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Four Applications for Adjustment of Claim were filed in this matter which proceeded to hearing on April 19, 2017 in Geneva, Illinois.

Separate decisions will be issued for each case. The case at bar concerns 15 WC 32461.

FINDINGS OF FACT

Petitioner testified he worked as a store manager for National Tire and Battery ("Respondent"). His duties included managing personnel, customer service, telephone service, technical service, inventory, vehicle repairs, and store accounting. Petitioner testified that Respondent sold a wide variety of automobile vehicle repairs which involved moving tires up to the front service counter on a regular basis. Petitioner also ordered parts, dealt with parts that were returned, conducted inventory and store counts and opened and closed the store.

15 WC 32461

The parties stipulated that Petitioner sustained an accidental injury arising out of and in the course of his employment on July 22, 2013. (AX1)

Petitioner testified that while dealing with a customer issue, his right foot became stuck on an orthopedic mat located behind the service desk of National Tire & Battery. (TX 18). As he turned, his right knee popped and he began to fall. (Id. pgs. 18-19). He caught himself before hitting the ground. (Id. pg. 19). At the time, Petitioner weighed around 330 pounds. (Id.) He testified his current weigh was approximately 368 pounds. (Id.).

After the accident, Petitioner sought treatment with Dr. Robert Wilson, his general practitioner who recommended a conservative treatment plan consisting of medication management and physical therapy. (PX1, pg. 02). Petitioner testified that he took some personal time off work following the accident but continued working his regular duties as the manager of National Tire & Battery thereafter. (TX. pg. 21). Petitioner testified his right knee hurt following the accident and that he had a difficult time climbing stairs. The records of Dr. Robert F. Wilson, Petitioner's family doctor, indicate that Petitioner presented on July 22, 2013, December 27, 2013 and June 4, 2014 with complaints of right knee pain for which the doctor prescribed pain medications. (PX1, pg., 2).

On cross-exam, Petitioner testified that the only injury he sustained in this accident was to his right knee. (Id. pg. 49)

The handwritten notes of Dr. Robert F. Wilson, Petitioner's family physician, indicate that Petitioner presented on July 22, 2013, December 27, 2013 and June 4, 2014 with complaints of right knee pain for which the doctor prescribed pain medications. (PX1, pg., 2).

15 WC 9502

Petitioner was involved in a second undisputed accident while working for Respondent on March 7, 2015. (AX2). Petitioner testified that as he walked towards the front service desk at National Tire & Battery, he tripped on the same orthopedic floor mat involved in the above-described accident. Petitioner testified that as he was falling, it felt like someone had tied up his feet. He fell forward onto his right knee which landed on the orthopedic mat while his head hit the tile floor and the right side of his body hit a wall. Petitioner testified he laid on the ground for a few minutes. Petitioner testified his District Manager Matt Gearhardt would not allow him to leave the store to seek immediate medical treatment due to inventory duties that needed to be completed.

The next day, Petitioner presented to Beloit Memorial Hospital ER with a history of tripping on a mat at work falling onto his right side and hitting his chin upward on a desk. Complaints of pain to his neck, upper and lower back as well as bilateral knee pain were noted. (PX8, pg. 84). Pain medications were administered to upon discharge.

Petitioner presented to Beloit Health System Occupational Health Center on March 10, 2015. (PX 3, pg. 2). APN Brian Mulder noted Petitioner's various complaints including right knee pain since March 7, 2015 when he "got his left foot caught on a mat behind the cash register" causing him to fall hitting his head on a tile floor with his right arm extended to catch his fall. (Id.). Petitioner reported taking one Norco, twice a day for his various pain complaints. He further reported bilateral knee swelling with near "give away" sensation in his right knee at times. Petitioner reported tripping one year prior and injuring his right knee. He further reported treating with his family doctor who administered two injections and that his right knee pain had completely resolved prior to this injury. (Id.). APN Mulder instituted work restrictions consisting of: no bending or twisting, no lifting more than five pounds, sitting or standing for pain relief as needed, no over shoulder activity and no more than eight hours a day, 40 hours a week of work. (Id. pg. 01). Pain medications were prescribed and Petitioner was to follow up in two week's time. (Id.).

On March 13, 2015, Petitioner presented to his general practitioner, Dr. Wilson who noted a history of falling at work on March 7, 2015 with complaints of neck, back and bilateral knees pain. (PX1, pg. 3).

On March 17, 2015 APN Mulder noted Petitioner's complaints of bilateral knee pain amongst other complaints. (Id. pg. 9). He reported taking Vicoprofen four times a day and one Cyclopbenzaprine, three times a day for his pain. He reported these medications were prescribed by his family doctor. He reportedly was following work restrictions but would have an increase in knee, neck and back pain when he performed work duties outside those restrictions. (Id.). Petitioner's work restrictions were continued and he was to follow up in two weeks. (Id.).

On April 8, 2015, an MRI of Petitioner's right knee revealed patellar tendinopathy and chondromalacia. (PX4, pgs. 01-02).

On June 12, 2015, Petitioner followed up with APN Mulder reporting improvement in his bilateral knee pain but continued swelling.

On June 30, 2015, Petitioner presented to APN Mulder various complaints including bilateral knee pain although he did report popping at times. (Id. pg. 40). He was working within his restrictions but reported increased pain when he engaged in increased physical duties at work.

On July 14, 2015, Petitioner presented to APN Mulder with complaints of bilateral knee pain that was improving although he did report right knee swelling. APN Mulder continued Petitioner's work instructions and ordered physical therapy. (Id.).

Petitioner participated in physical therapy from July 21, 2015 through July 31, 2015. (PX3, pgs. 50-60).

On July 28, 2015 Petitioner presented to APN Mulder with improving bilateral knee pain. (Id.). APN Mulder noted he would not need further care with respect to his bilateral knees due to his continued improvement.

15 WC 29808

Petitioner was involved in a third undisputed work-related accident while employed by Respondent on August 15, 2015. (AX3). Petitioner testified while working at the front service counter he heard some swearing. He walked towards the noise where he found an irate customer in bay area one. Petitioner asked the customer if he could help him but the belligerent customer continued his tirade. Petitioner asked the customer to curtail his behavior. The customer then clenched his fist and started swinging at Petitioner who swung his neck backward and physically moved his body backward at the same time. As Petitioner turned to call the police, he tripped over the leg of a vehicle lift rack and caught himself on the service desk. He then called 911. Petitioner testified he would have hit the ground had he not extended his hands outward to support himself.

Petitioner testified that following the incident, he experienced pain in his whole body: neck, shoulders, arm, back, legs and knees. He left work early that day and went home.

On August 18, 2015, APN Brian Mulder noted Petitioner presented reporting a history of a work-related altercation three days before where a customer appeared as if he were going to hit the Petitioner, at which time, Petitioner "jarred his low back pain and neck" to avoid being hit. (PX3, pg. 66). APN Mulder noted Petitioner's complaints of intermittent numbness and tingling in his legs and feet, increased left leg pain radiating into his foot and increased left-sided neck pain radiating to his left hand along with intermittent numbness in his left pinky finger. Petitioner reported taking Vicoprofen four times and one Flexeril per day. APN Mulder noted Petitioner was to obtain a cervical and lumbar MRI and continued his work restrictions. (Id. at 68).

Petitioner testified he tried to abide by his work restrictions but his position as manager did not allow him to stay seated at a desk all day.

On October 30, 2015, Petitioner saw Dr. Thomas Poepping, an orthopedic surgeon, with a history of fall onto his right side on March 7, 2015 accompanied by various pain complaints, including right knee pain. (PX 9).

On January 20, 2016, Dr. Wingate noted Petitioner's complaints of right knee pain amongst other various complaints. At this visit Petitioner indicated he was working 55 hours a week. Dr. Wingate noted Petitioner's current duties at work where he was constantly on his feet, moving continuously, is more than his body can physiologically support. (PX8, pgs. 52-53).

16 WC 9942

It is undisputed that on March 25, 2016, Petitioner was employed by Respondent when he sustained a work-related accident. (AX4). Petitioner testified he was servicing a client, gathering and writing down vehicle

information onto a clipboard. As Petitioner was returning to the building from the parking lot, he slipped on ice, fell forward and hit his head on the cement pavement.

Beloit Fire Department records indicate that upon arrival, Petitioner was found lying prone in the walkway of a place of business. (PX2, pg. 16) A small head contusion was noted as well as complaints of back and neck pain. A C-collar was place on Petitioner and he was transported to Beloit Memorial Hospital whose records indicate Petitioner was then transferred to Mercy Hospital in Janesville, Wisconsin, after a determination that the 390-lb. patient was above the weight limit for the hospital's CT scanner. (PX2, pgs. 01-16)

Records from Mercy Hospital note Petitioner's complaints of headache, posterior neck pain, left sided back pain, right wrist pain, and other complaints were noted. Multiple x-rays were taken including images of Petitioner's right knee.

The hospital ER opined that Petitioner exacerbated his chronic pain during the fall. (Id.). Petitioner was nauseous and light-headed after ambulating. (Id.). He was prescribed a wheeled walker for one month. (Id.).

Three days later, Petitioner followed up with Dr. Wingate, at which time, the doctor again instructed Petitioner to stay off work. (PX8, pg. 75).

Petitioner did not return to work and has not since the March 25, 2016 work accident.

Petitioner on March 31, 2016, presented to Dr. Sajjad Murtaza (physical medicine and rehabilitation) for initial consult who noted a history of the March 25, 2016 work-related fall. (Id., pgs. 23). Petitioner complained of significant neck pain and lower back pain radiating into his bilateral lower extremities, left greater than right, along with numbness and pins-and-needles sensation. (Id.). Petitioner further complained of right knee swelling that was visible on exam. Petitioner was wearing a C-collar. Dr. Murtaza recommended a bilateral TFESI with orthopedic follow-up for his right knee. The doctor dispensed Meloxicam, Pantaprazole, Cyclobenzaprine, and Vicoprofen. Lidoderm patches were prescribed. Petitioner was restricted from working. (Id.).

Dr. Murtaza's May 5, 2016 records noted Petitioner's complaints of bilateral knee pain, worse on the right. Petitioner had yet to see an orthopedist. A consult with an orthopedist was again recommended. Petitioner was noted to walk with a cane. Antalgic gait was noted that develops from avoiding pain while walking. The doctor noted Petitioner "may not return to work as he is now applying for disability". (Id.). Gabapentin was prescribed for neuropathic pain and a refill for Vicoprofen was noted. (Id.).

Petitioner went to ATI physical therapy on July 11, 2016 for an initial evaluation. (PX14, pgs. 19-20). The therapist noted that Petitioner presented with signs and symptoms consistent with cervicalgia and right knee pain. (Id., pg. 19). Petitioner was notably ambulating with a quad cane and a walker. (Id., pgs. 05, 19).

Petitioner began physical therapy on July 13, 2016, and attended eight sessions, through July 29, 2016. (Id., pgs. 04-11). Petitioner suffered paralysis on July 28, 2016. (Id., pg. 02). Prior to the paralysis, the therapist stated that Petitioner will benefit from further medical follow up before attending any more therapy. (Id., pg. 02).

Petitioner, at the July 29, 2016 visit, felt worse, coughed, lost control of his muscles and fell. (Id., pg. 02).

Dr. Murtaza, at the August 4, 2016 visit, noted Petitioner's various complaints including right knee pain. The doctor opined that Petitioner is not a good candidate for therapy as such has only exacerbated his symptoms. No further treatment was recommended aside from long-term pain management. (Id. pg. 120).

Petitioner presented to Dr. Murtaza on October 18, 2016 and November 8, 2016 at which time he noted no change in Petitioner's condition. (Id. pgs. 37, 39).

At Petitioner's visit with Dr. Murtaza on December 6, 2016, the doctor noted that Petitioner's wife helps him bathe and dress. (Id. pg. 02).

On December 20, 2016, Petitioner presented to Dr. Murtaza with various complaints. With respect to his right knee, Petitioner reported increased swelling and that the knee was "giving out more". (PX8, pg. 3). Dr. Murtaza noted Petitioner would follow-up with orthopedics. (Id.).

At Petitioner's visit with Dr. Murtaza on January 31, 2017, amongst Petitioner's reported complaints was right knee pain. Petitioner was reportedly still awaiting follow-up for orthopedics. The doctor noted that his right knee continues to give out on him. (Id. pg. 05).

Petitioner saw Dr. Murtaza on February 28, 2017 with various complaints although right pain was not noted. (Id. pg. 06).

At the hearing, Petitioner testified he last saw Dr. Murtaza a few weeks before the hearing.

CONCLUSIONS OF LAW

The Arbitrator finds that Petitioner's right knee condition caused by the July 22, 2013 accident was aggravated and accelerated by his subsequent work accident on March 7, 2015 (15 WC 9502), August 15, 2015 (15 WC 29808) and March 25, 2016 (16 WC 9942) and that Petitioner's current condition of ill being in his right knee is causally connected to those accidents.

It is undisputed that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on July 22, 2013 when his right foot became stuck on an orthopedic mat located behind the service desk of National Tire & Battery. (TX 18). As he turned, his right knee popped and he began to fall. (Id. pgs. 18-19). He caught himself before hitting the ground. (Id. pg. 19). At the time, Petitioner weighed around 330 pounds. (Id.) He testified he currently weighed 368 pounds. (Id.).

After the accident, Petitioner sought treatment with Dr. Robert Wilson, his general practitioner who on July 22, 2013, December 27, 2013, and June 4, 2014 noted his complaints of pain for which the doctor prescribed pain medications. (PX1, pg. 02). Petitioner testified that he took some personal time off work following the accident but continued working his regular duties as the manager of National Tire & Battery thereafter. (TX. Pg. 21). Petitioner testified his right knee hurt following the accident and that he had a difficult time climbing stairs.

It has been stipulated between the parties that Petitioner was injured in an accident on March 7, 2015 (15 WC 9502) when he tripped on the same orthopedic floor mat involved in the above-described accident and fell forward onto his right knee which landed on the orthopedic mat while his head hit the tile floor and the right side of his body hit a wall. On April 8, 2015, an MRI of Petitioner's right knee revealed patellar tendinopathy and chondromalacia. (PX4, pgs. 01-02).

Petitioner continued treating with APN Mulder who noted his various physical complaints, including right knee pain on June 12, 2015, June 30, 2015, July 14, 2015. His knee pain was improving although he did report right knee swelling. APN Mulder continued Petitioner's work instructions and ordered physical therapy. (Id.). On July 28, 2015 Petitioner presented to APN Mulder with various physical complaints although his right knee

pain was improving. (Id.). APN Mulder noted he would not need further care with respect to his bilateral knees and neck due to his continued improvement. Petitioner was instructed to return to work with restrictions related to his low back, follow-up with a neurosurgeon and return in two weeks

Petitioner was involved in a third undisputed work-related accident while employed by Respondent on August 15, 2015. (AX3 -15 WC 29808). Petitioner testified while working at the front service counter he heard some swearing. He walked towards the noise where he found an irate customer in bay area one. Petitioner asked the customer if he could help him but the belligerent customer continued his tirade. Petitioner asked the customer to curtail his behavior. The customer then clenched his fist and started swinging at Petitioner who swung his neck backward and physically moved his body backward at the same time. As Petitioner turned to call the police, he tripped over the leg of a vehicle lift rack and caught himself on the service desk. He then called 911. Petitioner testified he would have hit the ground had he not extended his hands outward to support himself.

Petitioner testified that following the incident, he experienced pain in his whole body: neck, shoulders, arm, back, legs and knees. He left work early that day and went home.

Petitioner continued to treat with his PCP Dr. Wilson on September 25, 2015, October 23. 2015, November 23, 2015, December 21, 2015, January 20, 2016 and March 15, 2016 when Dr. Wilson noted Petitioner's complaints related to Petitioner's right knee. (Id., pg. 05).

Petitioner sustained a fourth undisputed accident while working for Respondent on March 25, 2016 when he slipped on ice in the parking lot and fell forward, hitting his head on the cement pavement. Beloit Fire Department records indicate that upon arrival, Petitioner was found lying prone in the walkway of a place of business. (PX2, pg. 16) A small head contusion was noted as well as complaints of back and neck pain. A C-collar was place on Petitioner and he was transported to Beloit Memorial Hospital whose records indicate Petitioner was then transferred to Mercy Hospital in Janesville, Wisconsin, after a determination that the 390-lb. patient was above the weight limit for the hospital's CT scanner. (PX2, pgs. 01-16)

Records from Mercy Hospital note Petitioner's various complaints of headache, posterior neck pain, left sided back pain, right wrist pain as well as multiple musculoskeletal pain complaints of the extremities. Multiple x-rays were taken including Petitioner's bilateral knees. (PX13)

The hospital ER opined that Petitioner exacerbated his chronic pain during the fall. (Id.). Petitioner was nauseous and light-headed after ambulating. (Id.). He was prescribed a wheeled walker for one month. (Id.). Three days later, Petitioner followed up with Dr. Wingate, at which time, the doctor again instructed Petitioner to stay off work. (PX8, pg. 75). Petitioner did not return to work and has not since the March 25, 2016 work accident.

Dr. Murtaza saw Petitioner on March 31, 2016, noting right knee pain, swelling and weakness.

On May 5, 2016, Dr. Murtaza recommended physical therapy, followed by a home exercise program. The doctor noted that Petitioner walks with a cane and may not return to work. (Id.). Petitioner was noted to walk with an antalgic gait, that develops from avoiding pain while walking.

On June 9, 2016, Petitioner complained to Dr. Murtaza of bilateral knee pain amongst other complaints. (PX8, pg. 17). On June 30, 2016, Dr. Murtaza noted that Petitioner walks with a rolling walker. (Id., pg. 113).

Petitioner began physical therapy on July 13, 2016, and attended eight sessions, through July 29, 2016. (Id., pgs. 04-11). Petitioner suffered a paralysis on July 28, 2016. (Id., pg. 02). Prior to the paralysis, the therapist stated that Petitioner will benefit from further medical follow up before attending any more therapy. (Id., pg. 02).

Petitioner, at the July 29, 2016 physical therapy session was noted to have felt worse, coughed, lost control of his muscles and fell. (Id., pg. 02).

Dr. Murtaza, at the August 4, 2016 visit, noted Petitioner's complaints including right knee pain. No further treatment was recommended aside from long-term pain management. (Id. pg. 120).

On December 20, 2016, Dr. Murtaza noted Petitioner presented with various complaints including right knee pain. (PX pg. 3) Petitioner stated his right knee has been swelling and "giving out on him more". (Id.). On exam, tenderness to palpation and mild swelling was noted. (Id.). The doctor noted that Petitioner would follow-up with orthopedics for his right knee pain and weakness. (Id.).

On January 31, 2017, Petitioner presented to Dr. Murtaza with complaints of right knee pain. Petitioner was noted to ambulate with a cane and reportedly was still awaiting a follow-up appointment with orthopedics regarding his right knee. (Id. pg. 5).

Petitioner saw Dr. Murtaza on February 28, 2017 and March 21, 2017 with no change, the doctor indicated Petitioner could not work. (Id. pg. 06).

At the hearing, Petitioner testified he last saw Dr. Murtaza a few weeks before the hearing.

Based on the totality of evidence contained in the record, the Arbitrator finds that Petitioner's right knee condition caused by the July 22, 2013 accident was aggravated accelerated by his subsequent work accident on March 7, 2015 (15 WC 9502), August 15, 2015 (15 WC 29808) and March 25, 2016 (16 WC 9942) and that Petitioner's current condition of ill being is causally connected to those accidents.

Any remaining disputed issues will be considered in the companion cases: 15 WC 9502, 15 WC 29808, 16 WC 9942.

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

SALAVATORE MESSINA,

Petitioner,

vs. NO: 15 WC 029808

NATIONAL TIRE & BATTERY,

19IWCC0413

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, TTD, and PPD 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 25, 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.

19IWCC0413

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 2 - 2019
LEC/mav
O: 5/21/19
43

L. Elizabeth Coppoletti

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MESSINA, SALVATORE
Employee/Petitioner

Case# **15WC029808**

15WC032461
15WC009502
16WC009942

NATIONAL TIRE & BATTERY
Employer/Respondent

19IWCC0413

On 8/25/2017, 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:

1927 HUGHES SOCOL PIERS RESNICK
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
TIMOTHY W ALBERTS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SALVATORE MESSINA
Employee/Petitioner

v.

NATIONAL TIRE & BATTERY
Employer/Respondent

Case # **15** WC **29808**

Consolidated cases: **15 WC 32461**
15 WC 9502
16 WC 9942

19IWCC0413

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **4/19/17**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

19IWCC0413

FINDINGS

On **8/15/15**, 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 $**66,202.76**; the average weekly wage was $**1,273.13**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**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 Arbitrator finds that all treatment to date has been reasonable and necessary. Respondent shall pay the following outstanding charges, according to the Fee Schedule:

ATI Physical Therapy	$3,715.36
Beloit Health System	$528.45
Illinois Orthopedic Network	$727.33
Metro Anesthesia Consultants	$2,052.78
Dr. Robert Wilson	$1,920.00

Permanent Total Disability: Respondent shall pay Petitioner permanent and total disability benefits of $848.75 per week for life, commencing 4/20/17, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the *Rate Adjustment Fund*, as provided in Section 8(g) of the Act.

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

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

Signature of Arbitrator

8/22/17
Date

AUG 25 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SALVATORE MESSINA
Petitioner,

v.

Case No: **15 WC 29808**

consolidated with: 15 WC 32461
15 WC 9502
16 WC 9942

NATIONAL TIRE & BATTERY
Respondent.

19IWCC0413

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Four Applications for Adjustment of Claim were filed in this matter which proceeded to hearing on April 19, 2017 in Geneva, Illinois.

Separate decisions will be issued for each case. The case at bar concerns 15 WC 29808.

FINDINGS OF FACT

Petitioner testified he worked as a store manager for National Tire and Battery ("Respondent"). His duties included managing personnel, customer service, telephone service, technical service, inventory, vehicle repairs, and store accounting. Petitioner testified that Respondent sold a wide variety of automobile vehicle repairs which involved moving tires up to the front service counter on a regular basis. Petitioner also ordered parts, dealt with parts that were returned, conducted inventory and store counts and opened and closed the store.

15 WC 32461

The parties stipulated that Petitioner sustained an accidental injury arising out of and in the course of his employment on July 22, 2013. (AX1)

Petitioner testified that while dealing with a customer issue, his right foot became stuck on an orthopedic mat located behind the service desk of National Tire & Battery. (TX 18). As he turned, his right knee popped and he began to fall. (Id. pgs. 18-19). He caught himself before hitting the ground. (Id. pg. 19). At the time, Petitioner weighed around 330 pounds. (Id.) He testified his current weigh was approximately 368 pounds. (Id.).

After the accident, Petitioner sought treatment with Dr. Robert Wilson, his general practitioner who recommended a conservative treatment plan consisting of medication management and physical therapy. (PX1, pg. 02). Petitioner testified that he took some personal time off work following the accident but continued working his regular duties as the manager of National Tire & Battery thereafter. (TX. pg. 21). Petitioner testified his right knee hurt following the accident and that he had a difficult time climbing stairs.

The records of Dr. Robert F. Wilson, Petitioner's family doctor, indicate that Petitioner presented on July 22, 2013, December 27, 2013 and June 4, 2014 with complaints of right knee pain for which the doctor prescribed pain medications.
(PX1, pg., 2).

~~15 WC 9502~~

The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on March 7, 2015. (AX2). Petitioner testified that as he walked towards the front service desk at National Tire & Battery, he tripped on the same orthopedic floor mat involved in the above-described accident. Petitioner testified that as he was falling, it felt like someone had tied up his feet. He fell forward onto his right knee which landed on the orthopedic mat while his head hit the tile floor and the right side of his body hit a wall. Petitioner testified he laid on the ground for a few minutes. Petitioner testified his District Manager Matt Gearhardt would not allow him to leave the store to seek immediate medical treatment due to inventory duties that needed to be completed.

The next day, Petitioner presented to the Beloit Memorial Hospital ER with a history of tripping on a mat at work falling onto his right side and hitting his chin upward on a desk. Complaints of pain to his neck, upper and lower back as well as bilateral knee pain were noted. (PX8, pg. 84). Petitioner further complained of pain that radiated down his lumbar spine into his right leg. (Id. at pg. 08). A CT of the brain and cervical spine were performed, as well as a CT's of Petitioner's thoracic and lumbar spine. (PX3, pg. 05). Pain medications were administered to Petitioner upon discharge.

Petitioner presented to Beloit Health System Occupational Health Center on March 10, 2015. (PX 3, pg. 2). Advance Practice Registered Nurse ("APRN"), Brian Mulder noted Petitioner's complaints of neck, bilateral knee and low back pain since March 7, 2015 when he "got his left foot caught on a mat behind the cash register" causing him to fall, hitting his head on a tile floor with his right arm extended to catch his fall. (Id.). Petitioner complained of numbness and tingling in his left hand, numbness and tingling in his right leg which extended to his right heel and weakness and burning in his right leg. Petitioner also reported difficulty sleeping due to neck, bilateral knee and low back pain. Petitioner reported taking one Norco, twice a day for his neck, for pain. He further reported bilateral knee swelling with near "give away" sensation in his right knee at times. Petitioner reported a history of injuring his right knee one year prior but that his right knee pain had resolved prior to this injury. (Id.). APRN Mulder instituted work restrictions consisting of: no bending or twisting, no lifting more than five pounds, sitting or standing for pain relief as needed, no over shoulder activity and no more than eight hours a day, 40 hours a week of work. (Id. pg. 01). Pain medications were prescribed and Petitioner was to follow up in two week's time. (Id.).

On March 17, 2015 APRN Mulder noted Petitioner's complaints of bilateral knee as well as neck and low back pain. (Id. pg. 9). Petitioner further reported numbness, tingling and weakness in his right leg at times and sleeplessness due to knee, neck and back pain. He reported taking Vicoprofen four times a day and one Cyclopbenzaprine, three times a day for his pain. He reported these medications were prescribed by his family doctor. He reportedly was following work restrictions but experienced an increase in knee, neck and back pain when he performed work duties outside those restrictions. (Id.). Petitioner's work restrictions were continued and he was to follow up in two weeks. (Id.).
On April 8, 2015, an MRI of Petitioner's right knee revealed patellar tendinopathy and chondromalacia. (PX4, pgs. 01-02).

On April 22, 2015, an MRI of Petitioner's lumbar spine showed moderate central spinal stenosis at L2-L3, moderate to severe bilateral foraminal stenosis at L3-L4, mild central stenosis and moderate to severe foraminal stenosis at L4-L5 and moderate to severe foraminal stenosis at L5-S1. (Id., pgs. 03-04).

An MRI of Petitioner's cervical spine, on June 5, 2015, revealed mild disc bulging diffusely at C3-C4 and C5-C6 with mild marginal bony spurring along the vertebral endplates and mild narrowing along the neural foramen bilaterally. (Id., pgs. 05-06).

A left knee MRI performed on June 5, 2015, showed edema along the anterior aspect of the left knee with a more conspicuous fluid intense collection noted as possibly posttraumatic. (Id., pgs. 07-08).

On June 10, 2015 Petitioner presented for initial consult with Dr. Fred A. Sweet, an orthopedic surgeon at Rockford Spine Center at the request of APRN Brian Mulder. (PX5, pg. 12). Petitioner reported a history of a work-related slip and fall accident on March 5, 2015 followed by "some numbness in the left arm and pain in the right buttock area with posterolateral thigh". He was noted to have pain in his left knee. (Id.). The doctor noted Petitioner "has had x-rays and MRI of the lumbar and cervical spine done on open magnets that are of very poor quality." (Id.). The doctor recommended MRI on closed magnet of the lumbar and right hip to determine if Petitioner has an acute disc herniation causing his right lower extremity pain versus injury to the right hip.

On June 12, 2015, Petitioner followed up with APRN Mulder with complaints of neck, upper back and low back pain that radiated into both thighs, primarily in the right leg as well as pain in the right buttock and right posterolateral thigh and left arm numbness. (Id., pg. 10, 12, 34). Petitioner reported improvement in his bilateral knee pain but reported continued swelling. Petitioner reported being "fairly miserable with the pain" which was worse with standing, walking and any kind of activity. (Id.). He reported taking Vicoprofen 4 times a day and Flexeril twice a day for pain.

An MRI of Petitioner's right hip on June 24, 2015, was significant for mile tendinosis and fraying at the gluteus medius attachment to the greater trochanter with mild adjacent soft tissue edema. (PX6, pg. 01).

A June 24, 2015, MRI of Petitioner's lumbar spine noted a small central and slightly paracentral inferior disc extrusion at L2-L3 interpreted as not appearing to cause nerve root displacement,
a small left paracentral disc extrusion at L3-L4 causing mild displacement of the left L4 nerve root, a small to moderate central and left paracentral disc extrusion at L5-S1 displacing the left S1 nerve root extending into the left lateral recess and minimal lumbar curvature convex on the left. (Id., pg. 6).

On June 29, 2015, Dr. Sweet noted he reviewed MRI studies of Petitioner' right hip and low back that were significantly better imaging studies than those he reviewed on initial consult. (Id. pg. 11). The doctor recalled that Petitioner initially presented with right buttock area and posterolateral thigh pain, noting upon review of the recent lumbar MRI, "he has predominately left-sided pathology that could give him some of the numbness that he was describing in the left leg but really does not account for his right buttock and hip pain." (Id.). The doctor further noted "MRI of the right hip does show some tendinosis and fraying of the gluteus medius attachment near the greater trochanter as well as some soft tissue edema; therefore, I suspect that most of his symptoms are most likely coming from soft tissue and tendinosis injury to the right hip". (Id.). Dr. Sweet recommended conservative treatment and indicated that given his findings and Petitioner's body mass index, surgical intervention was not indicated. (Id.). The doctor indicated follow-up appointments could be obtained on an as needed basis. (Id.).

On June 30, 2015, Petitioner presented to APRN Mulder with neck, low back, upper back and bilateral knee pain. (Id. pg. 40). He reported continued numbness, tingling and weakness in both legs. His bilateral knee complaints were improving although he did report popping at times. (Id.). Petitioner continued to take Vicoprofen 4 times daily and Flexeril 1 time per day. (Id.). He was working within his restrictions but reported increased pain when he engaged in increased physical duties at work.

On July 14, 2015, Petitioner presented to APRN Mulder with complaints of persistent numbness and tingling in both legs when sitting for long periods of time that increased initially when standing. (Id. pg. 46). He

further complained of shooting pain radiating down his legs with associated weakness. His bilateral knee pain was improving although he did report right knee swelling. Petitioner also reported shooting pain in his left arm two days prior, left arm numbness at times and increased neck pain. (Id.). Petitioner reported working within his restrictions with increased pain when he exceeded such. APRN Mulder continued Petitioner's work instructions and ordered physical therapy. (Id.).

Petitioner participated in physical therapy from July 21, 2015 through July 31, 2015. (PX3, pgs. 50-60).

On July 28, 2015 Petitioner presented to APRN Mulder with complaints of increased back pain that he related to the physical therapy he engaged in the day before. (Id. pg. 60). Petitioner further reported intermittent numbness and tingling in his left leg, bilateral leg weakness, and improving neck and bilateral knee pain. (Id.). APRN Mulder noted he would not need further care with respect to his bilateral knees and neck due to his continued improvement. Petitioner was instructed to return to work with restrictions related to his low back, follow-up with a neurosurgeon and return in two weeks

The Case at Issue
15 WC 29808

The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 15, 2015. (AX3). Petitioner testified while working at the front service counter he heard some swearing. He walked towards the noise where he found an irate customer in bay area one. Petitioner asked the customer if he could help him but the belligerent customer continued his tirade. Petitioner asked the customer to curtail his behavior. The customer then clenched his fist and started swinging at Petitioner who swung his neck backward and physically moved his body backward at the same time. As Petitioner turned to call the police, he tripped over the leg of a vehicle lift rack and caught himself on the service desk. He then called 911. Petitioner testified he would have hit the ground had he not extended his hands outward to support himself.

Petitioner testified that following the incident, he experienced pain in his whole body: neck, shoulders, arm, back, legs and knees. He left work early that day and went home.

Petitioner did not seek medical attention until three days after the occurrence. (PX3, pgs. 65-68). He testified that he does not like to be a problem person and tried to push through and do the best he could.

On August 18, 2015, APRN Brian Mulder noted Petitioner presented with a history of a work-related altercation three days before when a customer appeared as if he were going to hit the Petitioner, at which time, Petitioner "jarred his low back pain and neck" to avoid being hit. (PX3, pg. 66). APRN Mulder noted Petitioner's complaints of intermittent numbness and tingling in his legs and feet, increased left leg pain radiating into his foot and increased left-sided neck pain radiating to his left hand along with intermittent numbness in his left pinky finger. Petitioner reported taking Vicoprofen four times and one Flexeril per day. APRN Mulder noted Petitioner was to obtain a cervical and lumbar MRI and continued his work restrictions. (Id. at 68).

On September 1, 2015, APRN Mulder noted Petitioner's complaints of neck pain radiating into his left arm with left arm numbness, tingling and weakness. He further complained of numbness, tingling and weakness in his left leg. (PX3, pg. 70) Petitioner was instructed to engage in desk work only with the ability to sit or stand as needed.

On September 4, 2015, Petitioner presented to Dr. Jerome Kolavo on referral from Dr. Wilson. (PX7, pgs. 01-04). Petitioner complained of constant low back pain "that at times travels into the lateral thigh and posterior calf down to the heel." The doctor also noted a "variety of complaints referable to his neck, back and left arm."

Petitioner complained of pain in his left arm with numbness intermittently in an ulnar distribution of the forearm and fifth digit of the left hand as well as localized neck and left trapezius pain. On review of the June 24, 2015 lumbar MRI, the doctor noted a moderate left-sided L5-S1 disc herniation, a small left central bulging at L4-L5 and small central disc herniation at L2-L3, L3-L4 and to a lesser degree at L1-L2 which he noted as likely degenerative and chronic in nature. (Id.). Dr. Kolavo diagnosed intervertebral lumbar disc disorder with myelopathy, degeneration of lumbar or lumbosacral intervertebral disc, radiculitis of the left cervical region, and morbid obesity. Petitioner was instructed to perform light work only. (Id.). The doctor noted Petitioner's report that new lumbar and cervical MRI's were ordered by another physician which Dr. Kolavo thought appropriate. The doctor further noted, "My initial impression is that his pain and disability is disproportionate to radiographic and objective physical findings." (Id., pg. 4)

On September 25, 2015, Dr. Wilson noted Petitioner's complaints of right knee pain. (Id., pg. 05).

On October 13, 2015, a cervical MRI indicated minimal disc bulging with a possible small left lateral disc protrusion at C5-6 on the left. (PX6, pg. 04-08)

On October 13, 2015, a lumbar MRI indicated multiple levels of disc desiccation, disc bulging, disc protrusion and extrusion, causing multiple levels of neural foraminal and spinal canal narrowing:

- At L1-2, a question of a small central/right paracentral disc protrusion was noted.
- At L2-3, disc desiccation with a disc osteophyte complex formation and possible small protrusion to the left was indicated.
- At L3-4, disc desiccation with a central disc protrusion causing indentation in the thecal sac was noted.
- At L5-S1, disc desiccation with prominent disc protrusion and extrusion centrally with associated indentation on the thecal sac was indicated. (PX6, pg. 06).

On October 13, 2015, APRN Mulder referred Petitioner to orthopedic surgeon, Dr. Jeffrey Wingate of the Illinois Orthopedic Network.

Petitioner presented for initial consult with Dr. Wingate on October 21, 2015. (PX8, pgs. 51, 65). At that visit, Mr. Messina complained of severe low back pain with numbness and weakness in the left leg. He complained, secondarily, of severe neck pain radiating into his left upper extremity, left shooting pains across the shoulder into the back of the elbow and down through the dorsal aspect of his radial forearm into the ulnar two digits of the left hand. (Id.). Petitioner further complained of right-sided pain in the low back and knee, and pain in his right upper thigh. Petitioner reported a throbbing pain with standing or walking. (Id.).

On exam, the doctor noted Petitioner ambulated with a notable limp, antalgia, positive SLR on the left and a partial left drop foot. (Id.).

Dr. Wingate reviewed the MRI study from June 24, 2015, noting:

> *A massively herniated foraminal and extra-foraminal herniation of disc material on the left side from his L5-S1 disc space that severely displaces and even obliterates the normal exiting space for the L5 nerve root, as well as the transitioning left S1 nerve root. The radiologist agrees the disc material extends into the left lateral recess and neural foramen with remarkable narrowing. Above it at L4-L5, he has significant triangulations around the thecal sac, with left greater than right neural foraminal narrowing. I disagree with the radiologist's interpretation that this is 'no significant mass effect or canal narrowing appearance'.*

Above that at L3-L4, there is a left paracentral disk extrusion with inferior migration of the fragment displacing the L4 nerve root on the left side. [T]he patient has an element of congenital stenosis with shortening of the pedicles that creates some level of pre-existent narrowing from the exiting nerve roots within all of the neural foramina of the lumbar spine. (Id.).

The doctor also reviewed the October 13, 2015 cervical MRI scan noting disk dessication along the left central and paracentral herniation of disk material with narrowing of the central canal and left lateral recess and significant narrowing around the exiting C6 nerve root. No evidence of cervical myelopathy was noted although the doctor did note a reversal of normal lordotic curvature. The doctor indicated Petitioner is straight or kyphotic through the cervical spine, significant for increasing the effect against the C6 nerve root. (Id.).

Dr. Wingate noted both MRI's are low/resolution open scans, and given Petitioner's 380 lb. body weight, higher resolution scans would better elucidate the neural pathology. (Id.).

The doctor diagnosed Petitioner with left C6 radiculopathy, severe left L5-S1 radiculopathy, left extruded foraminal and extra-foraminal herniation at L5-S1 and a central herniated nucleus pulposus with radiculopathy at L3-4 and L4-5 on the left side. (Id. pgs. 66-67).

Dr. Wingate noted a treatment plan as follows: that Petitioner be imaged with high resolution MRI scans of the neck and back; the placement steroid solution into left side of cervical epidural space around the free fragment disk herniation at C5-6; selectively blockading the L5-S1 nerve roots, both in terms of diagnostically evaluating the radiculopathy complaints, as well as placing steroid solution around the highly inflamed nerve roots. (Id.).

The doctor further indicated that long-term, after more appropriately imaging the spine, invasive spinal care may be indicated given the duration of complaints and symptoms along with the severity of foraminal narrowing in the cervical and lumbar spine. (Id.).

Dr. Wingate forbade Mr. Messina from working. (Id.).

On October 30, 2015, Petitioner consulted with Dr. Thomas Poepping, an orthopedic surgeon at G & T Orthopaedics who noted a history of a March 7, 2015 work injury where Petitioner fell onto his right side. (PX9, pg. 1). Petitioner reported developing low back, right hip, and bilateral leg pain consequently. (Id.). Petitioner reported occasional right leg pain but his primary complaint concerned his numbness and pain radiating down the left leg. Petitioner further complained of some right knee pain. (Id.). On exam, the doctor noted right hip tenderness over the trochanteric bursa and severe midline and paraspinal tenderness of the lumbar region with positive SLR bilaterally. The doctor reviewed MRI of Petitioner's right hip noting some mild trochanteric bursitis. On review of a lumbar spine MRI, the doctor noted "severe L5-S1 degenerative disc disease with bulging of the disc at this level and severe bilateral neural foraminal narrowing." (Id., pg. 2). Dr. Poepping's noted an impression of lumbar radiculopathy and right hip trochanteric bursitis. The doctor further noted, "I think the majority of his symptomology is certainly coming from his back. I think his hip is fairly minimal at this point." (Id.). The doctor referred Petitioner to pain management for a trial injection and for a neuro surgery consult. He further noted Petitioner could return to seated work with position change as needed. (Id.).

On November 5, 2015, Dr. Sajjad Murtaza administered an epidural steroid injection to Petitioner's low back. (Id. pg. 126).

Cervical and Lumbar MRI's were performed on November 9, 2015. (Id., pgs. 138-139).

Petitioner next saw Dr. Wingate on December 2, 2015 at which time the doctor noted leftward free fragments at L5-S1 and a left paracentral disk extrusion with inferior migration at L3-4. (PX8, pgs. 94-95). Dr. Wingate

again noted that Petitioner not return to work. The doctor further noted that on a recent Saturday night, upon returning home after a 12- hour work day, Petitioner had the onset of a sudden feeling of warmth in his buttocks, and sustained an episode of encopresis in which he soiled his underwear. (Id.).

A CT lumbar myelogram with contrast on December 21, 2015 noted a clinical history of a herniated disk at L3-S1 and encopresis along with complaints of low back pain and pain extending into the lower extremities, left greater than right. (PX11, pgs. 01-04).

The lumbar CT was interpreted by Dr. Wingate on January 20, 2016, at which time he noted an "extruded left L5-S1 herniated nucleus pulposus completely filling/obliterating the left L5 neural foramen". (PX8, pg. 52). The doctor noted the study confirmed Petitioner had severe left L5 neural foraminal narrowing. The doctor further noted a "global level of spinal pathology" noting "severe retrolisthesis at multiple levels" and "moderate neural foraminal narrowing at L2-L3 where retrolisthesis exists" and degenerative scoliosis. (Id.). Dr. Wingate indicated "there is nothing normal anywhere in his lumbosacral spine" and that in order to "fix" or "directly address" Petitioner's severe degree of neural foraminal narrowing at L5, the severe level of retrolisthesis across the disc space and the end plate osteophyte spurring a combination of interbody and posterolateral fusion would be required. (Id.).

At the January 20, 2016 visit with Dr. Wingate, Petitioner complained of lower back, upper back, neck pain, numbness in the left arm and bilateral knee pain with numbness and tingling in the left knee (PX 8, pg. 55). He reported that laying down was extremely painful. (Id.).

At this visit Petitioner indicated he was working 55 hours a week. Dr. Wingate noted Petitioner's current duties at work where he was constantly on his feet and moving continuously, is more than Petitioner's body can physiologically support. (PX8, pgs. 52-53).

Dr. Wingate indicated he reviewed "several IMEs to date", that all of Petitioner's benefits had been terminated and that his employer was requiring him to work a 55-hour work week because he manages the facility. Petitioner reported when he first returned to this work schedule, after working two consecutive days on his feet for more than 13 hours per day, he experienced two episodes of encopresis. Petitioner further reported neck pain that has caused severe headaches and his left arm to go numb.

Dr. Wingate noted he disagreed with the IME opinion that Petitioner has been a long time opioid dependent. The doctor noted Petitioner had brought in 16 years of medical records dating back to October, 1999 and that his first prescription for opioid medication was for ankle pain in 2000 while the next prescription was not until the Petitioner's first July 2013 work accident. (Id.).

Dr. Wingate testified that the recent CT supported why Petitioner could potentially be losing control of his bowel and bladder function. (Id. pg. 23).

With respect to the doctor's actual recommendations regarding Petitioner's low back pain and left leg symptoms, the doctor did not recommend surgery, noting he did not have the "ability to provide care surgically for a patient" with a BMI of 52. (Id.).

Dr. Wingate recommended continued interventional pain management with application of steroids around the severely stenosed lumbosacral junction and cessation of all work. (Id.).

On February 18, 2016, Petitioner presented to Dr. Sajjad Murtaza with complaints of lower lumbar pain radiating "down his leg". The doctor noted significant pathology at L4-L5 with disk extrusions and nerve impingements at these levels. The doctor administered a lumbar transforaminal ESI on the left using fluoroscopic needle localization and epiroprim at L4-5 and L5-S1. (Id., pg. 125.

16 WC 9942

The parties stipulated that on March 25, 2016, Petitioner sustained accidental injuries arising out of and in the course of his employment. (AX4). Petitioner testified he was servicing a client, gathering and writing down vehicle information onto a clipboard. As he was returning to the building from the parking lot, he slipped on ice, fell forward and hit his head on the cement pavement.

Beloit Fire Department records indicate that upon arrival, Petitioner was found lying prone in the walkway of a place of business. (PX2, pg. 16) A small head contusion was noted as well as complaints of back and neck pain. A C-collar was place on Petitioner and he was transported to Beloit Memorial Hospital whose records indicate Petitioner was then transferred to Mercy Hospital in Janesville, Wisconsin, after a determination that the 390-lb. patient was above the weight limit for the hospital's CT scanner. (PX2, pgs. 01-16)

Records from Mercy Hospital note Petitioner's complaints of headache, posterior neck pain, left sided back pain, right wrist pain, amongst other complaints. Multiple x-rays of Petitioner's bilateral knees, pelvis and right wrist were taken as well as CT of Petitioner's head, neck, mid and low back. (PX13) Petitioner reported a history of chronic neck and low back pain with occasional paresthesia in the left lower extremity. (Id. p. 3).

The hospital ER opined that Petitioner exacerbated his chronic pain during the fall. (Id.). Petitioner was nauseous and light-headed after ambulating. (Id.). He was prescribed a wheeled walker for one month. (Id.).

Three days later, Petitioner followed up with Dr. Wingate, at which time, the doctor again instructed Petitioner to stay off work. (PX8, pg. 75).

Petitioner did not return to work and has not since the March 25, 2016 work accident.

Petitioner on March 31, 2016, presented to Dr. Murtaza who noted a history of the March 25, 2016 work-related fall. (Id., pgs. 23). Petitioner complained of significant neck pain and lower back pain radiating into his bilateral lower extremities, left greater than right, along with numbness and pins-and-needles sensation. (Id.). Petitioner further complained of right knee swelling that was visible on exam. Petitioner was wearing a C-collar. Dr. Murtaza recommended a bilateral TFESI with orthopedic follow-up for his right knee. The doctor dispensed Meloxicam, Pantaprazole, Cyclobenzaprine, and Vicoprofen. Lidoderm patches were prescribed. Petitioner was restricted from working. (Id.).

On April 7, 2016, Dr. Murtaza administered an L5-S1 lumbar transforaminal ESI. (Id., pg. 25).

Dr. Murtaza's May 5, 2016 records indicate Petitioner had been administered three lumbar injections to date with 5% relief. (Id. pg. 112). Petitioner continued to complain of significant low back pain with radiation to his bilateral lower extremities, left greater than right at a 9/10. (Id.). He further complained of bilateral knee pain, worse on the right. Petitioner had yet to see an orthopedist. He also complained of significant neck pain with radiation to the left upper extremity as well as constant headaches. Petitioner reportedly was applying for disability. Dr. Murtaza noted Petitioner was not a surgical candidate due to his weight and pathology in his spine. The doctor recommended re-starting physical therapy 2-3 times per week for 4 weeks, followed by a home exercise program. The doctor noted Petitioner "may not return to work". (Id.). Gabapentin was prescribed for neuropathic pain and a refill for Vicoprofen was noted. (Id.).

On July 7, 2016, Dr. Murtaza administered a cervical epidural injection at C5-6. (Id., pg. 26).

Petitioner went to ATI physical therapy on July 11, 2016 for an initial evaluation. (PX14, pgs. 19-20). The therapist noted that Petitioner presented with signs and symptoms consistent with cervicalgia and right knee pain. (Id., pg. 19). Petitioner was notably ambulating with a quad cane and a walker. (Id., pgs. 05, 19).

Petitioner began physical therapy on July 13, 2016, and attended eight sessions, through July 29, 2016. (Id., pgs. 04-11). Petitioner was noted to have suffered paralysis on July 28, 2016. (Id., pg. 02).

Petitioner, at the July 29, 2016 visit, felt worse, coughed, lost control of his muscles and fell. (Id., pg. 02).

At Petitioner's visit with Dr. Murtaza on August 4, 2016, Petitioner stated he experiences intermittent paralysis in the right arm which last for one to three minutes. (PX8, pg. 120). Petitioner also reported a 15% pain relief with the last cervical epidural injection on July 7, 2016. (Id.).

Dr. Murtaza, at the August 4, 2016 visit, noted Petitioner's complaints of headaches, neck pain, low back pain, upper extremity radiculitis, bilateral lower extremity radiculitis and right knee pain. The doctor opined that Petitioner is not a surgical candidate nor a good candidate for therapy as the therapy has only exacerbated his symptoms. No further treatment was recommended aside from long-term pain management. (Id. pg. 120).

Petitioner consulted with Dr. Edward Herba, a neurologist, on August 30, 2016. (PX8, pg. 34). Dr. Herba stated that Petitioner demonstrates a personal loss of sensation in both legs and both arms. (Id.) The doctor further stated he did not believe Petitioner had arthritic changes involving the spine. (Id.).

Petitioner presented to Dr. Murtaza on October 18, 2016 and November 8, 2016 at which time he noted no change in Petitioner's condition. (Id. pgs. 37, 39).

At Petitioner's visit with Dr. Murtaza on December 6, 2016, the doctor noted that Petitioner's wife helps him bathe and dress. (Id. pg. 02).

At Petitioner's visit with Dr. Murtaza on January 31, 2017, it was reported that Petitioner had another episode one week ago where his entire body became numb and tingly with paralysis for about one minute. (Id. pg. 05).

Petitioner saw Dr. Murtaza on February 28, 2017 and March 21, 2017 with no change, the doctor indicated Petitioner could not work. (Id. pg. 06).

At the hearing, Petitioner testified he last saw Dr. Murtaza a few weeks before the hearing.

CONCLUSIONS OF LAW

C) The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident of August 15, 2015.

The Arbitrator has already found a causal connection between Petitioner's accident of March 7, 2015 and his current condition of ill-being. (See Arbitrator's Decision and Addendum with respect to 15 WC 9502).

The parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 15, 2015. (AX3). Petitioner testified while working at the front service counter he heard some swearing. He walked towards the noise where he found an irate customer in bay area one. Petitioner asked the customer if he could help him but the belligerent customer continued his tirade. Petitioner asked the customer to curtail his behavior. The customer then clenched his fist and started swinging at Petitioner who swung his neck backward and physically moved his body backward at the same time. As Petitioner turned to call the police, he tripped over the leg of a vehicle lift rack and caught himself on the service desk. He then called 911. Petitioner testified he would have hit the ground had he not extended his hands outward to support himself.

Petitioner testified that following the incident, he experienced pain in his whole body: neck, shoulders, arm, back, legs and knees. He left work early that day and went home.

On August 18, 2015, APRN Brian Mulder noted Petitioner presented with a history of a work-related altercation three days before when a customer appeared as if he were going to hit the Petitioner, at which time, Petitioner "jarred his low back pain and neck" to avoid being hit. (PX3, pg. 66). APRN Mulder noted Petitioner's complaints of intermittent numbness and tingling in his legs and feet, increased left leg pain radiating into his foot and increased left-sided neck pain radiating to his left hand along with intermittent numbness in his left pinky finger. Petitioner reported taking Vicoprofen four times and one Flexeril per day. APRN Mulder noted Petitioner was to obtain a cervical and lumbar MRI and continued his work restrictions. (Id. at 68).

On September 1, 2015, APRN Mulder noted Petitioner's complaints of neck pain radiating into his left arm with left arm numbness, tingling and weakness. He further complained of numbness, tingling and weakness in his left leg. (PX3, pg. 70) Petitioner was instructed to engage in desk work only with the ability to sit or stand as needed.

At his deposition Dr. Wingate testified that Petitioner's underlying problems began with the March 7, 2015 work accident, opining that Petitioner's symptoms in his low back, legs, neck and left arm are causally related to that work-related accident. (PX15, pg. 29, 31).

The doctor further testified the subsequent injury of August 15, 2015, "did not do him any favors" in that "it certainly didn't lessen anything that was going on". (Id. pg. 31).

All IME doctors concede that Petitioner was injured on the date of the work accident although they conclude that Petitioner should have no continuing physical problems. All IME doctors opine that if Petitioner does have any current condition of ill-being, any such condition is simply degenerative in nature with no causal connection to any of the four work accidents. The Arbitrator finds this an untenable position given the preponderance of evidence contained in the record. (See Arbitrator's Decision and Addendum with respect to 15 WC 9502).

Based on the totality of evidence contained in the record, including the opinions of Dr. Wingate and the treating medical records, the Arbitrator finds the preponderance of evidence contained in the record supports a finding that the accident at issue aggravated and accelerated the injuries in Petitioner's low back, neck, bilateral knees, left arm and right hip caused by his March 7, 2015 accident (15 WC 9502). Accordingly, the Arbitrator finds there is a causal connection between the August 15, 2015 work-related accident and Petitioner's current condition of ill-being.

The Arbitrator finds that respondent has not paid all appropriate charges for all reasonable and necessary medical services and is liable for five medical bills that are currently in dispute.

The Arbitrator finds that all treatment to date has been reasonable and necessary. Respondent shall pay the following outstanding charges, per the Fee Schedule:

ATI Physical Therapy	$3,715.36
Beloit Health System	$528.45
Illinois Orthopedic Network	$727.33
Metro Anesthesia Consultants	$2,052.78
Dr. Robert Wilson	$1,920.00

What is the nature and extent of Petitioner's injuries?

Dr. Wingate testified that although Petitioner would benefit from a lumbar decompression and fusion, no hospital or surgery center in Illinois would allow such a procedure because of the risks involved in administering anesthesia to anyone with a BMI over 40. (PX15, pg. 24, 25).
Dr. Wingate further testified that if a fusion was performed on Petitioner, "we are not so much as fixing the problem as we are changing the problem". (Id., pg. 26). The doctor explained:

> *Unfortunately, that is a surgical procedure that carries a huge morbidity. There is probably at least an 80 or 85% chance that Mr. Messina would have some type of medical complication during that surgical procedure, or more importantly, in the first few days after that surgical procedure. And there is a huge problem that within two to four years after that operation that Mr. Messina would then have a surgically treatable lesion immediately above it at L3-4 and L2-3.* (Id., pg. 26).

Dr. Wingate testified Petitioner is medically unable to obtain gainful employment and that he should be considered completely and totally disabled. (Id. pg. 30). He further testified that "the most humane option" is to keep the inflammation down around the involved nerve roots and to lessen the stresses that go across that segment of the spine, even if it means taking the "unreconstructable patient completely out of work, completely removing him from the day to day stresses" and essentially putting him in a position where he can rest and "get rid of the inflammation" in these segments of the spine. (Id., pgs. 26-27).

Dr. Wingate testified that Petitioner's condition with respect to his left L5 and S1 nerve roots puts Petitioner at an increased risk for falls:

> *Indeed, this has already started to come true. He has now had several falls. I believe most recently he slipped on ice and was unable to recover his upright posture. There's no way that a patient of his stature with improperly functioning L5 and S1 nerve roots can possibly stay upright and keep themselves safe. (Id. pg. 29).*

When asked by Respondent if he considered referring Petitioner to physical therapy, work conditioning or vocational rehabilitation prior to concluding that Petitioner was medically unable to work, the doctor responded:

> *Physical therapy in this clinical scenario, in -- in my professional opinion, is -- is not warranted. With the degree of nerve root compression, with documented EMG and nerve conduction study findings of radiculopathy involving those nerve roots, and with severe stenosis around the nerve roots and, now, clinical episodes of encopresis, in my opinion it would be not warranted to pursue physical therapy per se.*
>
> *Pain management with steroid injections that could help to decrease the inflammation in those tissues as invasive forms of helping to manage the situation could be beneficial. And if there is a positive response to those injections then absolutely... would be warranted but to continue beating up severely constrained compressed nerve roots with further activity and further motion is not beneficial in this situation. (Id.).*

After questioning by Respondent's attorney, Dr. Wingate testified that he thought it was *possible* that Petitioner could perform sedentary work, but the following issues will arise:

> *[T]he sedentary position would have to accommodate to the fact*

that with his severe neurologic impingement and compression of those nerve roots he cannot maintain a seated position for probably more than 15 or 20 minutes he cannot maintain a standing position for more than 15 or 20 minutes he certainly cannot go out and walk any distances. (Id. pg. 37-38).

Dr. Wingate agreed with Respondent that if a hypothetical position that was sedentary in nature that could accommodate the switching from sitting to standing, then it would be a "win-win" for Petitioner. (Id. pg. 39).

At Petitioner's request, Thomas Grzesik, a certified rehabilitation counselor and licensed clinical professional counselor, met with Petitioner on November 30, 2016, reviewed treating medical records and conducted a battery of vocational tests. (PX17)

Mr. Grzesik opined, based on the opinions of Dr. Wingate and Dr. Murtaza, that Petitioner is unable to perform the responsibilities and duties of his former position for Respondent as a Store Manager. (PX15, dep. Ex. 2, pg. 26)

In determining that Petitioner was not an appropriate candidate for further vocational rehabilitation services, Mr. Grzesik considered Petitioner's post-work injury vocational profile (44 years old, 12 grade education, lack of transferable skills, work restrictions and learning and academic ability as tested) and applied the factors established in *National Tea Company v. IIC*, 73 Ill.Dec. 575 (1983).

He further testified that Petitioner is not qualified to do any at home, telecommuting-type of employment. There was nothing in the interview with Petitioner or in the records that would indicate Petitioner has a background for a home-based job. (PX17, pg. 27).

It was Mr. Grzesik's opinion that Petitioner is permanently and totally disabled under the guidelines set forth by the Illinois Workers' Compensation Commission. (PX17, dep. Ex. 2, pg. 26).

Based on the record as a whole, with particular reliance on the opinions of Dr. Wingate coupled and Mr. Grzesik, the Arbitrator finds Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act.

Respondent shall pay Petitioner $848.75/week for life, commencing April 19, 2017, as provided in Section 8(f) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MONTEL JONES,

Petitioner,

vs.

NO: 14 WC 30775
15 WC 20242
15 WC 20243 (cons)

FORD MOTOR COMPANY,

Respondents.

19IWCC0414

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 statute of limitations, causation, medical expenses, 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 or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

The Commission affirms the finding that Petitioner timely filed his Application of Adjustment of Claim. To summarize, Petitioner suffered an undisputed injury on June 6, 2011. Pursuant to Section 6(d), the filing deadline for an Application for Adjustment of Claim was three years from the date of injury or two years from the date of the last payment of compensation. There is no question the Application was filed outside the initial three-year period. As such, to survive Section 6(d), Petitioner's application must have been filed within two years of the last payment of compensation. Respondent's payment records demonstrate the last compensation was paid on December 16, 2013, that being payment of Dr. Sonnenberg's charges for the November 11, 2013 evaluation. RX7. Petitioner's unrebutted testimony was Dr. Sonnenberg was chosen by Respondent to evaluate Petitioner's work-related hand complaints. Given these facts, the statute of limitations for Petitioner to file an Application was extended to

19IWCC0414

December 16, 2015. As Petitioner filed his Application on September 12, 2014, the Application was timely and is not barred by the statute of limitations.

The Commission highlights Respondent stipulated that the accidental injury at issue herein manifested on June 6, 2011. ArbX2. Given the parties' stipulation on the issue, the Commission finds the Arbitrator's discussion of November 11, 2013 as a possible alternate manifestation date is unnecessary and we strike the second paragraph on Page 16 of the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $918.85 per week for a period of 11 2/7 weeks, representing July 14, 2015 through September 30, 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 shall pay the sum of $598.70 for medical expenses as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in §8(j).

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

IT IS FURTHER ORDERED BY THE COMMISSION that this 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.

19IWCC0414

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 - 2019

L. Elizabeth Coppoletti

LEC/mck

O: 6/19/19

43

Stephen Mathis

D. Douglas McCarthy

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

JONES, MONTEL
Employee/Petitioner

Case# **14WC030775**

15WC020242
15WC020243

FORD MOTOR COMPANY
Employer/Respondent

19IWCC0414

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:

0293 KATZ FRIEDMAN
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
DAN BRAINARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MONTEL JONES
Employee/Petitioner

v.

FORD MOTOR COMPANY
Employer/Respondent

Case # **14** WC **30775**

Consolidated cases: **15 WC 20242**
15 WC 20243

19IWCC0414

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **January 12, 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other **Statute of Limitations**

FINDINGS

On the date of accident, **June 6, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**71,670.56**; the average weekly wage was $**1,378.28**.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**5,785.39** in short term disability benefits under Section 8(j), for a total credit of $5,785.39.

Respondent is entitled to a credit of $**9,387.42** under Section 8(j) of the Act for medical expense.

ORDER

Respondent shall pay to Petitioner the sum of $918.85/week for temporary total disability for a period of 11-2/7 weeks, for the period from July 14, 2015 through September 30, 2015, pursuant to Section 8(b) of the Act, subject to the $5,785.39 credit Respondent shall receive, as described above, for amounts previously paid.

Respondent shall pay to Petitioner the sum of $598.70 for medical expenses, subject to the fee schedule, pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall further hold Petitioner harmless with respect to payments made by group health insurance in the amount of $9,387.42, pursuant to Section 8(j) of the Act.

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

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

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

19IWCC0414

Molly C Mason

Signature of Arbitrator

3/7/18
Date

ICArbDec19(b)

MAR 8 - 2018

19IWCC0414

Summary of Disputed Issues

In **14 WC 30775,** Petitioner, an assembly line worker, claims right hand injuries of June 6, 2011. Arb Exh 2B. The disputed issues in this case include causal connection, medical expenses, two intervals of temporary total disability, maintenance and whether the case is barred by the statute of limitations. In **15 WC 20242,** Petitioner claims a right thumb injury of January 9, 2008. Arb Exh 1B. The disputed issues include causal connection, medical expenses, the amount of Respondent's credit under Section 8(j), temporary total disability, maintenance and whether the case is barred by the statute of limitations. In **15 WC 20243,** Petitioner claims a right thumb injury of March 3, 2015 [as amended during the hearing, T. 95-96.] The disputed issues include accident, causal connection, medical expenses, temporary total disability and maintenance.

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent on December 6, 1999. Between late 2006 and 2012, he performed a job known as "moon roof secure." T. 20-21. His duties included using a handheld DC motor tool with a pistol grip to insert screws and bolts to secure the moon roof to the roof of a vehicle. T. 20, 22. Petitioner testified the tool vibrated only slightly but would "kick on the back end" as a bolt torqued out, "to make sure the bolt was secured to a specific torque reading." T. 21. Petitioner testified he held the tool in his right hand because he is right-handed. He had to turn the tool as necessary to shoot out bolts at different angles. T. 22-23. He testified he had to grip the tool tightly because otherwise it would "jump out of [his] hand" when it torqued. T. 22-23.

Petitioner testified his shifts lasted ten hours. He worked on approximately 600 vehicles per shift. He had approximately 50 to 52 seconds to work on each vehicle. The vehicles coming down the line included Tauruses, Explorers and Lincolns. He had to install five screws in each Taurus, six in each Explorer and seven in each Lincoln. T. 23-24.

Petitioner testified the "moon roof secure" job also involved "routing a floor loom," again within the 50 to 52-second window of time. He explained that wires from the gas tank ran through a rubber grommet that "had to be pushed through the floor pan" of the car. He had to lean over and forcefully use both thumbs to push down to fully "seat" the grommet so that water would not come back up into the bottom of the car. He also had to pus four locators down to make sure the loom stayed in a certain position. He used his right thumb and index finger to push each locator. T. 25-26. The Taurus vehicles differed from the others in that its loom was longer and had to be routed in an L shape. He had to push the Taurus locators at an angle rather than straight forward. T. 27-28.

Petitioner testified the "moon roof secure" job also involved installing mastic pads, or sound deadeners, into the front floor pan. Each pad was about 1 ½ or 2 feet long. He used his right thumb and index finger to peel a wax paper backing off of each pad and then flexed his wrist to get each pad inside the car. This task became more difficult when it was hot outside because the tar underneath the paper backing would get sticky, causing the paper to rip. When this happened, he had to go to the next pad because, if the paper was not properly removed, the pad would not adhere to the floor of the car. T. 29.

Petitioner testified that, while performing the "moon roof secure" job, he also had to use his right thumb to push a "big rubber plug" into the back fender. Each time a Taurus came down the line, he also had to lean into the vehicle, use his right hand to push a 3-headed "J" clip into a hole into the top part of the vehicle and then move his right index finger and wrist in such a way as to push the clip back toward him to get it to seat properly. He typically worked on at least 150 Taurus moon roof vehicles per shift. T. 31-32.

Petitioner testified that, on January 9, 2008, he was using his right hand to reach into a 6- to 8-inch opening over the right rear well of a vehicle when his cloth glove got caught on a metal berth that had not been properly shaved down. He felt his glove being pulled off. As he moved his right hand, in order to free the glove, his right thumb struck the top of the opening. The impact caused his right thumb to bend backward, toward his wrist. T. 33-34.

Petitioner testified he notified his supervisor of the accident. [Notice is not in dispute.] The supervisor gave him a pass so that he could go to Respondent's in-house medical facility. He underwent an X-ray at the direction of this facility and was then sent back to lighter work on a temporary basis.

Records in PX 1 reflect that Petitioner saw Maudester Fields, R.N., a nurse affiliated with Respondent, at 11:08 AM on January 9, 2008. Fields noted that Petitioner reported hyperextending his right thumb earlier that morning, after his glove got caught on a piece of metal. Fields indicated she sent Petitioner to Ingalls Hospital for X-rays, with the films showing subluxation of the thumb relative to the metacarpal to the ulnar side. Dr. Patricia Lewis, a physician affiliated with Respondent, provided Petitioner with an elastic bandage. PX 1, pp. 49-50.

Petitioner testified that, following the January 9, 2008 accident, he eventually resumed his "moon roof secure" duties but continued experiencing right thumb pain. He testified he continued to go to Respondent's medical facility, where he would be given ice, Ibuprofen and directions to resume working. He complained about his thumb to the point where he made a "nuisance" of himself. Personnel at the facility eventually told him to go across the hall to speak with "workers' comp." He followed this advice, spoke with someone called "Jennifer," who handled workers' compensation claims for employees whose names fell in "the first part of the alphabet" and obtained an appointment to see a doctor at Midland Orthopedics. Petitioner testified he had to speak with Jennifer five or six times before she set up the appointment. T. 37-38. He estimated that a "year or so" passed between the accident and the appointment. [The records in PX 2 do not correlate with this. They reflect that, after January 9, 2008, Petitioner underwent no thumb- or hand-related care at Midland Orthopedics until June 20, 2011.] During that period, the medical facility kept sending him back to his regular job. Petitioner believed it was this job that was causing his symptoms. T. 39. He also believed he had to wait for a referral because Respondent utilized a "queue." Although he felt he was not getting any results from the in-house physician, Dr. Lewis, he believed he had to wait his turn, per Respondent's protocol. T. 43-44.

Petitioner testified he reported another injury to Respondent on June 6, 2011. On that date, he asked his supervisor to send him to the in-house medical facility because he was experiencing burning in the palm of his right hand and numbness in his fingertips while performing his job. T. 40-41. Petitioner testified that, prior to June 6, 2011, Respondent brought "new motors over" that were "torqueing a lot harder." T. 40. When the gun "torqued out," it sometimes pushed on the back of his right hand and sometimes pushed his right thumb. T. 40-41.

Records in PX 1 reflect Petitioner saw Katrina Harvey, R.N. at Respondent's medical facility on June 6, 2011, with Harvey noting the following:

> "When the motor torques out it has a hard kick on the back end which puts stress on my wrist since 2006. States he has this problem in 2006 was seen in the medical dept x 2 but no follow for wrist until today."

On right wrist examination, Harvey noted no swelling and a normal range of motion. She diagnosed a right wrist sprain/strain secondary to "rep. mot." She provided Petitioner with an elastic bandage and found him fit for work. PX 1, pp. 80-81.

Petitioner returned to Respondent's medical facility the following day, June 7, 2011, and saw Dr. Lewis. The doctor recorded the following history:

> "C/o pain to R wrist since 2008. States he has been performing the same job since 2006 – moon roof secure job in trim department but lately pain has become increasingly worse and goes up R arm at times due to the increased number and longer work hours. R hand dominant. Denies previous R hand injury – other than a hyperextensi[on] injury to R thumb in 2006."

On right wrist examination, Dr. Lewis noted no swelling or erythema as well as full motion. She indicated Petitioner "refuses to allow passive extension or Finkelstein's test." She also described Petitioner as refusing ice and medication and taking an "unauthorized form." She found Petitioner fit for work. PX 1, pp. 82-83.

Records in PX 2 reflect Petitioner saw Dr. Brooker of Midland Orthopedic Associates on June 20, 2011. A medical history form bearing that date reflects a one-year history of right hand and wrist symptoms, with a date of onset of "10/ blank/10." The person who completed the form (apparently Petitioner) described the condition as work-related and indicated the condition developed when he was using a pistol grip tool at Ford to secure bolts in the moon roofs of various vehicle. PX 2, pp. 33-34. The doctor noted a complaint of intermittent numbness, tingling and pain on both surfaces of the right hand with resisted extension and flexion of the wrist. On examination, the doctor noted positive Tinel's, Phalen's and compression tests. He described Petitioner as "essentially involved with heavily repetitive usage of the hand." He recommended an EMG. PX 2, p. 26. Dr. Lipman conducted EMG/NCV studies of Petitioner's right upper extremity on June 30, 2011. He described Petitioner as right-handed. He noted that Petitioner "has worked at Ford for 13 years and, for the past 6 years, his job requires repetitive use of a pistol-grip on a power tool." He noted that Petitioner complained of numbness, tingling and pain in his right hand which was previously intermittent but now "nearly constant." He indicated the symptoms primarily affected Petitioner's first three fingers. He also noted "associated wrist pain." He noted positive Tinel's testing at the right wrist and significant callousing of both hands on examination. He rated the study as abnormal, indicating it showed "electrophysiologic evidence of right-sided median mononeuropathy at the wrist, or carpal tunnel syndrome." He described this condition as "mild in severity." PX 2, pp. 31-32.

Petitioner returned to Dr. Brooker on August 23, 2011. The doctor referenced the positive EMG findings but noted Petitioner did not have denervation or continuous numbness or tingling. He

prescribed a cock-up wrist splint to be worn when not working. He also prescribed therapy to "try and prevent the need for surgery." He directed Petitioner to return to him "in a few weeks." PX 1, pp. 14-17. PX 2, p. 25. There is no evidence indicating Petitioner returned to Dr. Brooker after August 23, 2011.

Based on the "workers' compensation system claim activity report" in RX 7, Respondent made payments to Neurology Consultants on July 28, 2011 and payments to Midland Orthopedics on August 31, 2011 and October 11, 2011. RX 7.

Under cross-examination, Petitioner acknowledged taking a medical leave of absence from work from March 2012 through May 2012. He took this leave due to foot and hip problems that were not related to work. T. 70.

Petitioner testified he spoke with Michelle Gregory, another of Respondent's workers' compensation employees, after "Jennifer" went out on a medical leave. He recalled first speaking with Gregory in 2012 or 2013. She told him she "would take care of it" but nothing happened. Over time, he spoke with her on ten or more occasions, asking her to send him to a specialist for his hand. She never refused to send him but, as time went by, she seemed to be "getting mad" at him for asking. On several occasions, she told him she could not access the necessary information because his file was "in her living room on the floor." T. 47-51. At one point, he suggested she send him to Dr. Brooker because he had seen this doctor for a leg problem in the past. [Records in PX 2 reflect Petitioner saw Dr. Brooker in 2007 and 2008 for treatment of a left femur fracture that required surgery.] She then came up with Dr. Sonnenberg, a physician he had never seen. T. 52.

Petitioner testified he first saw Dr. Sonnenberg in November 2013. T. 48, 51. He did not have to discuss billing arrangements with the doctor. To his knowledge, Respondent's workers' compensation department paid the bill. T. 52. Dr. Sonnenberg recommended both carpal tunnel surgery and right thumb surgery.

Dr. Sonnenberg's initial note of November 11, 2013 sets forth a history of a right thumb hyperextension injury at work "in 2011." The doctor noted complaints of intermittent right thumb pain and right hand numbness "for several years now." On right thumb examination, he noted an obvious deformity of the MP joint with varus angulation of the joint, tenderness and laxity over the radial collateral ligament and "discongruity [sic] movement over the right thumb MP joint" due to the laxity. He also noted positive Phalen's and Tinel's signs over the right wrist. He obtained X-rays of the right hand and thumb, with the thumb films showing a varus deformity.

Dr. Sonnenberg diagnosed a work-related ruptured radial collateral ligament of the right thumb. He also diagnosed right carpal tunnel syndrome which he felt might be work-related based on Petitioner's complaint of "constant pressure in his right wrist while at work." He recommended surgical reconstruction of the right thumb radial collateral ligament and a right carpal tunnel release. He indicated Petitioner agreed with this recommendation. He scheduled the surgery for December 3, 2013. He indicated he was sending a copy of his note to Michelle Gregory via facsimile. PX 1, pp. 11-13.

Petitioner testified he called a designated phone number on the day before the scheduled surgery to confirm. Dr. Sonnenberg's office later told him that the surgery had to be cancelled due to lack of workers' compensation authorization. T. 55. After he learned of the cancellation, he contacted

Gregory, who told him she was going to send him "for an IME." He did not know what she was referring to. T. 55.

On September 12, 2014, Petitioner filed an Application for Adjustment of Claim numbered 14 WC 30775 alleging injuries to his right hand and body on June 10, 2011. Arb Exh 2C.

On December 26, 2014, Respondent's counsel forwarded unidentified medical records to Petitioner's counsel, via E-mail, and raised a statute of limitations defense "as to both the thumb and the CTS." RX 4.

Petitioner returned to Dr. Sonnenberg on March 9, 2015. He completed a form on that date indicating his right thumb "gave out" while he was working on a right side dash pad. PX 2, p. 8. The doctor noted complaints of gradual deterioration of the right thumb as well as carpal tunnel. On re-examination, the doctor noted laxity of the radial collateral ligament to the right thumb, tenderness over the thumb MP joint, positive Tinel's and Phalen's signs over the median nerve at the wrist and no thenar atrophy. The doctor obtained right thumb X-rays which showed varus deformity of the MP joint with some early arthritic formation. The doctor indicated he now viewed a fusion of the MP joint as a more appropriate surgery, based on the developing degenerative changes in the MP joint, as opposed to the ligament reconstruction he previously recommended. He again recommended a right carpal tunnel release. After noting that Petitioner expressed uncertainty as to whether he would be able to secure approval for these procedures from workers' compensation, he fit Petitioner with a flexible thumb brace. He indicated he sent a copy of his note to Michelle Gregory via facsimile. PX 2, p. 6.

Petitioner saw Dr. Sonnenberg again on April 6, 2015. The doctor's note reflects that Petitioner reported deriving little benefit from the brace and expressed a desire to undergo a ligament reconstruction rather than a fusion. The doctor described Petitioner's right thumb problems as dating back to a work injury occurring in 2008. He again indicated that fusion would be a better choice, surgery-wise, but noted that Petitioner wanted "to take his chances with a radial collateral ligament reconstruction." He scheduled this surgery for April 24, 2015 and again indicated he was sending his note to Michelle Gregory via facsimile. PX 2, p. 5.

Petitioner testified that Dr. Sonnenberg ultimately provided him with a denial letter, which he took to his own physician. From there, he was referred to Dr. Moffitt, a different orthopedic surgeon. He felt he had "no choice" but to see Dr. Moffitt, given the denial and his worsening hand symptoms. T. 57. Dr. Moffitt is within his group insurance network. T. 57-58.

Records in PX 1 reflect that Petitioner saw Mary Brown, R.N. at Respondent's medical facility on April 22, 2015 and requested "heat for right hand." Brown noted a complaint of numbness and burning pain radiating up Petitioner's right arm. PX 1, p. 68. Petitioner returned to the facility later the same day, with a different nurse, Katrina Harvey, R.N., indicating he requested that "something [be] done for his hands" and that "this problem has been going on since 2011." PX 1, p. 68. Petitioner then saw Dr. Lewis, who noted Petitioner was scheduled to undergo surgery by Dr. Sonnenberg two days later. On examination, Dr. Lewis noted that Petitioner was unable to completely oppose his right thumb. She also noted weakness with extension at the DPJ of the right thumb. She "advised [Petitioner] to speak with workers' compensation concerning IME and upcoming surgery, as well as to contact Dr. Sonnenberg's office concerning restricted work." PX 1, p. 63. Petitioner returned to the facility the following day, with Mary Brown, R.N. indicating that Petitioner was again requesting heat, appeared to be upset and complained of 9/10 right hand pain. PX 1, p. 70. Also on that date, Phyllis Wright, R.N. noted that

Petitioner produced a slip from the Franciscan Hammond Clinic restricting him from using his right hand until he could be cleared by an orthopedist. PX 1, p. 72.

On May 13, 2015, Dr. Moffitt prescribed an EMG and released Petitioner to work with no use of the right hand. PX 1, p. 26.

On June 18, 2015, Petitioner filed an Application numbered 15 WC 20242 alleging a right thumb injury of September 1, 2011. Arb Exh 1C.

Petitioner testified that Dr. Moffitt performed a carpal tunnel release on July 14, 2015. PX 4, pp. 2-3. The doctor's records reflect he released Petitioner to light duty, with limited use of the right wrist, as of October 1, 2015. PX 1, p. 33.

Petitioner testified that, with respect to his thumb, Dr. Moffitt referred him to Dr. Mejia, who he described as a "super specialist." Dr. Mejia performed a right thumb fusion on November 6, 2015 and released him to restricted work as of November 16, 2015. [See below for a summary of Dr. Mejia's deposition testimony.]

Petitioner testified he underwent a functional capacity evaluation in August 2016, at Dr. Mejia's direction. Following this evaluation, Dr. Mejia imposed permanent restrictions. T. 59.

Records in PX 7 reflect Petitioner underwent a functional capacity assessment at ATI on June 30, 2016. The evaluator, David Noble, MS LAT, rated the evaluation as valid. He indicated he did not receive a job description. He described Petitioner as a right-handed assembler at Respondent who is required to use tools to assemble vehicles. PX 7, pp. 2-3. He found Petitioner capable of working an 8-hour day. With respect to specific activities, he found Petitioner capable of occasional bilateral lifting of 10.4 pounds above shoulder level, occasional lifting of 1.2 pounds above shoulder level with the right arm (versus 28.4 on the left), occasional bilateral desk/chair lifting of 43.4 pounds, frequent bilateral desk/chair lifting of 14.8 pounds, occasional right desk/chair lifting of 15.2 pounds (versus 58.8 on the left), occasional bilateral chair/floor lifting of 50.6 pounds, frequent bilateral chair/floor lifting of 17.0 pounds, occasional pushing/pulling of 106.3 pounds, frequent pushing/pulling of 29.5 pounds, occasional right carrying of 47 pounds (versus 62 on the left), frequent right carrying of 22 pounds (versus 42 on the left) and minimally occasional crawling and right hand firm grasping. He recommended against Petitioner performing any frequent bilateral or right lifting above shoulder level. He described Petitioner as demonstrating "deficits in lifting as well as grip tolerances with the right." Based on the Dictionary of Occupational Titles, he rated Petitioner's assembly job as a medium physical demand level occupation. He found Petitioner capable of performing at this level. PX 7, p. 2.

On August 25, 2016, Petitioner filed an Amended Application for Adjustment of Claim in 14 WC 30775 alleging a right hand injury of June 7, 2011. Arb Exh 2A. Petitioner also filed an Amended Application in 15 WC 20242 alleging a right thumb injury of January 8, 2008. Arb Exh 1A.

Petitioner testified he began working for Respondent on a light duty basis on November 16, 2015, driving cars from the "water line" to the "sell line" or repair area. T. 61. About a year later, in late 2016, he was transferred to the paint department for two months and then transferred to the trim department for two weeks. The trim job involved inspecting parts. He last worked for Respondent on March 1, 2017. He worked an entire shift that day. He reported to work the following morning, at which point he was told Respondent could no longer accommodate him. He was sent home. T. 60.

Petitioner testified he did not work in any capacity between March 2, 2017 and December 3, 2017. T. 63.

At Respondent's request, Dr. Vitello, an orthopedic surgeon, examined Petitioner on July 12, 2017. In his report of the same date, Dr. Vitello indicated he reviewed treatment records from Respondent's medical facility (with those records dating back to February 2003) along with records from Dr. Brooker, Dr. Sonnenberg, Dr. Mejia and ATI.

On right thumb examination, Dr. Vitello noted a well-healed 5-centimeter incision, 10 to 15 degrees of fixed flexion at the MP joint, no IP joint instability, solidity of the MP joint with no tenderness to varus and valgus stress, abduction of the CMC joint greater than 70 degrees and no triggering or locking of the A1 pulley. He noted right key pinch strength of 14 pounds on the right versus 19 on the left. On right wrist examination, he noted no swelling or tenderness, a range of motion to 60 to 70 degrees of both flexion and extension, 20 degrees of radial deviation and 30 degrees of ulnar deviation without pain. He also noted negative Tinel's and Phalen's tests, 5/5 strength and no atrophy. He noted grip strength of 42 pounds on the right versus 62 on the left. He obtained right hand X-rays. He interpreted the films as showing a well-fused MP joint of the right thumb fixed with a headless screw.

In response to a question asking "what is your diagnosis for the hand, wrist and thumb?", Dr. Vitello responded: "successful right thumb MP joint fusion." With respect to causation, he opined that the single reported event of hyperextending the thumb [on January 9, 2008] did not cause or accelerate the degenerative changes that ultimately led to the need for the fusion. He further opined that "over time, the unstable MP joint degenerated to a point that he required MP joint fusion." He characterized the right thumb treatment, including the fusion, as reasonable and necessary. Based on the X-ray, he felt Petitioner did not require any additional right thumb treatment. He found Petitioner capable of medium physical demand level work as determined by the June 30, 2016 functional capacity evaluation. He found Petitioner to be at maximum medical improvement. RX 6.

Dr. Mejia testified by way of evidence deposition on July 31, 2017. PX 4. Dr. Mejia testified he is board certified in orthopedic surgery and has added qualification in hand surgery. PX 4, pp. 5-6.

Dr. Mejia testified he first saw Petitioner on July 29, 2015, based on his records. PX 4, p. 7. Petitioner complained of right thumb pain of several years' duration. He indicated he was originally hurt on the assembly line, when his thumb was pulled after getting caught on a piece of metal. PX 4, p. 8. He had also undergone a carpal tunnel release but "that had resolved." PX 4, p. 8.

Dr. Mejia testified that, on initial examination, he noted ulnar deviation of the right thumb at the MCP joint, "indicating there is incompetence of the ligament supporting on the radial aspect." He also noted decreased grip strength compared with the left side and a tendency for the thumb to rotate with flexion. PX 4, pp. 8-9. Petitioner indicated he had access to X-rays taken on a previous occasion, which he planned to bring in. Dr. Mejia testified he provided Petitioner with a brace and a sleeve. He also prescribed occupational therapy. PX 4, p. 10.

Dr. Mejia testified he next saw Petitioner on October 6, 2015. The X-rays he obtained on that date showed marked subluxation in an ulnar direction. He ordered X-rays because Petitioner did not bring the previous X-rays and he did not want to operate "blind." PX 4, pp. 13-14.

Dr. Mejia testified that once an individual has had a torn ligament for a while, "the joint will not wear normally" and "will develop marked arthritis." He did not recommend ligament repair to Petitioner because "if you repair a ligament on a rough joint, an arthritic joint, all you're doing is increasing contact stress on a joint that no longer glides well." PX 4, p. 14. Petitioner was still in pain, despite undergoing therapy for six weeks. He thus recommended arthrodesis, or fusion. PX 4, p. 15. He has performed small bone and joint fusions every couple of months since 1996. PX 4, p. 16. Petitioner "did well" following the fusion but did not feel strong enough to resume full duty. A post-operative CT scan showed fusion of the joint but Petitioner lacks the ability, "by his estimation, to do the work he was doing before." PX 4, p. 16. Petitioner "works on an assembly line that requires probably more aggressive use of his hands than most." PX 4, p. 17.

Dr. Mejia testified he last saw Petitioner on August 4, 2016, following the CT scan. He imposed permanent restrictions on that date. He arrived at these restrictions by discussing Petitioner's job with him. He did not see any functional capacity evaluation. PX 4, p. 19. The restrictions he imposed were: no use of power tools, no repetitive use of the right hand, no lifting, pushing or pulling more than five pounds with the right hand, no lifting over ten pounds with both hands and "okay to drive with both hands." PX 4, p. 19. After looking at the functional capacity evaluation, Dr. Mejia testified the evaluation did not, for the most part, cause him to alter his restrictions. The evaluator actually recommended that Petitioner lift no more than one pound overhead. PX 4, p. 21.

Dr. Mejia testified that the right thumb injury Petitioner described could have caused the collateral ligament to tear, based on the X-rays taken on January 9, 2008. PX 4, p. 23. If an acute radial collateral ligament tear goes untreated, the individual may develop arthritis. PX 4, p. 24. Such a tear requires casting, at a minimum. PX 4, p. 25. In the report he issued, he opined that the need for the fusion resulted from the original 2008 injury and the second, aggravating injury. PX 4, p. 26. Mejia Dep Exh 2. The degree of degeneration of Petitioner's joint does not typically result solely from the aging process.

Under cross-examination, Dr. Mejia testified that, at the initial visit, in 2015, Petitioner mentioned having injured his thumb a few years earlier. His initial and second notes do not mention any recent injury. PX 4, pp. 30-31. By the time he saw Petitioner, a fusion had already been recommended. PX 4, p. 30. He performed the fusion on November 6, 2015. In his October 17, 2016 note, he mentioned a reinjury but he did not provide specifics. PX 4, pp. 33-34. The lack of treatment in 2008 and 2009 caused the degeneration to increase. PX 4, p. 34. He knows Petitioner works on an assembly line but he does not recall his specific duties or the tools he uses. PX 4, p. 35.

On redirect, Dr. Mejia clarified that both the injury and the subsequent lack of treatment resulted in the progression of the arthritis. PX 4, p. 36.

Edward Rascati, a certified vocational counselor affiliated with EJR Consulting, conducted an initial vocational evaluation of Petitioner on October 5, 2017. In his report of October 6, 2017, Rascati described Petitioner as "very candid and cooperative" throughout the evaluation. He documented the treatment to date and noted Dr. Mejia's permanent restrictions. He also noted that Petitioner reported having a high pain tolerance and attempting to use his right hand as little as possible. He indicated that Petitioner reported graduating from Thornton High School in 1995 and taking various classes at Respondent and through his union. He noted that Petitioner had worked at UPS and in several warehouse jobs for a few years before beginning to work for Respondent in 1999. He indicated

Petitioner was currently on a medical leave and wanted to return to work for Respondent. He described Petitioner as having only basic computer skills.

Rascati opined that Petitioner's "greatest vocational opportunities would be in returning to work at [Respondent] in the EQI position (or similar), which is within his restrictions and is a position that he has performed." He went on to state that, if this was not possible, Petitioner would benefit from professional vocational placement assistance, given his limited transferable skills. He indicated Petitioner "would be precluded from even light factory work due to the restriction of no repetitive use of his right hand." He stated Petitioner would likely earn between minimum wage and $10 per hour. PX 10.

Respondent's Section 12 examiner, Dr. Vitello, testified by way of evidence deposition on November 6, 2017. RX 5. Dr. Vitello is a fellowship-trained physician who specializes in hand and upper extremity surgery. He is board certified in both orthopedic and hand surgery. RX 5, p. 4. Vitello Dep Exh 1. He performs 400 to 500 hand surgeries annually. RX 5, p. 5.

Dr. Vitello testified he examined Petitioner on July 12, 2017, at Respondent's request. In connection with the examination, he reviewed multiple treatment records, including records from Respondent's medical facility. Those records dated back to 2003. The first record to mention the right thumb was dated January 9, 2008. RX 5, p. 7.

Dr. Vitello testified that Petitioner provided a history of a January 8, 2008 right thumb hyperextension injury and right hand and wrist symptoms developing in June 2011. RX 5, p. 10. Petitioner did not mention any February 2015 or March 2015 work accident to him. RX 5, pp. 10-11. After examining Petitioner, he diagnosed a healed MP joint fusion. In his opinion, the reported hyperextension injury "did not accelerate or contribute to [Petitioner's] underlying condition because he had a chronic radial collateral ligament tear and the degeneration of the right thumb was a natural progression of the pre-existing 2008 injury." All of Petitioner's right thumb treatment was reasonable and necessary. RX 5, p. 12. It was a judgment call as to what type of surgery to perform but a ligament repair is typically not recommended when the patient has any degree of arthritic change or wear in the joint. RX 5, p. 12. A ligament repair could make an arthritic joint worse. RX 5, p. 13.

Dr. Vitello found Petitioner to be at maximum medical improvement and capable of medium physical demand level work per the functional capacity evaluation. RX 5, p. 13.

Under cross-examination, Dr. Vitello testified that Petitioner likely signed a consent form at his office but did not complete any intake form. RX 5, p. 15. He confined his examination to Petitioner's right hand and right thumb. He found no evidence of carpal tunnel syndrome during his examination. He was not asked to render any opinions concerning carpal tunnel syndrome and has no such opinions. RX 5, p. 17. Dr. Sonnenberg originally recommended a ligament repair, in 2013, but by 2015, this was no longer the best surgical option. After Dr. Mejia recommended a fusion, Petitioner consented. RX 5, p. 21.

Dr. Vitello testified he charges $1,000 per examination. RX 5, p. 23.

Dr. Vitello agreed that the Respondent medical facility records predating January 2008 contain no mention of the right thumb. RX 5, p. 25. Petitioner had a chronic radial collateral ligament tear as of the fusion surgery but the real reason for the fusion was the underlying MP joint arthritis. RX 5, p. 26.

Petitioner developed arthritis in the joint due to the laxity of the joint and the abnormal wear and mechanics resulting from the tear. RX 5, p. 27. The tear played a role in the development of the arthritis. RX 5, p. 27. He does not know exactly when Petitioner tore his radial collateral ligament. He could have torn it, or not, when he hyperextended the thumb in January 2008. The only way to determine whether a tear exists is to perform an MRI but Petitioner only underwent X-rays in January 2008. RX 5, p. 28. Nothing he reviewed showed any right thumb problems predating January 2008. RX 5, p. 28. The radial collateral ligament plays less of a role than the ulnar collateral ligament when it comes to gripping objects but "it might play a role that is unquantifiable." RX 5, pp. 29-30. Without a job video, it is difficult to say whether certain activities performed by a person with a torn radial collateral ligament would accelerate the development of arthritis. RX 5, p. 30.

Petitioner testified that, around Thanksgiving 2017, Respondent contacted him and told him a light duty job was available. On December 4, 2017, he resumed working in Respondent's trim department. His current duties consist of seating one locator per vehicle. He explained that the manufacturer placed this locator "off spec," about an inch away from where it was supposed to be. He helps the regular operator by placing this locator. T. 64-65.

Petitioner testified he currently experiences constant pressure inside the second joint of his right thumb. The pressure is uncomfortable. When he bends the top thumb joint, he feels a clicking sensation. His symptoms get worse when he performs any sustained activity with his right hand. He now uses his left hand to open a bottle of soda. He has difficulty using his right hand to open a bag of chips. He can wiggle his right thumb but cannot bend the thumb at the joint closest to the hand. T. 66-67.

Under cross-examination, Petitioner testified he was working on a Taurus at the time of his January 9, 2008 injury. He underwent treatment at Ingalls Hospital following this injury. He spoke with Jennifer about the injury between 2008 and 2011. If a worker is injured at Respondent, he is required to speak with his "process coach," who gives him a pass to go to the in-house medical facility. Each pass should appear in his medical records from Respondent. T. 68-69. He performed full duty between January 9, 2008 and June 6, 2011. He went to Respondent's medical facility on June 6, 2011 and complained of right wrist pain since 2008. In July 2011, Dr. Brooker diagnosed him with carpal tunnel syndrome. He took a personal medical leave of absence from March through May 2012, due to hip and foot issues. T. 70. He underwent hip and foot care at Franciscan Hammond Clinic. PX 4. His hip and foot issues are not work-related. T. 71. He first saw Dr. Sonnenberg in November 2013. The doctor recommended a radial collateral ligament reconstruction. T. 71. He retained counsel in September 2014. He did not learn in December 2014 that his claims were being denied based on the statute of limitations. T. 72. He returned to Dr. Sonnenberg on March 9, 2015 and complained of right thumb pain since 2008. He told the doctor what happened on March 3, 2015. T. 72. Specifically, he told the doctor his right thumb "completely collapsed" on that date while he was pushing a plug into the fire wall of a vehicle. T. 73. He went to Respondent's medical facility on March 3, 2015, after reporting the injury to his supervisor, Eric Willis. It was Willis who gave him a pass to go to the facility. T. 74. Dr. Sonnenberg eventually recommended a right thumb fusion. Dr. Moffitt performed a carpal tunnel release in July 2015 and Dr. Mejia performed a right thumb fusion on November 6, 2015. He performed therapy at ATI following the surgeries. As of March 10, 2016, he was still subject to a restriction of no use of the right hand. He believes this restriction remained in place until the functional capacity evaluation. T. 75. He does not know whether the evaluator found him capable of resuming his prior job. T. 76. When he saw Dr. Mejia, following the evaluation, he (Petitioner) did not feel capable of resuming his "moon roof secure" duties. T. 76-77. Dr. Mejia imposed permanent restrictions of no pushing, pulling or lifting over

5 pounds with his right hand and no lifting over 10 pounds with both hands. He last saw Dr. Mejia in August 2016. T. 77.

On December 29, 2017, Petitioner filed a Second Amended Application for Adjustment of Claim in 14 WC 30775 changing the date of accident to June 6, 2011. Arb Exh 2B.

Petitioner testified he continues to bowl but now bowls left-handed. Before the accident, he did not feel as if he bowled frequently. He played a couple of hundred games per year. T. 78. He has frequently bowled in leagues. He does not keep track of the exact number of games he plays annually but he "guesses" he bowled about 123 league games in 2007 and 232 in 2009 – 2010. During that period, he used his right hand to bowl. He used a "fingertip grip." T. 79. The bowling ball he currently uses weighs 14 pounds. He originally stated he switched from right- to left-handed bowling in August 2017, when the season started. T. 81. He then corrected himself and indicated he began bowling left-handed in August 2016. He took a year off from bowling after the November 2015 thumb fusion. T. 81. He currently bowls three games every Friday. T. 82.

Petitioner testified he owns two motorcycles: a 1997 CBR and a 2006 Yamaha Stratoliner. Harley motorcycles vibrate but the ones he owns do not. He has not ridden the CBR since he underwent surgery. He bought the Yamaha because you do not have to lean down, putting pressure on your hand, with that brand. He rides the Yamaha from time to time. T. 83-84. Before his surgeries, his right hand hurt when he rode a motorcycle. In fact, almost everything he did caused right hand pain. T. 84. In 2013, he would ride for as long as an hour, "stop and go." T. 84.

Petitioner testified his son has a black belt in martial arts. He assists with his son's training only by getting him to practices and meets. He has never done anything interactive, in terms of the training, that would put his right hand in jeopardy. T. 85.

On redirect, Petitioner testified he took a year off after the 2014-2015 bowling season ended. That season ended in April 2015. He has bowled since he was 6 years old. He grew up in bowling alleys. He has had bowling balls customized by having resin poured into the holes and moving the thumb hole over, to try to take pressure off his hand. He has had this done "countless times over the years." T. 87. The first customization did not work. The hole was moved but it still was not in the right spot. He found it painful to bowl with his right hand but he continued to bowl. Prior to his thumb fusion, he was worried he would never be able to resume bowling. Since the fusion, he has not tried to bowl right-handed. It would not be worth it because his thumb could get stuck, causing the internal fixation to "snap." T. 89.

Petitioner identified page 20 of PX 1 as an accident report he completed at the request of the medical department. The handwriting in the margins is not his but the other writing is. T. 90. This report describes the plug-related accident. He had to put his thumbs together and forcefully push the plug. The fit was tight and he had to lean his body weight into it. As he pushed, his right thumb collapsed and bent inward. The pain he felt after this incident was a "whole lot" worse than his previous right thumb pain. T. 93. His thumb never went back into its proper position after the incident. T. 94. He completed the accident report on the date of the accident but the report is undated. He knows the accident did not occur in February 2015. He believes it took place on March 3, 2015. T. 95. [At this point in the hearing, Petitioner's counsel made an oral motion to amend the date of accident in 15 WC 20243 to March 3, 2015. Respondent did not object to the amendment. T. 95-96.]

Under re-cross, Petitioner testified that the United States Bowling Congress records in RX 10 appear to be accurate, in terms of the games he played and the leagues he played in. T. 97.

On further redirect, Petitioner testified the records in RX 10 show the league he played in, his average scores, the hand he used to achieve that average and the bowling alleys the leagues were associated with. The records show he bowled left-handed during the 2016 – 2017 season. T. 99. His left-handed scores do not compare with his right-handed scores but he is proud of them. T. 100.

Robert Kinsch, a social media investigator affiliated with Frasco Investigative Services, testified on behalf of Respondent. Kinsch testified he has worked as a team lead for Frasco for almost two years. T. 102. Respondent retained him to perform a social media investigation of Petitioner. He was provided with Petitioner's name and date of birth but no picture. He correctly identified Petitioner in the hearing room. T. 104. He used Google and a website called "socialintel.com" to conduct his search. He took screenshots of the information he found and put these into a Word document. He identified RX 11 as the report he prepared on January 9, 2018. T. 107. He determined that Petitioner has several social media profiles, on Facebook, Pinterest, Google Plus and YouTube. Petitioner's Facebook profile mentions Respondent. T. 108. Petitioner used the nickname "Ricky Bobby" and used the same profile photograph on Facebook and YouTube.

Kinsch testified that, in 2013, Petitioner posted several videos of motorcycle rides. On May 22, 2013, Petitioner uploaded a video entitled "GoPro First Ride." The Arbitrator, counsel and Petitioner viewed this video during the hearing. Petitioner's face can be seen at the beginning of the video. The remainder of the video is taken from the vantage point of the rider. T. 113. Some of the videos that Petitioner posted show rides lasting for 12 or 22 minutes. T. 113. Petitioner uploaded all of these videos in 2013. One video, entitled True Breed MC Chicago, shows Petitioner and some other people standing and talking inside a garage. At one point, Petitioner mentions that his wrist cramped up while he was riding a motorcycle. T. 114. Another video, uploaded on April 20, 2016, shows Petitioner (on the far right of the screen) holding a board. A boy approaches him, at which point he is holding the board with his right hand, and kicks the board. This video is entitled "Black Belt Jones." T. 115-116. Kinsch testified he did not alter these videos in any way. Petitioner's counsel raised no objection to the admission of the videos or report. RX 11-12. T. 116-117.

Under cross-examination, Kinsch testified he does not know when the "True Breed" video was uploaded. T. 119-120.

Alan Brooks, another investigator affiliated with Frasco, also testified on behalf of Respondent. Brooks testified he has worked as an investigator for 27 years. At Respondent's request, he conducted surveillance of Petitioner on January 5, 9 and 10, 2018. He was provided with Petitioner's address and physical description before he conducted the surveillance. He correctly identified Petitioner in the hearing room. T. 122-123. He identified RX 13 as the report he prepared.

The Arbitrator, counsel and parties then viewed video obtained on January 5, 2013. This video shows Petitioner pushing a trash can out to the street at about 9:14 AM, stopping at a gas station convenience store at 9:39 AM and arriving at a bowling alley at 9:54 AM. After he arrives at the bowling alley, he uses his right hand to remove a ball bag from his vehicle. Brooks testified the bag appeared to weigh more than five pounds. T. 128. Petitioner can then be seen pulling the wheeled bag across a lot and entering a building. The next section shows Petitioner using his left hand to bowl but using both

hands to balance the ball before he releases it. T. 129. At 1:51 PM, Petitioner can be seen heading back to his vehicle, using his right hand to pull the wheeled bag.

Under cross-examination, Brooks testified he conducted surveillance for at least eight hours on January 5, 2018 but obtained only five minutes of footage that day. T. 133. Petitioner did not go to work that day. T. 133-134. On January 9, 2018, he conducted surveillance for four hours, from 7 to 11 AM, and did not see Petitioner. T. 135. With respect to the garbage can footage obtained on January 5, 2018, he could only brief see Petitioner's right hand contacting the can. He cannot tell whether Petitioner was using his right thumb. T. 135. It is not possible to see how Petitioner uses his hand(s) to open his car door at the convenience store. T. 135. At one point, Petitioner can be seen using his right index finger to open the car door. T. 136. It does not appear Petitioner used his right thumb at that time. The ball bag Petitioner pulled has wheels on it. He does not know the amount of force involved in pulling this bag. T. 136-137. He cannot tell whether Petitioner was putting stress on his right thumb when he balanced the bowling ball in both hands. T. 137. He did not conduct surveillance of Petitioner on any days other than the three days he mentioned. He is not aware of any other Frasco investigator conducting surveillance of Petitioner. T. 137-138. [At this point in the hearing, Petitioner's counsel indicated he had no objection to the admission of Brooks' report [RX 13] or the video [RX 14].]

Petitioner was then recalled in rebuttal. He testified it is "very easy" to pull the wheeled bag. The bag contained his bowling balls and shoes. The ball weighed 14 pounds. When he balances the ball in his hands, his right thumb is barely touching the ball. T. 140-141. He uses his index finger to open a car door because, if he used his thumb, it would hurt. T. 141. When his son kicked the board out of his hands, he was holding the board with his fingers and bracing the board with his forearm. The kick took place so quickly he did not feel much of anything. His son is a first degree black belt and state champion. The video shows a state tournament. T. 142. The video taken inside a garage was taken after a "quick" motorcycle ride. He rode the CBR, a "sports bike," that day. He stopped using the CBR after that day because he felt pressure in his right wrist while riding it. The throttle is located on the right handlebar. He operates it with his fingers, not his thumb. He bought his other motorcycle because the handlebars are positioned in such a way that he does not have to lean down. His hands are at about shoulder height. His right hand just sits on the throttle. T. 145. He rode motorcycles before his thumb fusion. If he put his entire hand around the throttle, he would feel thumb pain but he learned how to move his thumb out of the way. He started doing this before the fusion surgery. T. 146. He no longer rides the CBR. The set-up is completely different on the motorcycle he still uses. T. 147.

Under cross-examination, Petitioner acknowledged there might have been two balls in the bag he wheeled. Each ball would have weighed no more than 14 pounds. He bowls left-handed. He does not use his right hand to position the ball. His left hand is underneath the ball. He uses his left palm to support the ball. He positions his right hand on the right side of the ball. T. 149. He cannot recall the exact date on which the garage video footage was obtained. T. 150. They did ride to Detroit before the video was taken. He posted other rides that lasted 20 minutes. T. 151. A motorcycle does not vibrate when you ride fast. You do not have to grip tighter when you increase your speed. T. 152. That is because he is "down inside the wind screen with the wind going over" him. The "bike balances itself." He last rode a motorcycle when it was "still a little warm outside." He does not know whether he posted a video a year ago showing him using his right hand to "rev" a motorcycle. T. 153.

Arbitrator's Credibility Assessment

Petitioner was an engaging, responsive witness. His lengthy tenure with Respondent weighs in his favor, credibility-wise. His description of his various job duties was detailed and unrebutted. None of the physicians who treated or examined him noted symptom magnification.

The Arbitrator does not view the surveillance videos or social media video posts as undermining Petitioner's credibility. The investigator who conducted surveillance on January 5, 2018 acknowledged he obtained only five minutes of footage during an eight-hour period. The videos show relatively innocuous activities and, in some respects (i.e., the footage showing use of the right index finger to open a car door) bolster Petitioner's testimony that he avoids using his right thumb. At one point, Petitioner used his right hand to lift a bag containing two bowling balls out of his vehicle but this activity is very brief. Petitioner's testimony that he now uses his unaffected left hand to bowl is corroborated by the United States Bowling Congress records.

Arbitrator's Conclusions of Law With Respect to 15 WC 20242

Is this claim barred by the statute of limitations?

In 15 WC 20242, Respondent stipulated to accident and notice but maintains the claim is barred by the statute of limitations. Arb Exh 1. Petitioner concedes the claim was not filed within three years of the January 9, 2008 accident but maintains it was filed within two years of the last payment of compensation, pursuant to Section 6(d) of the Act. Petitioner targets December 16, 2013 as the date on which compensation was last paid. This is the date Respondent paid Midland Orthopedic's bill for Dr. Sonnenberg's initial visit of November 11, 2013. [See RX 7.] Petitioner also argues that Respondent is estopped from asserting a statute of limitations defense. Respondent maintains that medical payments do not constitute compensation for statute of limitations purposes. Alternatively, Respondent maintains that timeliness is governed not by Section 6(d) but by the more specific provisions of Section 8(j)(3) and that the December 16, 2013 payment did not revive the statute, since there had been earlier payments in 2011, with the last occurring more than two years before December 16, 2013. RX 7. Respondent also contends that the doctrine of estoppel is not applicable.

Section 6(d) of the Act provides, in relevant part, that:

> "In any case, other than one where the injury was caused by exposure to radiological materials or equipment or asbestos unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such an application shall be barred."

Section 8(j)(1) provides, in relevant part, that the period for filing a claim does not commence to run until the termination of payments made under a group plan and, in paragraph (3), that "the extension of time for the filing of [a claim] as provided in paragraph 1 above shall not apply to those cases where the time for such filing had expired prior to the date on which payments or benefits enumerated herein have been initiated or resumed."

The Arbitrator finds that medical payments do constitute compensation for statute of limitations purposes, under Legris v. Industrial Commission, 323 Ill.App.3d 789 (2001) and that the filing comports with the specific timeline set forth in Section 6(d). Petitioner filed his Application on June 18, 2015, within two years of Respondent's December 16, 2013 payment to Midland Orthopedics. Arb Exh 1C. The legislature has never acted to attach the tenets of Section 8(j)(3) to 6(d). Moreover, RX 7 reflects that Respondent made the payment to Midland Orthopedics within its "workers' compensation system" and not pursuant to any group plan. Also see Creel v. Industrial Commission, 54 Ill.2d 580 (1973).

The Arbitrator further finds that Petitioner relied to his detriment on Respondent's conduct and, as a result, Respondent is estopped from asserting a statute of limitations defense. From the outset, Petitioner "toed the line" by seeking, or attempting to seek, care at Respondent's in-house facility, while continuing to work. The Arbitrator finds credible Petitioner's testimony concerning his interactions with workers' compensation representatives, including Michelle Gregory (who is identified as a recipient of the notes Drs. Brooker and Sonnenberg generated). There is no evidence indicating that anyone affiliated with Respondent informed Petitioner of the statute of limitations or provided him with a Commission handbook. The consultation with Dr. Sonnenberg, which Respondent eventually authorized, did not take place until November 2013, almost five years after the January 9, 2008 accident. Respondent paid Dr. Sonnenberg's bill but declined to act on his recommendations, even though he explicitly found causation as to the right thumb injury and described causation as to the carpal tunnel as probable. Petitioner testified that Gregory repeatedly told him she planned to set up an "IME," without explaining what this was (T. 54-55), but Respondent did not in fact schedule any such examination until 2017. [Petitioner's testimony as to Gregory's reaction is bolstered by the November 14, 2013 "referral form" that appears in PX 1. Via this form, Dr. Sonnenberg sought authorization for the recommended surgery. The handwritten phrase "needs IME" appears on the form. PX 1, p. 13.] These facts mirror those set forth in Herlihy Mid-Continent Co. v. Industrial Commission, 252 Ill.App.3d 211 (1st Dist. 1993), a case in which the Appellate Court held that the employer was estopped from raising a statute of limitations defense.

Did Petitioner establish a causal connection between the January 9, 2008 accident and his current right thumb condition of ill-being?

The Arbitrator finds that the accident of January 9, 2008 was a cause of Petitioner's current post-operative right thumb condition of ill-being and contributed to the need for the fusion surgery. In so finding, the Arbitrator relies on the following: 1) the records from Respondent's medical facility (PX 1), which do not document any right thumb complaints or treatment prior to January 9, 2008; 2) Petitioner's credible description of the mechanism of the January 9, 2008 accident; 3) the results of the right thumb X-rays performed on January 9, 2008; 4) Dr. Mejia's persuasive opinion that the accident could have caused a radial collateral ligament tear; and 5) Dr. Vitello's concession that the accident could have caused this tear and that such a tear, if left untreated, could lead to arthritis.

Is Petitioner entitled to temporary total disability benefits and maintenance? Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator addresses Petitioner's claims for weekly benefits and medical expenses below.

Arbitrator's Conclusions of Law in 14 WC 30775

Is this claim barred by the statute of limitations?

In 14 WC 30775, Respondent stipulated to accident and notice but, as in 15 WC 20242, maintains the claim is barred by the statute of limitations. Arb Exh 2. The Arbitrator applies the same analysis [see above] and finds Petitioner met the requirements of Section 6(d) and Respondent is estopped from asserting a statute of limitations defense. Petitioner filed his Application (Arb Exh 2C) on September 12, 2014, within two years of the last payment of compensation, i.e., Respondent's December 16, 2013 payment to Midland Orthopedics. RX 7.

The Arbitrator finds another basis for viewing this claim as timely. Based on the medical evidence, the claim involves repetitive rather than specific trauma. When Petitioner sought care at Respondent's medical facility on June 6, 2011, he reported longstanding complaints stemming from repetitive torqueing of a tool. PX 1, p. 80. The Commission has the authority to amend a manifestation date where appropriate. Standards of "fairness and flexibility" are to be applied in determining a manifestation date. November 11, 2013, the date of Petitioner's first visit to Dr. Sonnenberg, a physician of Respondent's selection, is a reasonable manifestation date in the instant case, based on the causation-related opinions and treatment recommendations set forth in the doctor's note. PX 2, pp. 12-13. While Petitioner had previously seen Dr. Brooker in June 2011, with that doctor recommending EMG studies that showed mild right carpal tunnel syndrome, the doctor did not impose restrictions. Nor did he address the right thumb. Petitioner continued working thereafter (with the exception of a brief period in 2012 when he took a leave due to unrelated hip and foot problems), exposing himself to the same repetitive assembly line duties, until Respondent finally arranged for him to see Dr. Sonnenberg in November 2013. It was Dr. Sonnenberg who commented on causation with respect to both the carpal tunnel and the thumb and recommended a combined surgery (i.e., a carpal tunnel release plus ligament reconstruction) that would result in the need for Petitioner to be off work. With the exception of a brief period in 2012, Petitioner was in the same position between June 2011 and November 11, 2013 as the claimants in Three "D" Discount Store v. Industrial Commission, 198 Ill.App.3d 43 (1989) and Durand v. Industrial Commission, 224 Ill.2d 53 (2006), i.e., "continuing to work on a regular basis despite his own progressive ill-being." The courts have emphasized that any employee in this position "should not be punished merely for trying to perform his duties without complaint." Petitioner filed this claim in September 2014, less than a year after seeing Dr. Sonnenberg and while still continuing to work and seek the surgery the doctor recommended. As for the "reasonable person" standard, the only admission Petitioner made concerning his understanding of his conditions and their causes was his testimony, under cross-examination, that Dr. Brooker diagnosed him with carpal tunnel syndrome in July 2011. T. 70. At no time did he indicate that he understood that condition to be work-related at that time. The evidence and law support the amendment of the claim to allege a manifestation date of November 11, 2013.

Did Petitioner establish a causal connection as to right thumb and right carpal tunnel conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his repetitive trauma injuries and his right carpal tunnel syndrome, which initially led to the need for therapy and, ultimately, surgery. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible and detailed testimony concerning his lengthy workdays, the pace at which he worked, and the nature of the assembly tasks he performed; and 2) the causation-related opinions expressed by Drs. Brooker and Sonnenberg. The Arbitrator also notes that Respondent's examiner, Dr. Vitello, declined to express any opinions concerning carpal tunnel syndrome.

The Arbitrator further finds that Petitioner established a causal connection between his repetitive trauma injuries and his right thumb condition of ill-being, which eventually required fusion surgery. In so finding, the Arbitrator again relies on Petitioner's testimony along with the causation-related opinions expressed by Dr. Sonnenberg, a physician of Respondent's selection. For reasons explained further below, the Arbitrator concludes that several factors, including Petitioner's repetitive assembly line duties, contributed to the worsening of his right thumb condition. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003).

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from July 14, 2015 through September 30, 2015. Respondent disputes this claim, based on its defenses. The Arbitrator finds that Petitioner was temporarily totally disabled from July 14, 2015 through September 30, 2015, a period of 11/27 weeks. The parties have stipulated that Respondent is entitled to Section 8(j) credit for the $512.53/week in disability benefits it paid during this period.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator awards the following medical expenses, subject to the fee schedule: 1) Franciscan Alliance, $135.00; 2) Franciscan Hammond Clinic, $25.00 (co-pay); and 3) ATI Physical Therapy, $438.70 (therapy, PX 11, p. 44).

Arbitrator's Conclusions of Law in 15 WC 20243

Did Petitioner sustain an accident arising out of and in the course of his employment on March 3, 2015?

The Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment on March 3, 2015. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony, given under cross-examination and on redirect, as to the circumstances of the accident (T. 73, 91-93); 2) the information Petitioner provided via a workers' compensation intake form he completed at Dr. Sonnenberg's office on March 9, 2015 (PX 2, pp. 7-8); 3) the information Petitioner provided to Respondent via an "injury/accident investigation" form (PX 1, p. 20); and 4) the Respondent "summary reports" concerning Petitioner's visits to the medical facility on March 3 and 11, 2015 (PX 1, pp. 53, 61).

Petitioner credibly testified his right thumb "collapsed" while he was using his body weight to "seat", or push, a plug through the dash pad and into the fire wall of a vehicle while working on the assembly line. T. 73, 91-93. Petitioner also credibly testified he immediately notified his supervisor, Eric Willis, of this incident, with Willis giving him a "pass" to go to the medical facility. The "injury/accident investigation" form referenced above is undated but, in it, Petitioner identified Willis as his supervisor and indicated his right thumb "collapsed and gave out" while he was "trying to seat a plug." PX 1, p. 20. While Respondent placed accident in dispute in this claim, it stipulated to receiving timely notice. Arb Exh 3.

The Arbitrator does not find it surprising that Petitioner would have also mentioned his 2008 injury to Dr. Sonnenberg on March 9, 2015 (see PX 2, p. 6). Nor is it surprising that Petitioner originally

mentioned only this injury to Dr. Mejia. While this event did not result in lost time, as did the accident of March 3, 2015, it was the starting point of Petitioner's right thumb problems.

Did Petitioner establish a causal connection between the March 3, 2015 accident and his current right thumb condition of ill-being?

The Arbitrator finds that the accident of March 3, 2015 was a cause of Petitioner's current, post-operative right thumb condition and contributed to the need for the fusion. The Arbitrator finds it significant that Petitioner described his right thumb as "collapsing" and becoming much more painful as of the accident. T. 92-93. While Petitioner had clearly experienced right thumb symptoms for several years before March 3, 2015, the accident caused those symptoms to worsen and brought about the need for additional care. The Arbitrator finds persuasive Dr. Mejia's opinion that the accident, which involved forceful pushing with the thumb, aggravated Petitioner's underlying right thumb condition. PX 4, pp. 28-29.

The Arbitrator views Petitioner's current right thumb condition as multi-factorial, with the 2008 hyperextension injury, the subsequent assembly line duties, the delays in care and the March 3, 2015 accident contributing. In Illinois, it has long been held that an injured worker need only establish that an accident was a cause of his condition. He is not obligated to prove it was the sole, or even a significant, cause. Nor is he required to eliminate all other possible causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003).

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator, having found in Petitioner's favor on the issues of accident and causation, and noting Dr. Vitello's opinions as to reasonableness and necessity, awards Petitioner the following medical expenses, subject to the fee schedule: 1) ATI, functional capacity evaluation, 6/30/16-7/1/16, $4,221.72 (PX 11, p. 22); 2) Midland Orthopedic Associates (Dr. Sonnenberg), 3/9/15 and 4/6/15 office visits, $412.27 (PX 2, p. 4); and 3) UIC, $3,705.00 (PX 11);

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from November 6, 2015 (the date of the fusion surgery) through November 12, 2015. [Petitioner modified his original claim, set forth on Arb Exh 3, based on attendance records]. Respondent disputes this claim, based on its accident and causation defenses. Arb Exh 3. The Arbitrator, having found in Petitioner's favor on accident and causation, and noting Dr. Vitello's concession that the fusion was reasonable and necessary, finds that Petitioner was temporarily totally disabled from November 9, 2015 through November 12, 2015, a period of 4/7 weeks. The Arbitrator does not include the first three days of disability, November 6-8, 2015, in accordance with Section 8(b). The parties have stipulated that Respondent is entitled to Section 8(j) credit in the amount of $529.77 for the benefits it paid during this period.

Is Petitioner entitled to maintenance?

Petitioner claims he is entitled to maintenance benefits from March 2, 2017 (the day after Respondent informed him he could no longer be accommodated) through December 3, 2017 (the day before he resumed light duty at Respondent). Respondent disputes this claim, based on its accident and

causation defenses as well as Dr. Vitello's opinion that Petitioner is capable of medium physical demand level work per the functional capacity evaluation. Arb Exh 3.

The Arbitrator elects to rely on Dr. Mejia rather than Dr. Vitello with respect to the issue of appropriate restrictions. The individual who conducted the functional capacity evaluation did not have a job description and expressed only a superficial understanding of Petitioner's job duties. He expressed no understanding of the pace at which vehicles come down the line. He assumed an eight-hour workday, although Petitioner testified his shifts last ten hours. T. 23. In contrast, Dr. Mejia arrived at permanent restrictions after discussing Petitioner's job with him. He specifically addressed power tool usage.

The Arbitrator, having considered the foregoing and having found in Petitioner's favor on the issues of accident and causation, finds that Petitioner is entitled to maintenance from March 2, 2017 through December 3, 2017, a period of 39 4/7 weeks. The parties have stipulated that Respondent is entitled to credit for the $20,282.62 in disability benefits it paid during this period.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MONTEL JONES,

Petitioner,

vs.

NO: 15 WC 20242
14 WC 30775
15 WC 20243 (cons)

FORD MOTOR COMPANY,

Respondents.

19IWCC0415

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 statute of limitations, causation, medical expenses, and temporary disability, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds claim 15 WC 20242 is barred by the statute of limitations.

The Commission adopts the Findings of Fact as set forth in companion case 14 WC 30775 and incorporates them herein.

Conclusions of Law

The Commission reverses the Arbitrator and finds Petitioner's claim for his injury occurring on January 8, 2009 is barred by the statute of limitations. The Arbitrator found Petitioner's claim was timely filed as such filing was effectuated within two years of last payment of compensation on December 16, 2013. Respondent's payment records certainly evidence such payment, but this payment was made for services rendered in connection with Petitioner's injury and treatment regarding his June 6, 2011 date of accident. Both Dr. Sonnenberg's medical referral form and Respondent's payment ledger reference a date of accident of June 6, 2011. PX2 & RX7. (For further discussion, see decision in 14 WC 30775). Given such, Respondent's payment to Dr. Sonnenberg on December 16, 2013 did not toll the

statute of limitations in relation to Petitioner's injury sustained on January 9, 2008. Petitioner filed his Application of Adjustment of Claim on June 8, 2015 which falls outside the limitations period. Pursuant to Section 6(d) of the Act, Petitioner's Application of Adjustment of Claim is barred.

As to the Arbitrator's finding that Respondent is barred from asserting the statute of limitations defense based upon the doctrine of estoppel, the Commission disagrees and vacates such finding. In arriving at her decision, the Arbitrator relied on *Herlihy Mid-Continent Co. v. Industrial Commission*, 252 Ill. App. 3d 211, 625 N.E.2d 108 (1993). In *Herlihy*, the Court acknowledged the employer's insured continued to pay for medical expenses following the expiration of the statute of limitations but found such payments were not compensation for purposes of Section 6(d) instead finding estoppel applicable. Since this holding, the Court has expressly held the payment of medical expenses constitutes compensation under Section 6(d) of the Act. See *Legris v. Industrial Commission*, 33 Ill. App. 3d 789, 754 N.E.2d 402 (2001). Therefore, the Court's holding in *Herlihy* is questionable and inapplicable.

In any event, the Supreme Court has expressly stated "[e]stoppel applies when the conduct or statement of an employer or its representative lull the employee into a false sense of security, thereby causing the employee to delay the assertion of his or her rights. [citations omitted]." *Tegeler v. Industrial Commission*, 173 Ill. 2d 498, 506, 672 N.E.2d 1126 (1996). Such circumstances are not present here. Petitioner testified after injuring his thumb in 2008, he sought medical care at Respondent's in-house facility after which time he returned to work. T. 35. Petitioner testified he did not attempt to see a physician outside of Respondent's medical department. T. 36. Petitioner testified he eventually spoke with Jennifer, date unknown, who scheduled an appointment with an orthopedic hand specialist. T. 36-37. Such appointment was scheduled with Dr. Booker in 2011 following Petitioner's June 6, 2011 accident. T. 40. These facts do not support the application of estoppel.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2018, is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that claim 15 WC 20242 is hereby dismissed.

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.

19IWCC0415

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 - 2019

L. Elizabeth Coppoletti

LEC/mck

O: 6/19/19

43

Stephen Mathis

D. Douglas McCarthy

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

JONES, MONTEL
Employee/Petitioner

Case# **15WC020242**

14WC030775
15WC020243

FORD MOTOR COMPANY
Employer/Respondent

19IWCC0415

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:

0293 KATZ FRIEDMAN
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
DAN BRIANARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MONTEL JONES
Employee/Petitioner
v.
FORD MOTOR COMPANY
Employer/Respondent

Case # **15** WC **20242**

Consolidated cases: **14 WC 30775**
15 WC 20243

19IWCC0415

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **January 12, 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. ☐ 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 **Statute of Limitations**

FINDINGS

On the date of accident, **January 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 earned $**50,689.60**; the average weekly wage was $**974.80**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **3** dependent children.

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

ORDER

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation and that this claim was timely filed under Section 6(d). See the decisions in the companion cases for the Arbitrator's awards.

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

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

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

Molly C Mason

Signature of Arbitrator

3/7/18
Date

ICArbDec19(b)

MAR 8 - 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 Maintenance	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MONTEL JONES,

Petitioner,

vs.

NO: 15 WC 20243
14 WC 30775
15 WC 20242 (cons)

FORD MOTOR COMPANY,

Respondents.

19IWCC0416

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, 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 or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

The Commission adopts the Findings of Fact as set forth in companion case 14 WC 30775 and incorporates them herein.

Maintenance

The Arbitrator found Petitioner was entitled to maintenance benefits from March 2, 2017 through December 3, 2017, this being the period Respondent could not provide a position to accommodate Petitioner's restrictions. The Commission views the evidence differently.

By its own terms, the Act grants maintenance benefits only while a claimant is engaged in a rehabilitation program; if the claimant is not engaged in some type of "rehabilitation" such

as physical rehabilitation, formal job training, or a self-directed job search, there is no obligation to provide maintenance. *Greaney v. Industrial Commission*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331 (2005); see also, *W.B. Olson v. Illinois Workers' Compensation Commission*, 2012 IL App (1st) 113129WC, ¶39, 981 N.E.2d 25 (An employer is obligated to pay maintenance benefits only "while a claimant is engaged in" a rehabilitation program.) The Commission first observes Petitioner did not engage in a vocational rehabilitation program during the period in question. While a vocational assessment did take place, this was not until October 6, 2017, and no vocational services were instituted as a result thereof. There is also no evidence that Petitioner engaged in a self-directed job search. As such, there was no vocational rehabilitation to trigger the concomitant maintenance benefits. The Commission further notes Petitioner underwent no treatment during that period; in fact, Petitioner's last evaluation with his treating physician was in 2016. Therefore, Petitioner was not engaged in anything which could be construed as the physical rehabilitation contemplated by Section 8(a). Therefore, the Commission finds Petitioner is not entitled to maintenance under Section 8(a) and vacates the award of maintenance benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $815.83 per week for a period of 4/7 weeks, representing November 9, 2015 through November 12, 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 the award of maintenance benefits from March 2, 2017 through December 3, 2017 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $8,338.99 for medical expenses as provided in §8(a), subject to §8.2 of the Act. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims from any providers of the services for which Respondent is receiving this credit, as provided in §8(j).

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

IT IS FURTHER ORDERED BY THE COMMISSION that this 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.

19IWCC0416

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 - 2019

LEC/mck

O: 6/19/19

43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

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

JONES, MONTEL
Employee/Petitioner

Case# **15WC020243**

14WC030775
15WC020242

FORD MOTOR COMPANY
Employer/Respondent

19IWCC0416

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:

0293 KATZ FRIEDMAN
CHRISTOPHER MOSE
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
DAN BRIANARD
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MONTEL JONES
Employee/Petitioner

v.

FORD MOTOR COMPANY
Employer/Respondent

Case # **15** WC **20243**

Consolidated cases: **14 WC 30775**
15 WC 20242

19IWCC0416

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **January 12, 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. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☒ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On the date of accident, **March 3, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**63,634.48**; the average weekly wage was $**1,223.74**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**20,888.17** in short term disability benefits under Section 8(j), for a total credit of $**20,888.17**. Arb Exh 3.

Respondent is entitled to a credit of $**61,554.00** under Section 8(j) of the Act for medical expense.

ORDER

Respondent shall pay to Petitioner the sum of $815.83 per week for temporary total disability for a period of 4/7 weeks, for the period from November 9, 2015 through November 12, 2015, pursuant to Section 8(b) of the Act, subject to the credit Respondent shall receive of $529.77 for amounts paid under Section 8(j).

Respondent shall pay to Petitioner the sum of $815.83 per week for maintenance benefits for a period of 39-4/7 weeks, for the period from March 2, 2017 through December 3, 2017, pursuant to Section 8(a) of the Act, subject to the credit Respondent shall receive of $20,282.62 for amounts paid under Section 8(j).

Respondent shall pay to Petitioner the sum of $8,338.99 for medical expense, subject to the fee schedule, pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall further hold Petitioner harmless with respect to payments made by group health insurance in the amount of $61,554.00, pursuant to Section 8(j) of the Act.

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

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

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

Molly C Mason

Signature of Arbitrator

3/7/18
Date

ICArbDec19(b)

MAR 8 - 2018

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES SMITH,

Petitioner,

vs. NO: 15 WC 41537

SUPERIOR EXPRESS,

Respondent.

19IWCC0417

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection of cervical spine condition of ill-being, medical expenses, and prospective medical, and being advised of the facts and law, reverses the denial of causal connection and modifies the decision of the Arbitrator as set forth below. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

Causal Connection

In concluding Petitioner's neck condition of ill-being is not causally related to his undisputed September 18, 2015 work accident, the Arbitrator found Petitioner did not have any complaints relatable to the neck until October 31, 2015, nor did he give a report of an immediate onset of left arm numbness until the February 8, 2016 evaluation with Dr. Gornet. The Commission's review of the medical evidence leads us to a different conclusion.

The Commission observes the Concentra records from both September 18 and September 22, 2015 document Petitioner's "neurological review of symptoms" included arm weakness, tingling, numbness. PX1. Moreover, the physical therapy initial evaluation, conducted four days after Petitioner's undisputed accident, contains the following history:

> Mechanism of Injury – fell off the back of a trailer and got scuffed up on the bumper and hardest knock was on his left elbow and this shot caused residual [left] shoulder soreness that remains and initially [left upper extremity] was numb for about [two] hours and it resolved to current tingly feeling in fingers. Patient describes ulnar nerve distribution. PX1 (Emphasis added).

The Commission observes similar reports of left arm numbness are repeatedly memorialized throughout the medical records well before February 8, 2016. For instance, at the November 17, 2015 evaluation with Dr. Kostman, Petitioner's pre-visit questionnaire reflects his complaints of "numbness in arms sometime, weakness in shoulder, neck collarbone area, pain" and Dr. Kostman recorded Petitioner's report of numbness on the day of the accident and ongoing "numbness and weakness in his left upper extremity." PX4. The Commission finds the medical records are consistent with and corroborate Petitioner's testimony of an immediate onset of cervical complaints on the date of undisputed accident.

The Commission finds Petitioner sustained a cervical spine injury during his undisputed work accident. Given this determination, we must resolve the corollary issue of Petitioner's request for prospective care in the form of a three-level cervical disc replacement. This requires us to weigh the conflicting opinions of Dr. Gornet and Dr. Kitchens.

Section 8(a) of the Act requires Respondent to pay for medical expenses which are "reasonably required to cure or relieve from the effects of the accidental injury..." *820 ILCS 305/8(a)* (West 2013). See *F & B Manufacturing Co. v. Industrial Commission of Illinois*, 325 Ill. App. 527, 534, 758 N.E.2d 18 (2001) ("Under Section 8(a) of the Act, the claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of claimant's injury").

The Commission finds an award of a three-level disc replacement, particularly in such a young individual, highly problematic. See *Krantz v. Industrial Commission*, 289 Ill. App. 3d 447, 450-51, 681 N.E.2d 1100 (1997) (The Commission is an administrative tribunal that hears only workers' compensation cases and deals extensively with medical issues) and *Long v. Industrial Commission*, 76 Ill. 2d 561, 566, 394 N.E.2d 1192 (1979) (The Commission possesses inherent expertise regarding medical issues).

The Commission finds Dr. Kitchens' opinions as to Petitioner's need for this medical treatment, or more accurately Petitioner's lack of need, to be highly credible. We are persuaded by his opinion that a three-level disc replacement is not supported by either the objective diagnostic findings or Petitioner's subjective complaints. Dr. Kitchens testified unequivocally

19IWCC0417

that Petitioner "does not have signs or symptoms of cervical radiculopathy or cervical myelopathy." RX1, p.15. Moreover, the MRI evidenced disc bulges and congenital stenosis. As such, the Commission denies the request for a three-level disc replacement as we find that specific intervention is neither reasonable nor necessary as contemplated by Section 8(a).

IT IS THEREFORE ORDERED BY THE COMMISSION that, in addition to the undisputed left shoulder condition of ill-being, Petitioner's September 18, 2015 work accident resulted in a cervical spine condition of ill-being.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable and necessary medical expenses incurred for treatment of Petitioner's left shoulder and cervical spine conditions of ill-being as set forth in Petitioner's Exhibit 9, as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the recommendation of a three-level cervical disc replacement is neither reasonable nor necessary, and Petitioner's request for same is denied.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,500.00. 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 2 - 2019

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

LEC/mck

Stephen Mathis

O: 6/4/19

D. Douglas McCarthy

43

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

SMITH, JAMES
Employee/Petitioner

Case# **15WC041537**

SUPERIOR EXPRESS
Employer/Respondent

19IWCC0417

On 4/16/2018, 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 1.88% shall accrue from the date listed above to the day before the 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:

0438 BROWN & CROUPPEN PC
KERRY O'SULLIVAN
211 N BROADWAY 16TH FL
ST LOUIS, MO 63102

0180 EVANS & DIXON LLC
MICHELLE SYMANK
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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)

James Smith
Employee/Petitioner

v.

Superior Express
Employer/Respondent

Case # 15 WC 41537

Consolidated cases: n/a

19IWCC0417

An *Application for Adjustment 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 Collinsville, on February 22, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, September 18, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $37,147.24; the average weekly wage was $714.37.

On the date of accident, Petitioner was 31 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner from September 21, 2015, through January 5, 2016, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Based upon the Conclusions of Law attached hereto, Petitioner's petition for prospective medical treatment is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

March 22, 2018
Date

APR 16 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 September 18, 2015. The Application alleged that Petitioner fell off of a truck while unloading a pallet and sustained an injury to the "Back, neck, head and left shoulder" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident, but disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1). In regard to the prospective medical treatment sought by Petitioner, it consisted primarily of disc replacement surgery at three levels of the cervical spine, C3-C4, C4-C5 and C5-C6.

Petitioner worked for Respondent as a truck driver and, at the time of the accident, had worked for Respondent for approximately three and one-half years. On September 18, 2015, Petitioner was in the process of unloading a piece of freight when he fell off of the trailer. Petitioner testified that he landed on his back with his shoulders and neck striking the ground. Petitioner stated his left arm was pinned underneath his body at the time he sustained the fall and his left arm went completely numb.

Petitioner initially sought medical treatment at Concentra Medical Center on September 18, 2015, for he was seen by Dr. Gary Gray. According to Concentra's record of that date, Petitioner fell backward out of a truck trailer and landed on his back injuring his left shin, left elbow, left shoulder and left AC joint. There was no reference to Petitioner having sustained a neck injury Petitioner was diagnosed with a shoulder strain and contusion to the elbow and tibia. Dr. Gray authorized Petitioner to return to work on light duty with no truck driving (Petitioner's Exhibit 1).

Petitioner was subsequently seen by Dr. Gray on September 21, 2015. At that time, Dr. Gray ordered x-rays of the left shoulder, left elbow and left lower leg. They were all negative for fractures. Dr. Gray's diagnosis remained the same and he ordered physical therapy. Again, there was no reference to Petitioner having sustained a neck injury (Petitioner's Exhibit 1).

Petitioner began physical therapy and saw Dr. Gray the following day, September 22, 2015. Petitioner still had some left shoulder pain at the AC joint, but he requested to be returned to work without restrictions. Again, there was no reference to Petitioner having sustained a neck injury (Petitioner's Exhibit 1).

Petitioner was subsequently seen at Concentra on October 3, 2015, by Dr. James Belcher. Petitioner still complained of left shoulder pain, but Dr. Belcher noted Petitioner had not been taking the medication that was prescribed for him and had also missed some physical therapy appointments. Because of Petitioner's left shoulder complaints, Dr. Belcher ordered an MRI scan of the left shoulder. Again, there was no reference to Petitioner having sustained a neck injury (Petitioner's Exhibit 1).

The MRI was performed on October 14, 2015. According to the radiologist, the MRI revealed supraspinatus and infraspinatus partial thickness tears (Petitioner's Exhibit 4).

Petitioner was seen at Concentra by Dr. Dennis Keesal on October 31, 2015. At that time, Petitioner continued to complain of left shoulder pain as well as pain in the left side of his neck. Dr. Keesal diagnosed Petitioner with a neck strain in addition to Petitioner's shoulder injury. He reviewed the MRI scan and recommended Petitioner be seen by an orthopedic specialist (Petitioner's Exhibit 1).

Petitioner was seen by Dr. W. Chris Kostman, an orthopedic surgeon, on November 17, 2015. At that time, Petitioner informed Dr. Kostman about the accident and that he had left shoulder pain as well as numbness/weakness in the left arm. While there was nothing in Dr. Kostman's record of that date of Petitioner having any neck complaints, Dr. Kostman noted on examination that Petitioner had no cervical spine tenderness. Dr. Kostman reviewed the MRI of October 13, 2015, but opined it was of poor diagnostic quality. He ordered another MRI scan. Dr. Kostman also administered a steroid injection into Petitioner's left shoulder (Petitioner's Exhibit 4).

The MRI ordered by Dr. Kostman was performed on November 17, 2015. According to the radiologist, the MRI revealed thickening of the distal supraspinatus but no full thickness tear and an intact labrum (Petitioner's Exhibit 4).

Dr. Kostman saw Petitioner on December 1, 2015, and reviewed the findings of the MRI scan of November 17, 2015, with Petitioner. He opined Petitioner had left shoulder rotator cuff tendinitis and long head biceps tendinitis/bursitis. He recommended further stretching/strengthening exercises in therapy and over-the-counter pain medication as needed. There was no reference in his record of that date of Petitioner having neck symptoms (Petitioner's Exhibit 4).

Petitioner was subsequently evaluated by Dr. Nathan Mall, an orthopedic surgeon, on December 9, 2015. Petitioner was not referred to Dr. Mall by another physician; he found Dr. Mall on his own. At that time, Petitioner advised Dr. Mall of the accident and treatment he had received afterward. Petitioner complained of left shoulder pain going into his neck and pain when he turned his neck. Dr. Mall examined Petitioner's cervical spine and noted a limited range of motion and shooting pain up his neck. He opined Petitioner had either a likely cervical disc herniation or cervical strain. In regard to Petitioner's left shoulder, he agreed that the most recent MRI did not reveal any pathology and his findings on examination of Petitioner's left shoulder were benign. Because of Petitioner's cervical spine complaints, he referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 6).

Petitioner continued to receive physical therapy in December, 2015. He was again seen by Dr. Kostman on January 5, 2016. When Dr. Kostman saw Petitioner at that time, he reviewed the physical therapy record of December 26, 2015, and noted that Petitioner had exhibited self limiting behavior. Dr. Kostman's examination of Petitioner's left shoulder was essentially normal, but he did recommend Petitioner have an injection in the long head of the biceps which Petitioner declined. He recommended Petitioner continue with home exercises and resume regular activities. There was no reference to Petitioner having neck symptoms. Further, Dr. Kostman stated there was no cervical spine tenderness on examination (Petitioner's Exhibit 4).

On February 8, 2016, Petitioner was evaluated by Dr. Gornet. At that time, Petitioner complained of neck pain and pain between his shoulder blades. Petitioner advised Dr. Gornet that he fell out of the back of a truck on September 18, 2015, but he was "...not sure how he landed." Petitioner advised that shortly after the fall his left arm went "completely numb" and he was subsequently treated for left shoulder symptoms. Dr. Gornet ordered an MRI of Petitioner's cervical spine (Petitioner's Exhibit 2).

The MRI of Petitioner's cervical spine was performed on February 8, 2016. According to the radiologist, the MRI revealed annular tears, central disc herniations and foraminal disc herniations at multiple levels of the cervical spine (Petitioner's Exhibit 3).

Dr. Gornet reviewed the MRI of February 8, 2016, and opined Petitioner had sustained disc injuries at C3-C4, C4-C5, C5-C6 and C6-C7. He also opined that they were caused by the work accident. He recommended Petitioner undergo injections at C4-C5 and C5-C6 (Petitioner's Exhibit 2).

Dr. Gornet referred Petitioner to Dr. Helen Burke who administered injections at C4-C5 and C5-C6 on February 23, 2016; and at C4-C5 on March 8, 2016. Petitioner was subsequently seen by Dr. Gornet on April 28, 2016, and advised that the injections only provided some temporary relief. At that time, Dr. Gornet recommended Petitioner undergo disc replacement surgeries at C3-C4, C4-C5 and C5-C6 (Petitioner's Exhibits 2 and 5).

Dr. Gornet subsequently saw Petitioner on June 30, 2016. He reaffirmed his diagnosis that Petitioner had "low level herniations" at three levels of the cervical spine. He noted Petitioner did not have significant nerve compression, but a structural injury to the disc mechanism which caused structural pain and symptoms (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Daniel Kitchens, a neurosurgeon, on August 17, 2016. In connection with his examination of Petitioner, Dr. Kitchens reviewed medical records and diagnostic studies provided to him by Respondent. In his report of that date, Dr. Kitchens abstracted/summarized many of the treatment records. He opined that the MRI of the cervical spine revealed congenital stenosis at multiple levels and disc bulges at C3-C4 and C5-C6. He also opined that Petitioner's initial complaint of neck pain was in Dr. Gornet's record of February 8, 2016. He stated the delay in neck symptoms was inconsistent with Petitioner having sustained an acute injury to his cervical spine on September 18, 2015. Dr. Kitchens opined that Petitioner's current neck symptoms were related to the congenital abnormalities, degenerative disc disease and disc bulging. He also opined the treatment Petitioner had received for his cervical spine condition was not related to the accident, Petitioner was at MMI and that a three level cervical disc replacement surgery was not indicated because of the lack of cervical radiculopathy (Respondent's Exhibit 1; Deposition Exhibit B).

When Dr. Gornet last saw Petitioner on February 2, 2017, he reviewed Dr. Kitchens' report of August 17, 2016. He stated he agreed Petitioner had congenital stenosis, but that it was the disc herniations related to the fall that caused Petitioner's symptoms. He noted that Petitioner's onset of severe left shoulder pain could have occurred in conjunction with the disc herniations and neck symptoms he developed afterward (Petitioner's Exhibit 2).

Dr. Gornet was deposed on April 20, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed his opinions that Petitioner sustained disc injuries at C3-C4, C4-C5 and C5-C6 which were caused by the fall and that disc replacement surgeries at those levels was appropriate. In regard to Dr. Kitchens' opinion that Petitioner had congenital stenosis, Dr. Gornet agreed that Petitioner had congenital stenosis; however, he maintained that the Petitioner's onset of neck symptoms was the work-related injury and not the congenital stenosis (Petitioner's Exhibit 8; pp 11-17).

While Dr. Gornet opined that Petitioner's left shoulder symptoms could be referred pain from the cervical spine, he agreed on cross-examination that Petitioner's left shoulder symptoms had resolved. He also agreed that Petitioner did not have any dermatomal types of findings on examination, but that Petitioner's complaints were consistent with a disc injury (Petitioner's Exhibit 8; pp 12, 18, 25-26).

Dr. Kitchens was deposed on June 30, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Kitchens' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Kitchens testified that Petitioner's current symptoms were related to Petitioner's congenital anomalies, degenerative disc disease and disc bulging; Petitioner was at MMI; and that a three level disc replacement surgery was not appropriate because Petitioner did not have any findings of cervical radiculopathy (Respondent's Exhibit 1; pp 14-15).

At trial, Petitioner testified that his left arm went completely numb at the time he sustained the accident and that the neck pain began a couple weeks thereafter. Petitioner stated he has pain complaints in the left deltoid and trapezius areas with numbness from the shoulder to the tips of his fingers, more on the left than right. Petitioner has been able to work for Respondent consistently since the time of the accident, but he wants to proceed with the surgery recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is, in part, causally related to the accident of September 18, 2015.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on September 18, 2015, which caused an injury to his left shoulder.

Petitioner sought medical treatment on the same day that he sustained the accident at Concentra Medical Center and was treated there on several occasions in September and October, 2015. It was not until Petitioner was seen at Concentra for the fifth time, October 31, 2015, that he had any complaints referable to the neck.

When seen by Dr. Kostman on November 17, 2015, there was no record of Petitioner having any cervical spine symptoms, and Dr. Kostman's examination of the cervical spine revealed no tenderness.

When Dr. Kostman saw Petitioner on December 1, 2015, there was no record of Petitioner having any neck symptoms.

The first time Petitioner appeared to have significant neck symptoms was when he was seen by Dr. Mall on December 9, 2015, approximately two and one-half months after the accident.

While Dr. Kitchens' report erroneously indicated that the initial complaint of neck pain was in Dr. Gornet's medical record of February 8, 2016, there was still a significant lapse of time between the accident and when Petitioner first complained of neck symptoms (October 31, 2015).

Petitioner informed Dr. Gornet and testified at trial that his left arm when completely numb at the time of the accident. However, that complaint of what would be a significant symptom was not contained in any of the medical records prior to Petitioner being seen by Dr. Gornet on February 8, 2016. Further, Petitioner informed Dr. Gornet he was not certain as to how he landed at the time he sustained the accident.

While Dr. Gornet opined Petitioner's left shoulder symptoms could be related to the cervical disc pathology, he agreed that Petitioner's left shoulder symptoms had resolved.

Respondent's Section 12 examiner, Dr. Kitchens, opined Petitioner's current neck symptoms were related to congenital stenosis, degenerative disc disease and disc bulging and there was no relationship between Petitioner's current neck symptoms and the accident.

Based upon the preceding, the Arbitrator concludes Petitioner's neck condition is not related to the accident of September 18, 2015.

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

The Arbitrator concludes the medical treatment Petitioner received for his left shoulder condition was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith through January 5, 2016.

Respondent shall pay reasonable and necessary medical services provided to Petitioner from September 21, 2015, through January 5, 2016, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

As aforestated, the Arbitrator concluded that Petitioner's neck condition was not related to the accident of September 18, 2015.

When Dr. Kostman saw Petitioner on January 5, 2016, his examination of Petitioner's left shoulder was essentially normal and he released Petitioner to return to work.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F), the Arbitrator concludes Petitioner is not entitled to prospective medical treatment in regard to the neck condition.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DIANE STATEMAN,

Petitioner,

vs. NO: 14 WC 029964

SOUTHWEST AIRLINES,

19IWCC0418

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 both incurred and prospective, 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 supplemental analysis as indicated below.

Conclusions of Law

A claimant who claims injury based upon a theory of repetitive trauma must show a causal connection between her work duties and her resulting condition of ill-being. *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill. 2d 524, 505 N.E.2d 1026 (1987). In order to prove such a causal link, a claimant must establish the manner and method of her work duties is sufficiently repetitive in nature. *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177 (1993). The same standard applies to proof of an aggravation of a pre-existing condition. *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 476, 510

N.E.2d 502 (1987). "Furthermore, in cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. [citations omitted]." *Id.* at 477. See *Berry v. Industrial Commission*, 99 Ill. 2d 401, 459 N.E.2d 963 (1984).

Petitioner failed to prove the necessary causal relationship. Dr. Vender's opinions carry more weight than those of Dr. Fakhouri. Dr. Vender unequivocally testified Petitioner's work duties were not sufficiently repetitive in method or manner to cause or aggravate Petitioner's conditions of ill-being. Dr. Fakhouri agreed with Dr. Vender in that Petitioner's work duties did not cause her carpal tunnel syndrome but testified it was possible such duties aggravated her condition.

Petitioner argues the Arbitrator failed to apply the appropriate legal standard in discounting Dr. Fakhouri's opinion as to aggravation. In so arguing, Petitioner relies on *Mason & Dixon Lines, Inc. v. Industrial Commission*, which states "[a] finding of a causal relation may be based on a medical expert's opinion that an accident 'could have' or 'might have' caused an injury. [citation omitted]." 99 Ill. 2d 174, 182, 457 N.E.2d 1222 (1983). As the Court noted, the finder of fact may find a causal relationship based on this standard, but it is certainly not required to do so. Moreover, the Commission in arriving at its decision reviewed the totality of Dr. Fakhouri's testimony and found it lacking.

Petitioner further argues that all the medical evidence including Dr. Fakhouri's opinion should be ignored and causation found based upon a chain of events analysis relying on *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 63, 442 N.E.2d 908 (1982). As the Court noted in *International Harvester*, causation may be premised on a chain of events analysis under certain circumstances. Such circumstances are not present here. Moreover, as the Court noted in *Berry v. Industrial Commission*, "[c]ases involving aggravation of a preexisting condition concern primarily medical questions and not legal ones." 99 Ill. 2d 401, 459 N.E.2d 963 (1984), quoting *Long v. Industrial Commission*, 76 Ill. 2d 561 (1979).

The Commission in affirming the Arbitrator's decision finds that the method and manner of Petitioner's job duties is not sufficiently repetitive to support a finding of causation or aggravation of Petitioner's conditions of ill-being.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 26, 2018 is hereby affirmed and adopted.

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

No bond for removal of this cause to the Circuit Court by Respondent is required as the Commission has not entered an award for the payment of money has been entered. The party

commencing 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 - 2019
LEC/mav
O: 05/21/19
43

L. Elizabeth Coppoletti

Maria E. Portela

DISSENT

I found the opinion of Dr. Fakhouri to be decidedly more persuasive than that of Respondent's hired-gun, Dr. Vender. More to the point, I take issue with Dr. Vender's categorical refusal to even consider the fact that repetitive activities such as using a keyboard can cause the type of hand and wrist injuries experienced by Petitioner in this case.

As a result, I would reverse the Arbitrator's decision and find that Petitioner sustained repetitive trauma-type injuries arising out of and in the course of her employment on or about August 15, 2014, and that a causal relationship existed between said accident and Petitioner's current condition of ill-being.

And for that reason, I respectfully dissent.

Thomas J. Tyrrell

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

STATEMAN, DIANE
Employee/Petitioner

Case# **14WC029964**

19IWCC0418

SOUTHWEST AIRLINES
Employer/Respondent

On 2/26/2018, 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 1.82% shall accrue from the date listed above to the day before the 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:

1425 HEALY SCANLON
JACK CANNON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
DANIEL S WELLNER
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DIANE STATEMAN
Employee/Petitioner

v.

SOUTHWEST AIRLINES
Employer/Respondent

Case # **14** WC **29964**

Consolidated cases: **n/a**

19IWCC0418

An *Application for Adjustment 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 **CHOICE OF PHYSICIAN**

FINDINGS

On the date of accident, **AUGUST 15, 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 $**20,715.23**; the average weekly wage was $**414.30**.

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

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

Respondent shall be given a credit of $**0.00** 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.

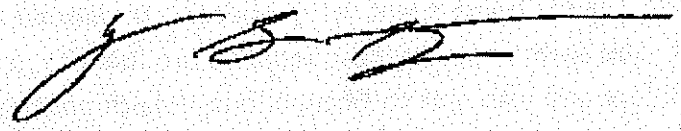
ORDER

As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law:*

> The Petitioner failed both to prove that she sustained accidental injuries that arose out of and in the course of her employment with the Respondent and that her current condition of ill-being is causally connected to her alleged injury. As such, the Petitioner's request benefits under the Act 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

February 23, 2018
Date

FEB 26 2018

ICArbDec19(b)

DIANE STATEMAN v. SOUTHWEST AIRLINES

14 WC 29964

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried on the Petitioner's Section 19(b) Petition before Arbitrator Steffenson on January 26, 2017. The issues in dispute were accident, causal connection, average weekly wage, medical bills, TTD, and the Petitioner's choice of physicians. (*Arbitrator's Exhibit* 1). The parties agreed to receipt of this Arbitration Decision via e-mail and requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

Direct Examination

On August 15, 2014, the Petitioner had been an employee of the Respondent for three and half years. (*Transcript* at 15). She was a Customer Service/ Sales Representative. (*Transcript* (hereinafter, *T.*) at 16). She took incoming phone calls and assisted customers through the company's reservation system. She would assist with flight bookings, frequent flier information, refunds and general travel information (*T.* at 16-17). She worked 40 hours, five days a week. (*T.* at 17). Her work station was a cubicle and had a computer unit, two monitors, a keyboard, and a mouse. (*T.* at 18). There was a phone system, which was used with headphones. (*T.* at 18). She worked seven hours at her desk, typing and maneuvering the mouse between the two screens, in and out of the seven applications used. (*T.* at 19).

In the couple of weeks prior to August 15, 2014, the Petitioner had cramping fatigue and a little more pain in her right hand. (*T.* at 20). On August 15, 2014, she was on a call when she felt a sharp burning pain in her right hand. The Petitioner spent seven hours on the phone and using the mouse and keyboard (*T.* at 21). She always met the Respondent's productivity goals. (*T.* at 23). The Petitioner reported her injury and was sent to Occupational Health on August 15, 2014. (*T.* at 26). She then followed up with them on August 19, 2014 and her Primary Care Physician at Palos Medical Group, the same day. She was taken off work and advised to remain off with the expectation of attempting to return to work in three days. (*T.* at 27). She continued treatment with Dr. Boll, who provided medication and splints. He referred her to Dr.

Nagle, who treated her with a steroid injection on October 21, 2014. (*T.* at 27). The injection helped temporarily and Dr. Nagle then referred her for occupational therapy. (*T.* at 28).

The Petitioner switched her treatment to Dr. Fakhouri in December 2014. She chose him because his office was closer to home. (*T.* at 29). He recommended an injection, which she had in January 2015. He then referred her for an EMG, which also occurred in January 2015. (*T.* at 30). Dr. Fakhouri then ordered MRI scans of the right hand and wrist. He also recommended surgery. Her problem area was her right thumb, palm of hand and right wrist. (*T.* at 30). The surgery, which occurred on May 1, 2015, did not relieve her pain. She also developed a mass in her wrist at that time, which was removed during the procedure. (*T.* at 31).

Following surgery, the Petitioner had physical therapy, which did not help. Dr. Fakhouri released The Petitioner on July 23, 2015. (*T.* at 32). She returned to Dr. Boll, who referred her to Kleiser Physical Therapy (*T.* at 32). Dr. Boll referred the Petitioner to Dr. Welch, who she saw on September 14, 2015. (*T.* at 33). He provided another injection that temporarily helped. (T. at 34). Dr. Welch recommended another surgery which was performed on November 20, 2015. The surgery released the main hand complaints, but she had flare-ups. (*T.* at 34). After surgery she had physical therapy. (*T.* at 35). She continued treatment with Dr. Welch into the Spring of 2016, but did not get complete relief from her pain. (*T.* at 35).

Dr. Boll referred the Petitioner to Marianjoy in April 2016. The Petitioner was at the pain management clinic under the care of Dr. Katta, in the summer of 2016. (*T.* at 36). She treated there until September 2016, when she was put at maximum medical improvement. (*T.* at 37). They put her on restrictions including minimal typing and no use of the mouse with the right hand. (*T.* at 37). The Petitioner informed Southwest of her restrictions, and she had not been offered a job. (*T.* at 39). The Petitioner engaged in her own job search as listed in her Exhibit 12. (*T.* at 39). She was helped by her sister and did the search on-line using a computer. (*T.* at 39-40). She's had no job offers. (*T.* at 40).

During course of her treatment the Petitioner noticed fatigue, cramping and tingling in her left hand. (*T.* at 40). She had an EMG on the left hand and surgery was recommended. (*T.* at 41). The Petitioner's first physician was Occupational Health, where she was sent by employer. Her first choice was Dr. Boll. She then went to Dr. Nagle. A friend referred her to Dr. Fakhouri (*T.* at 42). Dr. Boll referred her to Dr. Welch. (T. at 43). Dr. Boll also referred her to Marianjoy (*T.* at 81).

When she started work in the morning, she would turn on her equipment, open up the computer applications and get set up for her calls. (*T.* at 45). She would perform her duties and then go on a break after about two hours. She would take a fifteen-minute break. (*T.* at

45). The Petitioner would then return to work for another two hours and then have a half hour lunch break. She would return for another two hours and then take a fifteen-minute break. (*T.* at 46). She would then finish her shift. There was also a 15 minute "huddle" in the morning or late afternoon to recap with leaders, which would be a chance to stretch. (*T.* at 47). While working, The Petitioner was not restricted to sitting and able to move around. (*T.* at 50).

Cross Examination

The Petitioner's workload did not change in August 2014. (*T.* at 60). Her desk and chair were adjustable. (*T.* at 61). When she came to work each day, she would adjust her equipment to make herself comfortable. (*T.* at 62). She was aware of correct positioning to maximize comfort and had ergonomic training. (*T.* at 62). She did not have to hold a phone as she used a headset and the calls came in automatically. (*T.* at 63). The job did not involve lifting or other physical activity. (*T.* at 63). The information she typed during each call was different depending on what the customer needed. She would type brief notes, reservation numbers, names or cities. (*T.* at 65). The Petitioner would use her mouse or keyboard to get into various fields to enter the information. (*T.* at 65). She didn't always use mouse to change fields. She could use tab key. (*T.* at 66).

The amount of calls would vary each day. The length of calls varied. There was a three-minute average, but some calls could be 45 minutes, two minutes or one minute. (*T.* at 68). The Petitioner would point and click at different screens during a call or even one place for one call and one place for another. (*T.* at 69). Where she pointed to would depend on which information was entered. (*T.* at 69).

The Petitioner has not had any other work since August 2014, except three days she returned to work. (*T.* at 70). During the days she returned to work, she had to read about new equipment and did not take phone calls. (*T.* at 70). She had not attempted to work since February 29, 2016. The Petitioner had no treatment since September 19, 2016. The Petitioner utilizes a Dell laptop for her job search. (*T.* at 79). Her sister helps her, but is not a professional job consultant. (*T.* at 79).

Testimony of Dr. Fakhouri

Dr. Fakhouri is a board certified orthopedic surgeon. (*Petitioner's Exhibit* 6 at 5). He began treating The Petitioner on December 11, 2014. (*Petitioner's Exhibit* (hereinafter, *PX*) 6 at 6). She was chiefly complaining of the right side. He diagnosed the Petitioner with carpal tunnel syndrome and arthritis of the thumb. (*PX* 6 at 8). He recommended injections, a splint and therapy. In his next visit he ordered an EMG. (*PX* 6 at 10). He also recommended work restrictions. (*PX* 6 at 11). During his February 26, 2015 visit, Dr. Fakhouri noted a mass in the palm of the right wrist. (*PX* 6 at 13). When the Petitioner returned on March 12, 2015, he

noted that the Petitioner complained that her symptoms were worsened by her daily activities at work, including typing and writing. (*PX* 6 at 14). The Petitioner mentioned the symptoms subsided when not working. (*PX* 6 at 15).

In April 2015, the Petitioner complained of tingling numbness and pain greater on the left than the right. (*PX* 6 at 17). Dr. Fakhouri noted three conditions: the arthritis, the carpal tunnel and the mass. (*PX* 6 at 18). The Petitioner wanted to move forward with surgical intervention. (*PX* 6 at 18). On May 1, 2015, Dr. Fakhouri performed a right carpal tunnel release and excision of the mass. (*PX* 6 at 19). When the Petitioner returned in June 2015, he recommended continued therapy. The Petitioner did not feel she could return to full duty work. (*PX* 6 at 21).

On July 23, 2015, Dr. Fakhouri recommended that she discontinue therapy. (*PX* 6 at 22). She was not very symptomatic on the left side and he noted that she could have surgery in the future if it worsened. (*PX* 6 at 23). He released her to return to work with no restrictions and placed her at MMI on the right. (*PX* 6 at 23). He had no restrictions for the left hand. (*PX* 6 at 23-24). Dr. Fakhouri noted that the Petitioner's work activities did not cause her carpal tunnel syndrome but was not sure that the activities may have aggravated her syndrome as he would need more information rather than just a list of things. (*PX* 6 at 28-29). The Petitioner had complete resolution of her carpal tunnel syndrome. (*PX* 6 at 30). Dr. Fakhouri had no comment about a statement noted in Dr. Boll's records that the Petitioner became symptomatic due to the repetitive nature of her work. (*PX* 6 at 34).

On cross examination, Dr. Fakhouri conceded that the statement in his March 2015 medical record that noted it was possible that her condition was aggravated by work activities was based upon the Petitioner telling him it was worked related. (*PX* 6 at 38). He did not know her job duties and explained that her work activities did not directly cause her conditions. He issued that statement in response to her questions on the issue. (*PX* 6 at 39). The Petitioner's basal joint arthritis was not work related, nor was her mass or ganglion cyst. (*PX* 6 at 39-40).

Dr. Fakhouri found that half of the causes of carpal tunnel have no known cause and that other cause may be related to diabetes, thyroid disease, rheumatoid, autoimmune diseases and masses in the tunnel. (*PX* 6 at 41). He also noted work activities of various types such as jackhammer work and the like were causes. (*PX* 6 at 41). Carpal tunnel can arise in absence of trauma or any repetitive forceful activity. (*PX* 6 at 42). Forceful repetitive activities could aggravate carpal tunnel syndrome. (*PX* 6 at 43). The Petitioner provided no history of direct trauma to her wrist. (*PX* 6 at 45). Dr. Fakhouri was aware of studies that find no relationship between carpal tunnel syndrome and typing. (*PX* 6 at 46). The Petitioner never provided any specifics on her work activities. (*PX* 6 at 46). His saying that an aggravation was possible did not mean it was probable. (*PX* 6 at 46). If her wrist was in a hyperextended

position for a long period or she had to do a lot of stapling, there could be an aggravation, but without any details he could not say it was probable. (*PX* 6 at 47).

On re-direct examination, in response to questions about repetitive flexion and extension of the wrist, Dr. Fakhouri stated the following:

> "You know, you can ask these questions in all these different angles; but the answer is still the same, it's not caused by work. All based on a reasonable degree of medical and surgical certainty, my answers have been that it is possible; but to be clear, it's not probable, if that answers it with respect to aggravation." (PX 6 at 54-55).

Testimony of Dr. Vender

Dr. Vender is a board certified orthopedic surgeon, with an active practice performing hand and elbow surgeries. (*Respondent's Exhibit* 1 at 5). He examined the Petitioner at the request of Sedgwick on September 24, 2014 and drafted a report of his findings dated September 29, 2014. (*Respondent's Exhibit* (hereinafter, *RX*) 1). He took a history, physical examination and x-rays. (*RX* 1 at 9-10). Dr. Vender diagnosed the Petitioner with degenerative arthritis of the right thumb CMC joint, flexor carpi radialis tendinitis and possible thumb flexor stenosing tenosynovitis. (*RX* 1 at 13).

Based upon his review of records and job description and his examination, he did not find that her conditions were caused or aggravated by her work. (*RX* 1 at 13-14). The arthritis in the thumb was a routine degenerative condition. (*RX* 1 at 14). Forceful use of the thumb on a regular basis could aggravate it, but not utilization of a keyboard and computer. (*RX* 1 at 14). Even typing and use of a mouse for an extended period would not aggravate it. (*RX* 1 at 15). There was no acute injury to the Petitioner. Dr. Vender found no work restrictions necessary. (*RX* 1 at 16).

Dr. Vender examined the Petitioner again on September 30, 2015. (*RX* 1 at 16). He took another history and physical examination. (*RX* 1 at 17-19). He found that she had CMC thumb arthritis and indications of de Quervain's. (*RX* 1 at 20). He noted that the Petitioner did not have signs of carpal tunnel at the time of the current examination and his prior examination. (*RX* 1 at 20-21). He noted the positive findings on the EMG, but that it was not a valid test because it was not done by a physician. (*RX* 1 at 20). Dr. Vender also noted no signs of carpal tunnel on the left side. (*RX* 1 at 22).

Assuming that the Petitioner had carpal tunnel syndrome, Dr. Vender did not find that the Petitioner's work activities caused or aggravated the condition. (*RX* 1 at 22). There were no

forceful and exertional activities performed on a regular and persistent basis. Dr. Vender also found that there was no causation between the wrist ganglion and her work activities. (*RX* 1 at 23). It remained his opinion that the thumb CMC arthritis was not caused or aggravated by employment. (*RX* 1 at 23). Dr. Vender noted that conservative treatment would be appropriate but not related to work. (*RX* 1 at 24). He continued to find that she could return to work full duty. (*RX* 1 at 24).

On cross examination, Dr. Vender opined that there was no medical basis to state there was a relationship between the conditions discussed and repetitive typing or computer work. (*RX* 1 at 32). He noted that there's never been a study that showed carpal tunnel syndrome comes from typing. (*RX* 1 at 34). There has been literature that repetitive activities of certain types can contribute to carpal tunnel syndrome, but he did not believe there was a legitimate article. (*RX* 1 at 35).

On re-direct examination he explained that the literature in support of his opinion came from the Mayo Clinic and Harvard Medical School. (*RX* 1 at 62). Computer printouts he was shown on cross examination indicating causation between work activities and carpal tunnel syndrome were marketing materials without citations to peer-reviewed articles. (*RX* 1 at 62-64). He would not find causation even if the Petitioner typed all day and had symptoms while typing. An individual may notice symptoms while performing an activity without those symptoms being a cause of the underlying condition. (*RX* 1 at 66).

Medical Records

On August 15, 2014, the Petitioner was seen at Concentra in Bridgeview under the care of a Dr. Pratumngern. (*PX* 2). The Petitioner complained about pain in her arm and hand when using a mouse and typing on a computer. During the physical examination, the Petitioner had some tenderness and swelling in the hand. X-rays were taken which were negative. She was diagnosed with a right-hand sprain. Over the counter medication was advised, and the Petitioner was provided with a thumb spica brace. The Petitioner was released to return to work.

The Petitioner then saw Dr. Karam on August 19, 2014. She reported sudden hand pain and cramps on August 15, 2014 while at work. During the examination, the right hand had tenderness and some slight swelling. Dr. Karam assessed her with a strain and sprain of the hand. She was given Ibuprofen and a note to return to work on August 21, 2014. (*PX* 3).

The Petitioner returned to Concentra under the care of Dr. Chet on August 19, 2014. (*PX* 2). The Petitioner denied a previous history of injury to her right hand. She was recommended to take a few days off. Dr. Chet noted subjective tenderness during the physical examination. The Petitioner had diminished grip strength. Dr. Chet diagnosed her with a hand strain and transferred her care to Dr. Boll. On the same date The Petitioner was seen by Maya Karam, a nurse

practitioner at the family practice. She reported that her hand improved slightly but was still tender with pressure and palpation. The Petitioner had tenderness during the physical examination. She was diagnosed with a sprain and strain of a hand. She was given Ibuprofen and a note to return to work on August 21, 2014.

The Petitioner was seen by Dr. Boll at the family practice on August 21, 2014. (*PX* 3). He noted that she was scheduled to return to work, but she had increased swelling and tenderness in the right wrist and arm as well as the swelling the thumb. Dr. Boll assessed her with chronic pain syndrome, fibromyalgia, phlebitis of the veins and upper extremities and pain in her limb. She was provided with medications and advised not to work for a week.

The Petitioner returned to Dr. Boll on August 28, 2014. (*PX* 3). He noted that her update was somewhat confusing, but it appeared that her proximal forearm was better, her thumb may be better and that her phlebitis symptoms moved up to the distal arm. He diagnosed her with fibromyalgia, depression, pain in the limb and phlebitis. The Petitioner returned to Dr. Boll on September 16, 2014. The Petitioner reported significant pain worse with any movement in touch with grasping and gripping of the right hand. Dr. Boll then diagnosed her with tendonitis.

The Petitioner saw Dr. Nagle, a hand specialist, on October 21, 2014. The Petitioner complained of discomfort at the base of her right thumb. (*PX* 4). He noted that the Petitioner had first CMC degenerative disease on the right. The Petitioner felt repetitive mouse usage had aggravated her thumb symptoms. Dr. Nagle performed a steroid injection into the joint. He also provided the Petitioner with a right hand based thumb spica arthrosis. He provided her work restrictions of limited use of the hands with no repetitive pinching or grasping.

The Petitioner was seen by Dr. Fakhouri at MidAmerica Orthopedics on December 12, 2014. (*PX* 5). She gave a history that she worked as a customer service representative with a chief complaint of parathesia in the right hand as well as the based on the right thumb. She indicated that it started on August 15, 2014 while she was working. Dr. Fakhouri noted positive compression tests and a positive Phalen. He found that the Petitioner had right carpal tunnel syndrome and a basal joint arthritis of the right thumb. A new splint was provided and cortisone injections were discussed.

The Petitioner returned to Dr. Fakhouri on January 15, 2015. It was noted the Petitioner had returned to work after her last office visit, but she had been able to return to normal work duties, she believed her work activities were aggravating her right-hand conditions. Dr. Fakhouri recommended therapy and wearing a splint. He provided her with a work note of no lifting, carrying, pulling or pushing greater than five pounds and typing no more than 30 minutes per hour. (*PX* 5).

The Petitioner had an EMG/NCV of the right upper extremity on January 22, 2015. The study was interpreted as showing a focal demyelinating and axonal mononeuropathies of the median nerves in the area of the carpal tunnel syndrome bilaterally. In the history, the Petitioner indicated that her right hand had been bothering her since August and that using a mouse made her hands worse.

The Petitioner then returned to Dr. Fakhouri on February 5, 2015. She indicated that the cortisone injection only helped her to a mild extent but therapy had been helping her. Dr. Fakhouri found that EMG was consistent with bilateral carpal tunnel syndrome. Dr. Fakhouri recommended continued conservative measures. (*PX* 5).

On February 19, 2015, the Petitioner returned to Dr. Fakhouri. It was noted that she had a mass approximately three centimeters proximal to the proximal wrist crease but was non-tender. She was tender in the basal joint. She was diagnosed with a mass on the right wrist, basal joint arthritis to the right thumb and right carpal tunnel syndrome. Dr. Fakhouri recommended continued occupational therapy and an MRI was ordered to look at the mass. The Petitioner next saw Dr. Fahouri on February 26, 2015. The diagnostic ultrasound was performed and there was a small fluid collection. The area was non-tender. The findings were consistent with a ganglion cyst and therapy was recommended.

The Petitioner was seen by Dr. Fakhouri on March 12, 2015. (*PX* 5). She had basal joint arthritis as well as carpal tunnel syndrome. He also noted a mass over the palmar radial aspect of the right wrist. It was found it consistent with a ganglion cyst. The Petitioner provided a history that her symptoms were worsened by day to day activities including work and typing but that she had been off work. When she had been off work her symptoms subsided. It was recommended that she continue with a splint. Dr. Fakhouri opined that it was possible that her work activities aggravated her carpal tunnel conditions. He opined that the arthritis was not caused by her work activities. He found she needed additional time off. He provided a cortisone injection. The Petitioner wanted to return to work on April 20th, and Dr. Fakhouri provided her with a note.

On April 16, 2015, the Petitioner returned to Dr. Fakhouri. She complained of numbness and tingling in both hands but the left side was not as bad as the right side. She complained that the mass in the right wrist was getting larger. Surgery was recommended. Dr. Fakhouri performed a right carpal tunnel release and excision of mass over the palmer radial aspect of the right wrist on May 1, 2015. The post-operative diagnosis was right carpal tunnel syndrome and a right wrist mass. (*PX* 5).

Following surgery, the Petitioner returned to Dr. Fakhouri on May 14, 2015. (*PX* 5). She was doing well with minimal pain. She was recommended to have therapy. On June 11, 2015, the

Petitioner returned to Dr. Fakhouri. He recommended continued therapy. He kept her from full duty work. She next saw Dr. Fakhouri on July 23, 2015. She had good range of motion. He ordered her to discontinue therapy. She was not overtly symptomatic on the left side. He recommended that she consider a left side release in the future. Dr. Fakhouri released her as far as the right side.

The Petitioner complained to Dr. Boll on August 5, 2015, that she aggravated her hand when she returned to work, and was not able to return due to the severity and persistence of her pain. (*PX* 3). The Petitioner then was seen by Dr. Robert Welch, a hand specialist at DuPage Medical Group, on September 14, 2015. (*PX* 7). The Petitioner provided a history that she had right wrist pain since August 15, 2014. She provided a history of her treatment including a carpal tunnel release and ganglion removed by Dr. Fakhouri. The Petitioner complained of persistent pain. She had been wearing a wrist brace and undergoing therapy. Dr. Welch performed the physical examination. Dr. Welch noted that the Petitioner had evidence of deQuervain tenosynovitis of the right wrist. He performed an injection. The Petitioner returned to Dr. Welch on October 19, 2015. She had a flare up of pain after a steroid injection with swelling. He noted that the Petitioner had arthritis in the right thumb and ST-T joint.

The Petitioner returned to Dr. Welch on October 28, 2015, with increasing pain in the right wrist. (*PX* 7). He performed physical examination and noted that the Petitioner had numbness and tingling in the left hand and a positive phalanx sign. Dr. Welch found the Petitioner's right deQuervain tenosynovitis was not improving. He recommended a first dorsal compartment release. He also provided a left wrist splint for the carpal tunnel syndrome on that side. On November 20, 2015, Dr. Welch performed a first dorsal compartment release on the right wrist. The post-operative diagnosis was right deQuervain's tenosynovitis. She returned to Dr. Welch on December 2, 2015. He recommended that she begin her regular duty work next week. She indicated that she had no further pain on her right side.

The Petitioner returned to Dr. Welch on December 9, 2015. (*PX* 7). She had some complaints of swelling on the operative side. He gave her prednisone. On December 23, 2015, the Petitioner returned to Dr. Welch. She was doing better but had some pain and paresthesia in the dorsum of her thumb. He found that she was making progress and wanted her to attend hand therapy.

The Petitioner was seen by Dr. Katta at Marian Joy Medical Group on April 26, 2016. (*PX* 10). The Petitioner was there for an evaluation of chronic pain. She described working as a reservationist with a lot of computer work and repetitive mouse usage. She indicated her problems began on August 2014. She went through the history of her treatment. The doctor performed a review of symptoms. A physical examination was performed. She was assessed with ADL and mobility dysfunction, right carpal tunnel syndrome, deQuervain's tenosynovitis

and chronic pain syndrome. It was found the Petitioner could benefit from comprehensive pain management. She would also benefit from a neuroprolotherapy.

On May 24, 2016, the Petitioner returned to Dr. Katta. (*PX* 10). It was noted the Petitioner had been in single service therapy. Dr. Katta noted the Petitioner had exhausted all conservative therapy options. She recommended a comprehensive pain management program. He gave her a gel for her right wrist. It was noted she would follow up with Dr. Katta as needed.

Dr. Vender re-examined the Petitioner on June 8, 2016. (*RX* 2). Dr. Vender took a history from the Petitioner and performed a complete examination. He found that the Petitioner was status post-DeQuervain's release. Although the Petitioner had additional complaints in the right upper extremity, he did not see any other diagnoses. He found there was no causal relationship of her job activities to development of a mass on the wrist and it was also not clear that she had carpal tunnel syndrome from which to develop a causal relationship. He opined that her work activities were of a non-forceful nature and would not be considered a cause of carpal tunnel syndrome. He also likewise said there were no physical activities that would place unusual stresses on her thumb extensor tendons and therefore her work activities did not contribute to the DeQuervain's syndrome. He could not explain her multiple complaints. He found the Petitioner was at maximum medical improvement for any injuries to her hand and wrist. He found that the Petitioner could return to work full duty.

On July 18, 2016, the Petitioner returned to Dr. Katta. (*PX* 10). It was noted she was starting a pain management program. The Petitioner was diagnosed with chronic pain syndrome, moderate median mononeuropathy bilaterally and sensitive scars. The plan was to initiate the comprehensive pain management program and engage in scar deactivation. On August 1, 2016, the Petitioner reported to Dr. Katta that she had a fall one week earlier. She fell on the ulnar aspect of the right hand. She noted increased swelling in the medial anterior forearm. She was using her left arm primarily. She was to continue the program.

On August 3, 2016, Dr. Katta noted that the Petitioner would continue work related job work in finding modified office work working with the elderly. On August 15, 2016, Dr. Katta performed a scar deactivation with a trigger point injection. She was to continue in occupational therapy. She was to continue other options for employment and discharged. (*PX* 10).

On September 19, 2016, it was noted the Petitioner was planning on returning to work in October. Her pain was at 5-6/10 at its best. She had good range of motion. She was wearing a wrist brace. It was found that the Petitioner would need to eliminate mouse usage since positioning exacerbated her pain. She would benefit from answering phones and using a head

piece, minimal keyboard work, minimal lifting manipulation of no greater than five pounds and unlimited lifting on the left upper extremity. It was noted the Petitioner was at maximum medical improvement. It was also noted that the Petitioner was a smoker which interfered with her healing and could be an exacerbation of her pain. (*PX* 10).

CONCLUSIONS OF LAW

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

Issues C & F: *Accident & Causal connection*

The burden is upon a claimant to establish evidence of his or her workers compensation claim by a preponderance of credible evidence. *Board of Education of the City of Chicago v. Industrial Commission*, 83 Ill. 2d 475, 479 (1981). The Arbitrator finds the Petitioner did not meet this burden. She alleges that her bilateral wrist conditions were caused by repetitive trauma from excessive typing and use of a computer mouse. Her allegations of a repetitive trauma injury are held to the same standard of proof as those alleging a specific accidental injury. They must show the injury is work-related, and not the result of a normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n,* 115 Ill.2d 524 (1987). The Petitioner failed to show there was a causal connection between her work activities and her conditions.

The opinions of the orthopedic doctors, Dr. Fakhouri, Dr. Vender and Dr. Welch, all overlap, but there appears general agreement that the Petitioner had CMC thumb arthritis, a ganglion cyst, and deQuervains. There is, however, a disagreement between Dr. Fakhouri and Dr. Vender as to whether Petitioner had bilateral carpal tunnel syndrome, worse on the right. They had different physical examination findings and disagreed over the validity of the EMG study. The Arbitrator notes the conflict was resolved in favor of a carpal tunnel diagnosis by the Petitioner's improvement after surgery to the point of being released from treatment and being returned to work by Dr. Fakhouri. Whatever the ultimate diagnoses, the experts applied the same concepts concerning causation of the conditions.

At issue is whether these various right-hand conditions were related to the Petitioner's work duties, specifically her typing and use of a computer mouse. The Arbitrator notes that to find a compensable accident the conditions had to be caused by the work or aggravated by it. The Arbitrator finds that a preponderance of the evidence demonstrates the Petitioner's job duties neither caused nor aggravated her conditions. The Petitioner presented Dr. Fakhouri's testimony in support of causation. He clearly stated that her arthritis and ganglion cyst

conditions were not related to her employment. At numerous points in his testimony, Dr. Fakhouri admitted to not knowing the Petitioner's exact job duties. Having only the general job description of a customer service representative, he stressed that carpal tunnel syndrome was not caused by her job duties as he understood them, generally. When pressed on whether the Petitioner's job duties could aggravate her condition, he conceded that they may aggravate the condition. However, he explained:

> "You know, you can ask these questions in all these different angles; but the answer is still the same, it's not caused by work. All based on a reasonable degree of medical and surgical certainty, my answers have been that it is possible; but to be clear, it's not probable, if that answers it with respect to aggravation." (PX 6 at 54-55).

Therefore, when Dr. Fakhouri indicated that work activities "may" aggravate then Petitioner's her conditions, he meant only that it was possible. It is clear from his testimony that he felt that he did not have enough information to opine that the Petitioner's work activities aggravated her conditions and in fact believed it "not probable" that there was a connection. Based upon the weight of the other evidence, the Arbitrator finds that Dr. Fakhouri's testimony about causation being "not probable" but possible is not enough to find causation by a preponderance of the evidence.

Dr. Vender's testimony on whether the Petitioner's conditions were caused or aggravated by the work activities is unequivocal. Dr. Vender found that use of a computer was unrelated to the development of the Petitioner's medical conditions, no matter the amount and duration of that use. He did not find that the Petitioner performed forceful and exertional activities on a regular and persistent basis, which would have been necessary to find a causal connection. The Arbitrator notes that Dr. Fakhouri's testimony is consistent with Dr. Vender on this point and the general causes of carpal tunnel syndrome. For example, Dr. Fakhouri opined that there was a causal relationship between carpal tunnel syndrome and work involving forceful repetitive activities such as jackhammering. Dr. Vender also noted that experiencing symptoms while performing an activity does not mean that the activity caused the condition.

The Petitioner's job duties must be scrutinized to determine if her work involved forceful repetitive activities. During her testimony, the Petitioner confirmed the job involved no physical activity such as lifting pushing or pulling. The only activity was use of a computer. Thus, it is hard to see how she can show performed any forceful or exertional acts. It is undisputed that the Petitioner was in front of the computer most of her day, but she failed to offer a medical opinion that her positioning in front of the computer applied any force causing

injury. The Petitioner also did not present evidence that the equipment she used was defective. She acknowledged that the desk and chair were adjustable and that she was trained in proper positioning.

The Petitioner testified to using her computer in two-hour periods between breaks and lunch. She was not holding her hands in one position during the entirety of her work day. Her typing was not repetitive. The Petitioner also did not have to type long paragraphs. Rather, she was entering information into various fields on her screens. The information would be relatively short, such as names of passengers or brief notes as to what the customer needed. Each customer would have different needs, so the information entered each time was different. Each call varied in length. The average was three minutes, but a call could be up to 45 minutes or as short as one minute.

The Petitioner used her computer mouse throughout the day. However, the use was not repetitive. She testified she would have to use the mouse to point and click at points on the two screens used. Again, she did not move the mouse at the same point and click at the same ratio throughout her day. Her use of the mouse was dictated by the information needed from the customer or the information that the customer needed to be entered. The Petitioner admitted to moving through seven different applications. She would have to move the mouse in a different fashion at any time depending on what she was entering. She also would not always use the mouse and use a tab key to move between fields. The Arbitrator finds that there is no evidence of the Petitioner performing a forceful repetitive activity with her hands. Therefore, based upon the opinions of both experts, there is no basis to find a causal connection between the Petitioner's work activities and her right-hand conditions.

For these reasons the Arbitrator also finds no causation for the left-hand injuries. The Arbitrator notes the left-hand symptoms arose several months after the Petitioner began treatment and during a stretch of time when she had not worked. At the same time, the Petitioner allegedly continued to have a lack of improvement in her right hand, which contradicts her assertions to her physicians that her condition worsened while working or when she returned to work. The Arbitrator notes the Petitioner stipulated she returned to work on three occasions, months apart, during the almost two-year period between the alleged accident and her release from treatment with Marianjoy. She admitted to not taking calls during those dates and reading manuals and doing other training. However, on August 5, 2015, the Petitioner complained to Dr. Boll that she aggravated her hand when she returned to work, and was not able to return due to the severity and persistence of her pain. This was only a few weeks after Dr. Fakhouri released her from treatment and advised her she could return to full duty work. The Petitioner's reporting of her condition was not credible and the Arbitrator declines to adopt

the opinions of Dr. Welch and Marianjoy about her medical condition after July of 2015 as they relied on her reporting of her job duties and symptoms.

A preponderance of the credible evidence supports a finding that there was no causal relationship between the Petitioner's work activities and her hand conditions. This finding is consistent with prior Commission Decisions involving customer service positions involving daily use of computers to enter information. *See, Morgan v. AT&T*, 10 IWCC 0451, *Rosich v. State of Illinois, Dept. of Human Services*, 16 IWCC 0779, and *Cook v. Rainbow Book Company*, 17 IWCC 553.

As such, the Arbitrator finds the Petitioner failed both to prove that she sustained accidental injuries that arose out of and in the course of her employment with the Respondent and that her current condition of ill-being is causally connected to her alleged injury.

Issue G: *Average Weekly Wage*

The Petitioner asserted an average weekly wage (AWW) of $544.80. (*AX* 1). The Respondent offered into evidence, without objection, a wage statement detailing the Petitioner's earnings from August 16, 2013, through July 31, 2014, representing 50 weeks preceding her August 15, 2014, accident date. (*RX* 4). During this period, the Petitioner earned $20,715.23. When this figure is divided by the 50 weeks the Petitioner worked, an AWW of $414.30 results.

As such, the Arbitrator finds the Petitioner has an AWW of $414.30 pertaining to this claim.

Issue J: *Medical bills*

Based upon the findings regarding **Issues C & F** above, the issue of medical bills is moot.

Issue L: *TTD*

Based upon the findings regarding **Issues C & F** above, the issue of TTD is moot.

Issue O: *Choice of Physician*

Based upon the findings regarding **Issues C & F** above, the issue of choice of physician is moot.

Signature of Arbitrator

February 23, 2018
Date

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Goldie Cruse,

Petitioner,

vs. NO: 17 WC 30738

Choate Mental Health Center,

Respondent.

19IWCC0419

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, medical expenses, temporary total disability and prospective medical treatment, 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 Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission modifies the Arbitrator's decision to find that the medical charges relative to the MRI spectroscopy ordered by Dr. Gornet was neither reasonable nor necessary. The Commission notes that there is no evidence that such a test is generally accepted or recognized by the orthopedic community, and as such the charges associated with same are hereby denied.

All else otherwise affirmed and adopted.

19IWCC0419

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 10/9/18 is affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $869.30 per week for 57-2/7 weeks, commencing 7/25/17 through 8/30/18, 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 PX1 through PX9, with the exception of charges associated with the MRI spectroscopy ordered by Dr. Gornet, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment prescribed by Dr. Matthew Gornet, including multilevel fusion surgery, pursuant to §8(a) and §8.2 of the Act.

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

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

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.

DATED: AUG 6 - 2019
o:6/11/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

CRUSE, GOLDIE
Employee/Petitioner

Case# **17WC030738**

CHOATE MENTAL HEALTH CENTER
Employer/Respondent

19IWCC0419

On 10/9/2018, 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 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0355 WINTERS BREWSTER CROSBY ET AL
LINDA J CANTRELL
111 W MAIN PO BOX 700
MARION, IL 62959

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

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

OCT 9 - 2018

Brett A. Parris
Illinois Workers' Compensation Commission

19IWCC0419

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Goldie Cruse
Employee/Petitioner

Case # 17 WC 30738

v.

Consolidated cases: n/a

Choate Mental Health Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on August 30, 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. [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 19IWCC0419

On the date of accident, July 25, 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 sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $67,828.97; the average weekly wage was $1,304.40.

On the date of accident, Petitioner was 50 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $1,739.26 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,736.26. Petitioner was paid extended benefits of 100% of her pay from July 25, 2017, to August 1, 2018.

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner as identified in Petitioner's Exhibit 1 through 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the multilevel fusion surgery recommended by Dr. Matthew Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $869.30 per week for 57 2/7 weeks, commencing July 25, 2017, through August 30, 2018, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

October 3, 2018
Date

OCT 9 - 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on July 25, 2017. According to the Application, Petitioner was attacked by a patient and sustained an injury to her back (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated Petitioner sustained a work-related injury on July 25, 2017; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

In regard to temporary total disability benefits, Petitioner claimed she was entitled to 57 2/7 weeks of temporary total disability benefits, commencing July 25, 2017, through August 30, 2018 (the date of trial). The parties stipulated Petitioner received extended benefits (100% of her regular pay) from July 25, 2017, to August 1, 2018, and that Respondent paid Petitioner temporary total disability benefits from August 2, 2018, through August 15, 2018 (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as an RN and was a floor nurse who had significant patient contact. At the time of the accident of July 25, 2017, Petitioner had worked for Respondent for approximately five years. Petitioner testified that, as a floor nurse, she had to be on her feet most of the time and dealt with patients who have behavioral issues on a regular basis.

Petitioner testified that on July 25, 2017, she and some other employees were attempting to restrain a combative patient. The patient lunged forward attacking the employees who were attempting to restrain him. When this occurred, Petitioner fell to the floor and experienced an onset of low back pain with numbness/tingling in the right leg. Petitioner completed and signed a Notice of Injury form which described the accident of July 25, 2017, and that when the patient lunged forward, everyone fell to the floor and Petitioner twisted her back in the process (Respondent's Exhibit 2).

Following the accident, Petitioner was seen in the ER of Union County Hospital. At that time, the Petitioner complained of having low back pain and numbness/tingling in her right leg. A CT scan was performed which revealed disc bulging at L3-L4, L4-L5 and L5-S1. Petitioner was directed to follow-up with Dr. Paul Tolentino, a neurosurgeon (Petitioner's Exhibit 10).

On July 27, 2017, Petitioner was seen by Jared Lewis, a Physician Assistant in Dr. Tolentino's office. PA Lewis reviewed the CT scan and noted the presence of disc bulges in the lumbar spine. He ordered an MRI scan (Petitioner's Exhibit 11).

The MRI was performed on August 7, 2017. Dr. Tolentino reviewed the MRI and opined it revealed disc bulges at L3-L4, L4-L5 and L5-S1. In regard to the disc bulge at L5-S1, Dr. Tolentino opined the MRI also revealed a small left paracentral disc protrusion causing mild/moderate foraminal stenosis. Petitioner previously advised Dr. Tolentino that her right leg symptoms had improved, but she was experiencing worsening left leg symptoms of aching and numbness (Petitioner's Exhibit 11).

Dr. Tolentino ordered an epidural steroid injection at L5-S1. This was performed on August 18, 2017. Petitioner experienced some temporary relief of her symptoms following the injection. However, Petitioner developed urinary and bowel incontinence subsequent to the injection. Petitioner continued to be seen at Dr. Tolentino's office and her last visit there was October 4, 2017. At that time, Petitioner was not at MMI and was subject to a 10 pound lifting restriction, no repeated bending, stooping or twisting, no overhead work and no flexion or extension of the spine (Petitioner's Exhibit 11).

On October 9, 2017, Petitioner was evaluated by Dr. Matthew Gornet, an orthopedic surgeon. At that time, Petitioner stated that she and several other employees were attempting to subdue a mentally ill patient. When the patient threw himself forward, Petitioner twisted, was pushed up against a wall and felt a "pop" in her low back. Dr. Gornet reviewed the MRI of August 7, 2017, and opined it was of moderate/poor quality, but it revealed disc pathology at L3-L4 and L5-S1. Petitioner complained of low back pain with radiation into the left hip, buttocks and leg. Dr. Gornet opined Petitioner's radicular symptoms were consistent with a disc injury at L5-S1. He recommended Petitioner undergo some epidural steroid injections at L3-L4 and L5-S1. Dr. Gornet kept Petitioner off work imposing light duty restrictions (Petitioner's Exhibit 13).

Petitioner was subsequently seen by Dr. Kaylea Boutwell, who administered epidural steroid injections at L3-L4 and L5-S1 on October 9, 2017, and November 2, 2017, respectively. The injections did not provide Petitioner with any long term relief from her symptoms (Petitioner's Exhibit 13).

When Dr. Gornet saw Petitioner on December 7, 2017, he ordered an MRI, discogram, CT scan and also noted that a bone density study might be necessary. He continued to impose light duty work restrictions. The discogram and CT scan were performed on February 9, 2018. The discogram revealed provocative discs at L3-L4 and L5-S1 with annular tears. The CT scan had findings consistent with the discogram (Petitioner's Exhibit 13).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on February 14, 2018. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records provided to him by Respondent. In regard to Petitioner's prior medical history, she advised Dr. Chabot she had been previously diagnosed with fibromyalgia with chronic pain syndrome referable to the left hip and SI region (Respondent's Exhibit 3).

Dr. Chabot diagnosed Petitioner with back strain, back contusion and back pain. He opined Petitioner was at MMI and Petitioner's subjective complaints were not supported by significant objective findings. In regard to causality, Dr. Chabot opined that there might be some causal relationship between Petitioner's current complaints and her injury; however, he noted that he wanted to review Petitioner's prior treatment records. He further opined Petitioner was not a good surgical candidate for either a fusion or disc replacement surgery (Respondent's Exhibit 3).

Dr. Gornet saw Petitioner on March 17, 2018. At that time, he noted that the bone density test had a finding of -3.0, so Petitioner was not a candidate for disc replacement surgery (Petitioner's Exhibit 13).

Petitioner was subsequently seen by Dr. Gornet on May 14, 2018, and Dr. Gornet reviewed Dr. Chabot's report. Dr. Gornet noted that the diagnostic tests revealed disc pathology at L3-L4 and L5-S1. Dr. Gornet opined that a multilevel fusion procedure was the only option given Petitioner's bone density. He continued to impose light duty work restrictions (Petitioner's Exhibit 13).

Dr. Chabot was subsequently provided Petitioner's prior medical records and he prepared a supplemental report dated July 12, 2018. The prior medical records Dr. Chabot reviewed/summarized were for treatment provided to Petitioner for her left hip problem from July 28, 2014, through July 7, 2017. Dr. Chabot also reviewed additional records that were for treatment Petitioner received after the accident that he had not previously reviewed. None of the preceding records were tendered into evidence at trial. Dr. Chabot opined that, because of Petitioner's prior chronic pain condition, the fusion procedure recommended by Dr. Gornet was not medically reasonable (Respondent's Exhibit 4).

Dr. Gornet was deposed on May 31, 2018, and his deposition testimony was received into evidence at trial. In regard to his diagnosis, treatment and recommended surgery, Dr. Gornet's deposition testimony was consistent with his medical records and he reaffirmed the opinions contained therein. In regard to causality, Dr. Gornet testified that Petitioner's current condition was related to the accident which, at a minimum, was an aggravation of an underlying condition. As to Petitioner's prior left hip symptoms, Dr. Gornet testified that the symptoms Petitioner experienced as result of the accident of July 25, 2017, were completely different symptoms than Petitioner experienced prior to the accident. Dr. Gornet also testified regarding the fact that Petitioner's lower extremity complaints were initially in regard to the right leg, but subsequently included the left leg. Dr. Gornet testified Petitioner had a disc issue at two levels and that the change in symptoms reported was an evolution of the inflammatory process and a morphing of the symptoms (Petitioner's Exhibit 15; pp 14-17; 22-23).

Dr. Chabot was deposed on August 1, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Chabot's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. On cross-examination, Dr. Chabot was asked about the fact that Petitioner was able to work full duty, 40 hours per week, often with over time without any significant problems prior to the accident, if he would agree that Petitioner was not at her pre-accident baseline. Dr. Chabot responded that Petitioner probably had work restrictions, but these were primarily based on her long standing pre-existing conditions and not the strain injury that she sustained (Respondent's Exhibit 5; p 39).

At trial, Petitioner testified she has been unable to work since the date of accident. Petitioner stated that prior to the accident, her left hip condition did not prevent her from working. Further, Petitioner stated that she was never diagnosed with any disc injuries prior to the accident. Petitioner wants to proceed with surgery recommended by Dr. Gornet.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of July 25, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related injury on July 25, 2017, while attempting to restrain a combative patient.

Petitioner's lower extremity complaints were initially in regard to the right leg, but subsequently there were complaints in regard to the left leg. The Arbitrator is persuaded by the opinion of Dr. Gornet regarding the evolution of the inflammatory process. Further, when Dr. Tolentino reviewed the MRI of August 7, 2017, he noted there was a left paracentral disc protrusion, which the Arbitrator found persuasive.

There was no question Petitioner had a pre-existing left hip condition; however, the medical records pertaining to same were not tendered into evidence at trial. The Arbitrator only had Dr. Chabot's summary of the records to review. Petitioner credibly testified she had no disc pathology and was able to work full time prior to the accident.

When Dr. Chabot was questioned about the fact Petitioner was able to work prior to the accident, but not afterward, he restated his opinion that Petitioner's current condition was due to her pre-existing condition. Further, he provided no explanation as to why Petitioner was able to work before the accident but not after.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Gornet to be more persuasive than that of Dr. Chabot.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 1 through 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment, including, but not limited to, the multilevel fusion surgery recommended by Dr. Gornet.

In support of this conclusion the Arbitrator notes the following:

As noted in disputed issue (F), the Arbitrator found the opinion of Dr. Gornet to be more persuasive than that of Dr. Chabot.

In the absence of undergoing the surgery as recommended by Dr. Gornet, the only real option for Petitioner is to continue to live with her current level of symptoms.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 57 2/7 weeks commencing July 25, 2017, through August 30, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been under active medical treatment and only authorized to work light duty during the above noted period of time.

William R. Gallagher, Arbitrator

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Parks,

Petitioner,

vs.

NO: 13 WC 29010

Qual-A-Wash,

19IWCC0420

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 treatment, and temporary total disability ("TTD"), and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission finds Petitioner's current condition of ill-being regarding his left knee is causally related to the January 10, 2013, work accident. However, the Commission finds Petitioner's low back and left hip complaints are not causally related to the work accident. As such, the Commission awards appropriate medical expenses, prospective medical treatment, and TTD relating to Petitioner's left knee condition. 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 Facts

As an initial matter, the Commission notes a prior 19(b) Decision was filed on March 24, 2014. During that arbitration hearing, the parties amended the date of accident on the Application for Adjustment of Claim to allege an accident date of January 10, 2013. On the date of accident, Petitioner fell through a missing grate on a tank trailer he was washing and injured both of his knees. The Arbitrator concluded that Petitioner's bilateral knee condition was causally related to the work accident. She accordingly awarded TTD and prospective medical in the form of bilateral arthroscopic knee surgeries.

Pursuant to the prior 19(b) Decision, Dr. Kostman performed bilateral knee arthroscopies on August 11, 2014. The left knee postoperative diagnoses were left knee lateral meniscus tear,

chondromalacia, and medial meniscus tear. The right knee postoperative diagnoses were right knee medial meniscus tear and partial ACL tear. Petitioner testified that the knee surgeries only provided relief for six to eight months. (Tr. at 11). Petitioner testified that he wants to proceed with the left knee replacement recommended by Dr. Nunley. *Id.* at 14. He rated his left knee pain during the hearing at 8/10. *Id.* Petitioner testified that soon after the work accident he experienced lower left back pain. *Id.* at 20. He testified that his knee complaints were more severe than his back complaints. He testified that he first sought medical care for his back complaints during his November 2016 visit with Dr. Eavenson. *Id.* at 20-21. Upon further questioning, he testified that his low back began to bother him on October 2, 2014. He later testified that he complained of low back pain during his April 2013 IME with Dr. Miller. *Id.* at 21-23. Petitioner testified that he suffered no injuries to his low back since the work accident and he rated his current low back pain at 6-8/10. *Id.* at 24. On cross-examination, Petitioner agreed that during the prior 19(b) hearing, he only testified regarding complaints relating to his knees and mentioned no other allegedly affected body parts including his low back and hips. *Id.* at 28-29.

Less than a month after undergoing bilateral knee surgeries, Dr. Kostman cleared Petitioner to return to work. Petitioner soon began complaining of increased knee pain. Dr. Bell, a family medicine doctor, examined Petitioner on October 2, 2014. (PX 6). Petitioner complained of "horrible" bilateral knee pain. The doctor prescribed an anti-inflammatory as well as physical therapy. In an addendum to October 2, 2014, office visit note, Dr. Bell wrote that Petitioner also complained of some back discomfort going down his legs more on the left than the right. Dr. Bell diagnosed a lumbar disc protrusion, most likely with bilateral lower extremity radiculopathy causing the discomfort down Petitioner's legs, left worse than right. That same day Petitioner received treatment from both a physical therapist and Dr. Eavenson, a chiropractor. Petitioner complained of bilateral knee pain as well as left leg numbness to the chiropractor. Dr. Eavenson wrote, "On January 10, 2013 the patient states that he was cleaning out a tank and fell through a trailer. He struck his right knee on a crash box and twisted his left knee. Initially he had pain up into the lower back and hip." Petitioner continued to visit the chiropractor and physical therapist multiple times each week through October 2015.

Dr. Gornet first examined Petitioner on January 19, 2015. (PX 8). Petitioner complained of left buttock, hip, and leg pain down to his knee and occasionally to his foot. He also complained of bilateral low back pain. Petitioner reported twisting and injuring his low back during the work accident. The doctor diagnosed aggravation of preexisting facet arthritis at L4-L5 and a disc injury at L3-L4 on the left. Dr. Gornet wrote that he needed to review more records to determine whether Petitioner had significant back complaints at or near the time of his injury but believed the back complaints were related to the accident based on Petitioner's reported history. He cleared Petitioner to work full duty. Three months later, Dr. Gornet opined Petitioner's low back and hip complaints are causally connected to the work accident, writing,

> "To the best of my knowledge, the first time I can see mention of his low back symptoms is approximately three months from his injury by Dr. Miller's office, where he clearly mentions pain in his lower back and hip area. He feels comfortable that he filled out a pain diagram not only for Dr. Miller, but as well as at Concentra, but I do not have access to those records. From my standpoint, I

> believe his symptoms are causally related to his work-related injury."

Id.

Dr. Boutwell performed left lumbar ESIs at level L3-L4 on June 29, 2015 and September 3, 2015. (PX14). Dr. Boutwell later opined that Petitioner's back complaints are causally related to the work accident, stating, "We believe he aggravated an underlying condition of facet arthropathy at L4-5 making him symptomatic." Petitioner returned to his chiropractor, Dr. Eavenson, on November 21, 2016, with complaints of ongoing left knee pain and swelling. (PX 6). Petitioner also reported his back pain altered his gait and increased his knee pain. The chiropractor had not seen Petitioner since October 2015. The exam revealed bilateral thoracolumbar paraspinal muscular tightness as well as an antalgic gait leaning to the right. Petitioner sat on the exam table leaning to the right and had a positive left straight leg raise. There was low back pain with flexion and left lateral bending. Petitioner's left knee had medial lateral joint line tenderness, swelling, and crepitus with flexion. The chiropractor diagnosed lower back pain consistent with lumbar disc protrusion and internal derangement of the left knee. He referred Petitioner to Dr. Nunley and opined Petitioner might need a left knee replacement. Dr. Eavenson restricted Petitioner from working beginning December 1, 2016, and prescribed physical therapy. Petitioner participated in extensive physical therapy from December 2016 through February 1, 2018.

After examining Petitioner and reviewing the bilateral knee MRIs performed in January 2017, Dr. Paletta determined Petitioner's right knee symptoms relate to moderately severe arthritis without evidence of underlying ligament or meniscal pathology. He wrote that any right knee treatment should be directed to the underlying arthritis and did not believe surgery was appropriate. Regarding the left knee, Dr. Paletta found evidence of an old, healed, depressed, lateral tibial plateau fracture and a chronic avulsion of the medial collateral ligament resulting in instability of the left knee. There was also significant underlying osteoarthritis in the knee. Dr. Paletta opined that the underlying degenerative joint disease is longstanding and preexisting. He further opined that Petitioner's left knee condition is the result of the work-related injury and that the subsequent instability is a long-term consequence of that injury.

A January 31, 2017, lumbar MRI had the impression of central broad-based protrusions at L3-L4, L4-L5, and L5-S1 with moderate L4-L5 facet arthropathy and milder L5-S1 facet arthropathy. (PX 15). There was mild bilateral foraminal stenosis at L4-L5 and no central canal stenosis at any level. After reviewing the MRI, Dr. Gornet opined that Petitioner's low back complaints relate to an instability process at L4-L5 which relates to his work injury. He prescribed another round of facet blocks and facet rhizotomies but noted that if conservative measures failed he would consider a fusion at L4-L5 as a last resort. Dr. Nunley first examined Petitioner on February 6, 2017. (PX 12). Petitioner complained of bilateral knee pain, left worse than right, and did not feel physical therapy was helpful. Petitioner complained of significant instability on the left where the tibia subluxes forward. The doctor diagnosed a left knee chronic ACL tear with osteoarthritis and right knee early to moderate osteoarthritis. Petitioner did not feel he was able to return to work. Dr. Nunley wrote that Petitioner may be a candidate for a total left knee replacement if further conservative management failed; however, he noted Petitioner's surgical

results were unpredictable because a fair amount of the arthritis was in the patellofemoral joint. Bilateral knee injections were performed in the office and the doctor prescribed a hinged knee brace for the left knee.

Dr. Boutwell performed a left L3-L4 and L4-L5 medial branch block on February 9, 2017. (PX 14). The next day Petitioner complained of low back pain and left greater than right leg discomfort. Petitioner reported a dramatic improvement following the medial branch nerve blocks. Dr. Boutwell later performed a lumbar radiofrequency ablation of left L3-L4 and L4-L5. *Id.*

On March 8, 2017, Dr. Nunley took Petitioner off work until the left total knee replacement surgery occurs. (PX 12). He opined that Petitioner qualifies for a total knee replacement because of the instability, arthritis, joint space narrowing, subchondral cysts and sclerosis, and the fact that all conservative measures have failed. That same month, Petitioner told Dr. Gornet the facet rhizotomies performed by Dr. Boutwell provided some relief and made his low back pain tolerable. Petitioner last visited Dr. Gornet on December 14, 2017. (PX 8). Dr. Gornet prescribed medication and recommended repeating the prior facet rhizotomies at levels L3-L4 and L4-L5 bilaterally. He stated that while Petitioner was off work due to his knee complaints, he was able to work full duty regarding his low back complaints. In January 2018, Dr. Boutwell performed a lumbar radiofrequency ablation of right L3-L4 and L4-L5. (PX 14).

Expert Opinions and Testimony

Dr. Nunley — Treating Physician

Dr. Nunley testified on Petitioner's behalf via evidence deposition on October 30, 2017. (PX 13). He testified that Petitioner is a candidate for a total knee replacement because he failed conservative management and his left knee affected his quality of life. *Id.* at 8. He believes Petitioner's injury caused tearing and ACL injuries that ultimately led to degeneration and the need for the knee replacement. *Id.* at 13. He testified that when one loses the structural integrity of the meniscus, one loses the ability to more evenly distribute the forces, thus accelerating the wear to the cartilage that is the pressure point. *Id.* at 14. Dr. Nunley testified that Petitioner is not at MMI. He testified that even if Petitioner suffered from chronic degenerative arthritis, the work injury most likely exacerbated the preexisting condition. *Id.* at 23.

Dr. Miller — Respondent Section 12 Examiner

Petitioner submitted Dr. Miller's original April 24, 2013, IME report along with the questionnaire Petitioner completed listing his chief complaint as "both knees (lower back) hip area." (PX 17). Dr. Miller authored a second report on November 5, 2014 after reviewing updated medical records and reexamining Petitioner. Petitioner complained of bilateral knee pain as well as left lower back numbness, pain up and down the left leg, and left hip numbness. Dr. Miller opined that Petitioner had fully recovered from the surgeries because there was no effusion, there was full range of motion, and the quadriceps tone was well restored. He noted that Petitioner's lack of relief following the partial meniscectomies supported his opinion that Petitioner's symptoms were due to arthritis and not meniscus pathology. Dr. Miller opined that the prevailing factor was preexisting or coexisting degenerative joint disease. He opined that knees with

advanced arthritic changes will always have meniscal pathology and this pathology is related to the arthritic nature of Petitioner's knees as opposed to the work injuries.

Dr. Browdy — Respondent Section 12 Examiner

Dr. Browdy testified on behalf of Respondent via evidence deposition on November 15, 2017. (RX 3). The doctor examined Petitioner on May 31, 2017. *Id.* at Ex. 2. He took Petitioner's history, conducted a physical examination of Petitioner's knees, and reviewed medical records. Petitioner complained of left knee pain down his leg as well as pain into his back. He also complained of swelling and numbness of the left leg and rated his pain at 7-10/10. Regarding the right knee, he complained of pain in the anterior leg with associated popping that he rated at 5-7/10. Dr. Browdy opined that Petitioner had advanced, preexisting arthritis of both knees prior to the work accident and that the current complaints are not causally related to the accident. He opined Petitioner required no additional treatment relating to the work accident. Regardless of causation, he believed Petitioner is a good candidate for additional care for both knees. He thought a left knee replacement was appropriate but did not believe it related to the work accident.

Most of the doctor's practice involves the treatment of shoulder, knee, and elbow disorders. At least half of his practice involves knee conditions. He testified that his physical examination of Petitioner revealed that he had valgus posture of the left knee, meaning Petitioner is knock-kneed on that side. (RX 3 at 10). He testified that the valgus posture could be the result of the chronic tibial plateau fracture he likely sustained in the 2000 car accident in which the lateral side of the knee was depressed from the fracture. *Id.* This likely led to the development of arthritis in the lateral compartment. The doctor interpreted the February 2017 knee x-rays as showing the left knee was arthritic with a chronic plateau fracture and MCL tear and bone-on-bone changes of the patellofemoral joint on both sides. *Id.* at 11-12. There was moderate degenerative change on the right knee particularly of the medial side of the knee with osteophytes and joint space narrowing. *Id.* He testified Petitioner's bilateral knee arthritis was not caused by the work injury. *Id.* at 13. Dr. Browdy testified that the work accident caused only a temporary aggravation of Petitioner's preexisting arthritis. He testified that Petitioner had substantial arthritis before the work accident and he would inevitably require a left knee replacement even if the work accident had not occurred. *Id.* at 17-18. He testified that regardless of causation, Petitioner would benefit from a left knee replacement if he exhausts all conservative measures and still has symptoms Petitioner deems unacceptable. *Id.* at 21-22.

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). When a claimant suffers from a preexisting condition, the claimant must show that a work-related accidental injury aggravated or accelerated the preexisting condition "...such that the [claimant's] current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *Id.* at 204. After carefully reviewing the totality of the evidence, the Commission finds Petitioner proved by a preponderance of the evidence that his current condition of ill-being relating to his left knee is causally related to the January 10, 2013, work accident. However, Petitioner failed to meet his burden of proving his

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lumbar complaints are causally related to the work accident.

The Arbitrator concluded that Petitioner met his burden of proving both his left knee and lumbar spine complaints are causally related to the work accident. The Commission agrees that Petitioner's left knee condition is causally related to the work accident; however, the Commission interprets the evidence differently regarding Petitioner's lumbar spine condition. Petitioner testified that he began experiencing pain through his low back and left hip immediately following the accident. He testified that he did not immediately pursue treatment for his lumbar complaints because his bilateral knee pain was more severe. The medical records reveal that he told Dr. Gornet that he raised his low back and hip complaints during his initial treatment with Concentra. After carefully considering all of the evidence, including the findings of the prior 19(b) Decision, the Commission finds Petitioner's low back and hip complaints are not causally related to his work accident.

Petitioner sustained injuries on January 10, 2013. There is no credible evidence corroborating his testimony that he immediately felt pain in his low back and left hip as well as both knees after his fall. The evidence shows Petitioner made no reference to any low back or hip symptoms prior to attending the April 2013 IME appointment with Dr. Miller. At the IME, Petitioner listed low back and hip pain as complaints on the questionnaire Dr. Miller provided. However, there is no evidence in the medical records that Petitioner complained to any of his treating physicians about low back and left hip pain prior to his October 2014 appointments with Dr. Bell, Dr. Eavenson, and a physical therapist. On October 4, 2014, Petitioner first saw Dr. Bell and reported bilateral knee complaints. He then also saw both a physical therapist and Dr. Eavenson, a chiropractor. He told Dr. Eavenson as well as the physical therapist that on the date of accident he had bilateral knee pain as well as pain in his lower back and left hip. Dr. Bell later authored an addendum reflecting Petitioner's complaints of low back pain. The medical records show that Petitioner began treatment for his lumbar and hip complaints following that day.

While there are certainly circumstances where a claimant might prioritize treatment for their most significant injuries and delay treatment for less serious complaints, the Commission finds those circumstances are not present in this matter. Petitioner was injured in January 2013. Despite his testimony that he experienced low back and hip pain almost immediately, he never mentioned any complaints regarding his back or hip to any of his treating physicians until 22 months after the work accident. Even after Petitioner indicated low back and hip pain as a complaint on the April 2013 IME questionnaire, Petitioner still did not relay these complaints to his treating physicians. He also never raised these complaints during the January 2014 arbitration hearing. In the complete absence of any complaints to his medical providers for almost two years, the Commission finds Petitioner's testimony simply does not support a finding that his belated complaints of low back and left hip pain are causally related to the work accident.

Due to the Commission's finding that Petitioner's low back and left hip complaints are not causally related to the work accident, the Commission must accordingly modify the Arbitrator's award of medical expenses. The Commission therefore finds Respondent is liable only for medical expenses relating to Petitioner's bilateral knee complaints. Respondent is not liable for any medical expenses relating to Petitioner's low back and hip complaints.

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The Commission must also modify the Arbitrator's award of TTD to conform to both the prior 19(b) Decision and the credible evidence. The prior 19(b) Decision addressed all claims of TTD benefits from the date of accident through the January 29, 2014, hearing. Pursuant to the prior 19(b) Decision, Petitioner was entitled to TTD from January 29, 2013, through March 12, 2013, and from March 26, 2013, through May 7, 2013. The current hearing addresses only Petitioner's entitlement to TTD from January 30, 2014, through the February 14, 2018, hearing. The medical records show that on November 21, 2016, Dr. Eavenson took Petitioner off work effective December 1, 2016. Since that time, Petitioner's physicians have continued to keep him off work due to his chronic left knee pain. Therefore, the Commission finds Petitioner is entitled to TTD benefits from December 1, 2016, through February 14, 2018, or 63 weeks. As Petitioner's TTD rate is $313.96, he is entitled to TTD benefits in the amount of $19,779.48 for the applicable period since date of the prior 19(b) hearing. Respondent receives a credit for any TTD previously paid to Petitioner.

Finally, the earlier March 2014 19(b) Decision established an accident date of January 10, 2013, pursuant to agreement by the parties. However, the current 19(b) Decision mistakenly reflects an accident date of January 3, 2013. Thus, the Commission modifies the April 4, 2018, 19(b) Decision to reflect a date of accident of January 10, 2013, to conform to the law of this case.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 4, 2018, is modified as stated herein.

IT IS FURTHER ORDERED that the correct date of accident is January 10, 2013. The Commission thus corrects any reference to an accident date of January 3, 2013, to January 10, 2013.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being relating to his left knee is causally related to the January 10, 2013, work accident. Petitioner's low back and left hip complaints are not causally related to the work accident.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $**313.96**/week for **63** weeks, commencing **December 1, 2016,** through **February 14, 2018**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits previously paid to Petitioner.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical charges that relate only to treatment for Petitioner's bilateral knee condition, as provided in Sections 8(a) and 8.2 of the Act. Respondent is not liable for any expenses relating to Petitioner's low back or hips.

IT IS FURTHER ORDERED that Respondent shall pay for reasonable and necessary prospective medical treatment in the form of the recommended left total knee replacement surgery.

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IT IS FURTHER ORDERED that Respondent shall receive 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.

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 $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 6 - 2019

o: 6/11/19
TJT/jds
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Thomas J. Tyrrell

Stephen J. Mathis

Deborah L. Simpson

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

PARKS, GARY
Employee/Petitioner

Case# **13WC029010**

QUALAWASH
Employer/Respondent

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On 4/4/2018, 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 1.90% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
DAVID M GALANTI
PO BOX 99
EAST ALTON, IL 62024

1454 THOMAS & PORTELA
ROBERT A HOFFMAN
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

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STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gary Parks
Employee/Petitioner

v.

QualaWash
Employer/Respondent

Case # **13** WC **29010**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **2-14-18**. 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. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **1/3/13**, 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 **$24,488.64**; the average weekly wage was **$470.94**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$13,713.10** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$13,713.10**.

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

ORDER

See Attached.

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

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

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

Carl Lee
Signature of Arbitrator

3/28/18
Date

ICArbDec19(b)

APR 4 - 2018

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STATEMENT OF FACTS

This matter was previously tried as a 19(b) on January 29, 2014.See PX 1. Arbitrator Lindsay found that the Petitioner was temporarily and totally disabled secondary to a work place accident from January 29, 2013 through March 12, 2013, and March 26, 2013 through May 7, 2013, a period of 12 2/7 weeks. Further, Arbitrator Lindsay found the Petitioner's bilateral knee condition was causally related to his accident and ordered arthroscopic bilateral knee surgery as recommended by Dr. Kostman. See PX 1.

Subsequent to that hearing, Petitioner underwent surgery by Dr. Kostman on August 11, 2014. At that time, Dr. Kostman noted partial tears to both the lateral and medial meniscus. Dr. Kostman noted grade 3 and grade 4 chrondromalacia involving the patellofemoral joint. Dr. Kostman also debrided some fibers of the left ACL. See PX 4. Dr. Kostman also noted a partial ACL tear on the right side, along with a right medial meniscus tear. The right meniscus was debrided and a portion of the ACL. See PX 5. All associated TTD benefits were paid. Petitioner was released to return to work following these surgeries on October 13, 2014. See PX 6 at 8, 12.

Although Petitioner returned to work, a review of Petitioner's Exhibit 6, which are the physical therapy and chiropractic medical records from Multicare Specialists clearly indicate the Petitioner was continuing to have ongoing knee and back difficulties. He has continually complained of, and been treated for these complaints, and no new injuries were noted in these medical records. The Petitioner also testified that he had not sustained and additional injury to his knees or back since the initial injury of January 3, 2013.

Petitioner testified the initial surgeries performed by Dr. Kostman helped his knees for 6-8 months but then his knees began to become increasingly achy. Specifically, Petitioner testified that he was having pain from his knee down and that it was getting worse and causing him difficulties at work. This testimony is completely corroborated by the medical records from Multicare Specialists.

Due to his ongoing complaints with his knees, Petitioner was referred by Multicare Specialists to Dr. Nunley. Dr. Nunley has been a professor of Orthopedic Surgery at Washington University since 2014. See PX 12 at 2. Petitioner first saw Dr. Nunley on February 6, 2017. On that date, Petitioner filled out the history and he related both of his knee problems to an incident beginning in January of 2013. See PX 12 at 16. Following a clinical examination, Dr. Nunley diagnosed Petitioner with a left knee chronic ACL tear, along with osteoarthritis, and a right knee early to moderate osteoarthritis. He recommended an injection, and if that failed it indicated the Petitioner would be a candidate for a left total knee arthroplasty. See PX 12 at 14. As of March 8, 2017, Dr. Nunley opined that the Petitioner needed a left total knee replacement and that he was off work until that procedure was approved by Workers' Compensation. See PX 12 at 2. See PX 13 at Depo Exhibit EX1. Dr. Nunley reviewed the prior operative notes of Dr. Kostman. See PX 13 at 12. Assuming the first two surgeries were causally related to the initial accident, and that Petitioner had no intervening injuries, and that he continued to complain of pain into both knees subsequent to the knee surgeries, Dr. Nunley felt that the original injury caused ACL injury which ultimately lead to degeneration requiring a knee replacement. Id at 13.

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Since his injury involved both a meniscus injury and ACL injury the prior treatment by Dr. Kostman was just a patch along the process that ultimately lead to the need for a knee replacement. Id.

Petitioner was examined at the behest of the Respondent on March 31, 2017. See RX 3 at 8. Dr. Browdy felt Petitioner would benefit from a left knee replacement. Id at 21. Dr. Browdy felt the two surgeries performed by Dr. Kostman were not related to the original injury even though Arbitrator Lindsay awarded these surgeries as being causally related to Petitioner's injury. Id at 23,24. Dr. Browdy only reviewed the right knee operative note and not the left knee operative note which is the knee that Dr. Nunley is wanting to replace. Id at 24. Dr. Browdy has given the opinion that knee replacements were related to work accidents when a person has undergone multiple surgical procedures and he is worse off than he was before the original accident. Id at 27,28. Dr. Browdy also testified that Dr. Nunley is an excellent surgeon to whom he refers his complex knee replacement cases. Id at 17,19. Finally, Dr. Browdy opined that although the August 11, 2014 left knee meniscectomy performed by Dr. Kostman was not the prevailing factor in the need for Petitioner's knee replacement, it could have been a factor in the development of the Petitioner's arthritis. Id at 30.

Currently, Petitioner complains that his pain level in his left knee is approximately an 8 on most days. He feels his knee is "loose". The Petitioner understands Dr. Nunley is proposing a total knee replacement and he would like to proceed with this procedure so he can become pain free.

With respect to Petitioner's back condition, the Arbitrator notes that there were no testimony elicited at the first 19(b) hearing on January 29, 2014 concerning Petitioner's back. However, Petitioner's Exhibit 17 is the original IME from Dr. Miller taken on November 5, 2014 and April 24, 2013 and this document clearly states that Petitioner was complaining of back problems. See PX 17 at 14.

For his back condition, Petitioner was referred by Dr. Eavenson to Dr. Matthew Gornet. Dr. Gornet related Petitioner's ongoing problems of his lower back to the injury of January 3, 2013 and diagnosed Petitioner with an L3-L4 and pre-existing facet arthritis at L4-L5. Dr. Gornet specifically noted that he reviewed Dr. Miller's records as part as the initial exam. Id at 13. Petitioner was last seen by Dr. Gornet on December 14, 2017 following rhizotomies by Dr. Boutwell. Petitioner has been released to full duty on his back with no restrictions, however, it was noted he is still off work pending his knees. Petitioner is scheduled to see Dr. Gornet again in July of 2018.

The following medical bills were presented at trial:

Multicare Specialists: $83,308.11
Anderson Radiology: $6,941.90
MRI Partners of Chesterfield: $12,853.00
Dr. Gornet: $7,383.66
Gateway Regional: $2,971.64

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Orthopedic Ambulator Surgery Center: $25,997.99
Pain and Rehab Specialists: $12,291.89
St. Louis Spine & Orthopedic Surgery Center: $3,605.82

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner carried his burden of proof with respect to causation of his bilateral knee condition. Arbitrator Lindsay had already made a final and legal determination in the previous 19(b) that Petitioner's bilateral knee surgeries were casually related to the accident of January 3, 2013. The Arbitrator finds Dr. Nunley's testimony regarding causal connection on this matter more credible than Dr. Browdy. It is clear from review of the Multicare Specialists records that Petitioner had ongoing difficulties continually following the surgery by Dr. Kostman in both knees. Petitioner never made a full recovery and had no intervening injuries. Therefore, it is more likely than not that the need for the knee replacement is causally related to the accident of January 3, 2013. Even if one was to consider Dr. Browdy's opinion to be more credible than Dr. Nunley's, Dr. Browdy still felt the Petitioner needed a knee replacement and that the meniscectomy was at least one factor in aggravating his underlying arthritis.

With respect to causation as it relates to Petitioner's back condition, the Arbitrator finds that Petitioner's back condition is causally related to the accident of January 3, 2013. Petitioner's knee condition was clearly a bigger problem for him at the time of the first 19(b) than his lower back, yet the IME from Dr. Miller states explicitly that Petitioner was complaining of back issues before the first 19(b).

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 ARBITRAOTR FINDS AS FOLLOW:

The following medical bills are both reasonable and necessary for Petitioner's care and awarded pursuant to the Fee Schedule:

Multicare Specialists: $83,308.11
Anderson Radiology: $6,941.90
MRI Partners of Chesterfield: $12,853.00
Dr. Gornet: $7,383.66
Gateway Regional: $2,971.64
Orthopedic Ambulator Surgery Center: $25,997.99
Pain and Rehab Specialists: $12,291.89
St. Louis Spine & Orthopedic Surgery Center: $3,605.82

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WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

For the reasons listed above, the Arbitrator awards Petitioner a total left knee arthroplasty as recommended by both Dr. Nunley and Browdy.

WITH RESPECT TO ISSUE (L), WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds the Petitioner is entitled to benefits from January 29, 2013 through September 2, 2014, and November 21, 2016 through February 14, 2018, a period of 95 3/7 weeks. Respondent shall be given credit for any prior TTD paid under the prior 19(b).

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amado Ulloa,
Petitioner,

vs. No. 13 WC 21451

PSSI, Inc.,
Respondent.

19IWCC0421

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

Timely Petition for Review under §19(b) and §8(a) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, prospective medical care, and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and vacates the Arbitrator's award of benefits for claim 13 WC 21451.[1]

The Commission views the evidence differently than the Arbitrator regarding Petitioner's claim of accident on September 11, 2012. The Commission has considered the entire record and finds that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on September 11, 2012. In support of its decision, the Commission finds the following:

[1] The instant case was consolidated and tried with Petitioner's companion claim, 13 WC 21456, which alleged a different accident on June 21, 2013. Although the Arbitrator filed only one Arbitration decision for both of Petitioner's claims, the Commission is filing a separate decision for each claim.

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Petitioner testified that while moving a heavy tank on wheels in August 2012, he injured his shoulder, but did not seek medical treatment for that injury at that time. On September 1, 2012, Petitioner completed a First-Aid/Medical Refusal Report for Respondent. Petitioner reported therein that he told his employer that he hurt his back while pushing a large tank on August 17, 2012. As of the date of that report, Petitioner declined an offer to get treatment at a hospital, because he wanted to see how he felt after a few more days.

Petitioner decided on September 11, 2012 that he could no longer tolerate the pain and tingling he was then feeling. On that date, he had his boss, Jose, take him to Vista Medical Center. Over the next couple weeks, Petitioner received treatment consisting of x-rays, medications and injections to his shoulder. Petitioner testified that after September 11, 2012, he continued working for Respondent without any lost time from work until the date of his June 2013 accident.

At the arbitration hearing, Petitioner was asked to specifically describe his alleged September 11, 2012 work accident. His initial answer was, "I don't know. I don't remember." Following leading questions, Petitioner acknowledged that his boss took him to the doctor that day because of his shoulder. Petitioner was then asked again:

Q. What happened [to cause you to seek treatment]?
A. I couldn't tolerate the pain. I felt pain, and I felt like a tingling sensation. . . .

Notably absent from Petitioner's testimony was any mention that his pain began or increased with pushing the tank. Although he claimed he was experiencing pain at that moment, Petitioner did not testify that his pain was caused or increased by a new accident of that date.

The Commission's decision that Petitioner did not prove an accident on September 11, 2012 is further supported by medical records from his treating physicians. Contemporaneous medical records from Vista Medical Center on September 11, 2012, fail to corroborate that Petitioner sustained a work accident on that date. Instead, those records show that Petitioner was seen for pain which had begun three weeks earlier. While those records document that Petitioner did complain of chest/rib pain which developed that day, those records state that Petitioner's chest/rib pain began not when he was pushing a tank at work, but rather, when he was bending forward to put his boots on that morning.

Drs. Erickson's and Chunduri's records similarly fail to corroborate Petitioner's claim of a work accident on September 11, 2012. Their records document that Petitioner's low back pain began when he pushed a tank on August 17, 2012.

Based on Petitioner's testimony and the lack of corroborating medical histories, the Commission finds that Petitioner has failed to prove a work-related accident occurred on September 11, 2012. As a result of the Commission's findings herein, the Commission vacates the Arbitrator's conclusions in their entirety regarding claim # 13 WC 21451. The Commission reverses the Arbitrator's decision in that claim, and finds that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment with Respondent on September 11, 2012. The Commission finds all other issues moot.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 5, 2017, in this matter, 13 WC 21451, is hereby vacated and all benefits to Petitioner as a result of that claim are denied.

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

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

DATED: AUG 7 - 2019

o-06/20/19
mp/mcp
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Marc Parker

Deborah L. Simpson

Barbara N. Flores

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Amado Ulloa,
Petitioner,

vs. No. 13 WC 21456

19IWCC0422

PSSI, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §19(B) AND §8(A)

Timely Petition for Review under §19(b) and §8(a) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, modifies the Decision of the Arbitrator in claim 13 WC 21456 as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.[1] The Commission further remands this case, 13 WC 21456, to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission,* 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Findings of Fact

Petitioner, a 44-year-old factory worker, testified that on June 21, 2013, while walking at his workplace, he slipped and fell on a frozen floor near a freezer. His whole back hit the floor. One of his bosses, Pedro Grande, saw him fall. As Petitioner tried to get up, he fell back onto his knees. Mr. Grande helped him up and sat him down next to a machine. Petitioner immediately felt pain in his whole back and buttocks. However, he finished working the remaining 2½ to 3 hours left of his shift, before going home.

[1] The instant case was consolidated and tried with Petitioner's companion claim, 13 WC 21451, which alleged a different accident on September 11, 2012. Although the Arbitrator filed only one Arbitration decision for both of Petitioner's claims, the Commission is filing a separate decision for each claim.

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Petitioner testified that the day following his accident, he went to Vista Medical Center. He also sought care at New Life Medical Center, where he received authorization to be off work. Petitioner's chiropractor at New Life Medical Center, Dr. Carrion, prescribed 66 chiropractic therapy sessions and ordered lumbar and thoracic spine MRI's. Petitioner attended physical therapy at New Life from June 2013 through November 2013. His lumbar MRI revealed bulges/herniations at L4-L5 and L5-S1. Petitioner was referred to and seen by Drs. Neeraj Jain, Krishna Chunduri, Robert Erickson, Geoffrey Dixon and Kevin Koutsky. The latter three physicians recommended Petitioner undergo a lumbar fusion. In so doing, the physicians noted Petitioner had a positive test results including his straight leg raising, his discogram and his SSEP test. His lumbar MRI showed a right central herniation at L5-S1 and a broad-based herniation at L4-L5 which compromised the spinal canal. Petitioner had also exhausted and failed conservative treatment.

Petitioner now wishes to undergo back surgery because of his pain. Petitioner has never returned to work at Respondent, or anywhere else, since he was first authorized off work.

Currently, Petitioner performs some chores around his house, like washing dishes and cleaning the bathtub and toilet on his knees, but he cannot lift a lot of weight or bend. He lives with his mother and her husband. Petitioner admitted that he has accompanied his cousin, Helen, to keep her company when she worked at her house-cleaning business. He also admitted that his cousin helps him out financially by taking him out to eat and by buying him clothing. She also helps him by washing his clothes. However, Petitioner denied that he performed any work for his cousin's business. Respondent's surveillance video in evidence depicted Petitioner entering residences, but did not show him performing any cleaning activities or any other work.

Dr. Erickson testified via evidence deposition that he first examined Petitioner on October 4, 2013. Dr. Erickson reviewed Petitioner's films and obtained the results of his SSEP test, which was positive at L5 and S1. Dr. Erickson recommended Petitioner undergo either a single level L5-S1 laminectomy or a fusion, and thought that surgery at Petitioner's L4-5 level might also be required. Dr. Erickson opined that Petitioner's conservative care had failed, and that his June 2013 accident may have contributed to his current condition.

Respondent presented the evidence deposition testimony of its Section 12 expert, Dr. Ryon Hennessy, who examined Petitioner on October 18, 2013. Dr. Hennessy found Petitioner able to work without restrictions. Dr. Hennessy opined that: Petitioner's subjective symptoms did not match his objective tests, his L5-S1 disc was only a bulge and not a herniation, and that Petitioner needed no further treatment as a result of his June 21, 2013 accident. Dr. Hennessy found that Petitioner had no positive Waddell's signs. Dr. Hennessy admitted, however, that Petitioner's June 22, 2013 lumbar MRI did show an L5-S1 right disc bulge which did contact the right S1 nerve root. Dr. Hennessy's opinions were based, at least in part, upon his mistaken belief that neither Dr. Estrella nor Dr. Carrion documented in their records that Petitioner had sustained an accident on June 21, 2013. In fact, those doctors had.

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Respondent offered several Utilization Review reports into evidence. The report dated July 29, 2013 non-certified 12 additional physical therapy visits which were then requested, because the previous 11 physical therapy sessions which Petitioner attended through July 19, 2013, were at best only minimally effective. The July 29, 2013 report also non-certified Petitioner's June 22, 2013 lumbar MRI, because that MRI had been ordered only one day after Petitioner presented to the clinic, and no neurological deficits had been documented in Petitioner's June 21, 2013 and June 22, 2013 medical records. The July 29, 2013 Utilization Review report also non-certified the prescription for a compound topical cream, because Petitioner had taken NSAID drugs and Tylenol in the past and they were not helpful. There was no reason to expect a different result with the same medications.

Respondent's August 7, 2013 Utilization Review report non-certified 12 additional physical therapy sessions because there was little to indicate there had been functional improvement to Petitioner's left shoulder from prior therapy. The August 7, 2013 report again non-certified a prescription for a different compound topical cream containing topical analgesics, because the purpose of topical analgesics is to treat acute pains, and Petitioner's pains were chronic. Further, the August 7, 2013 Utilization Review report stated that Ketoprofen was not a drug that had been approved by the FDA for topical application.

Lastly, Respondent's September 19, 2013 Utilization Review report non-certified an order for a back brace. The reason that brace was non-certified was because such braces are recommended for treatment of back injuries, not for the prevention of them, as it was being ordered for Petitioner in this case.

Conclusions of Law

The Commission finds Petitioner proved that he sustained an accident which arose out of and in the course of his employment on June 21, 2013. Petitioner testified that he slipped on a "frozen floor," near a freezer. Multiple treating physicians corroborated that history from Petitioner. While Petitioner described slightly different injuries to Dr. Estrella and to Dr. Carrion, their records, along with those of other treating physicians, corroborate Petitioner's testimony that he slipped and fell that day while in the course and scope of his employment.

Respondent's arguments that Petitioner did not prove an accident are not persuasive. The fact that Petitioner did not seek medical treatment until after completing his work shift does not disprove his undisputed testimony that he slipped and injured himself. Nor was Petitioner required, in order to prove his case, to call witnesses to corroborate his testimony. Of note, Respondent did not call any witnesses to refute Petitioner's claim of accident on June 21, 2013.

The Commission finds that Petitioner proved notice of his accident. He testified that one of his bosses, Pedro Grande, observed him fall. Respondent offered no evidence to dispute Petitioner's testimony, which is corroborated overall by the histories contained in the medical records. Further, Petitioner filed and served his Application for Adjustment of Claim in this matter upon Respondent approximately 2 weeks after his accident, well within the statutory period. Either of those facts, standing alone, would suffice as proof that Petitioner provided sufficient notice of his June 21, 2013 accident to Respondent.

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The Commission affirms the Arbitrator's finding that Petitioner's herniated lumbar discs and radiculopathy were causally related to his accident, although the Commission clarifies that the "accident" to which these injuries were related was Petitioner's June, 21, 2013 accident, not his alleged September 11, 2012 accident. In so concluding, the Commission finds the testimony of Petitioner and his treating physicians more credible than that of Respondent's expert, Dr. Hennessy.

The Commission finds that Petitioner has not proven that any alleged conditions of ill-being other than to his lumbar spine were causally related to his June 21, 2013 accident. The Arbitrator did not find any other alleged conditions to be causally related, and the Commission specifically finds that Petitioner failed to prove a causal relationship of his alleged conditions affecting his cervical spine, thoracic spine, shoulders, scapular area and chest. In so finding, the Commission notes that Dr. Erickson did not treat Petitioner for any conditions other than to his lumbar spine, and he did not give causation opinions regarding any conditions other than Petitioner's lumbar spine.

With regard to Petitioner's shoulder condition, the Commission finds persuasive the records of Dr. Gabriel Levi, who saw Petitioner in July 2013. Dr. Levi reported that Petitioner's bilateral shoulder pain had been present "since 8/17/12 injury." Although the chiropractors and physicians at New Life Medical Center found all of Petitioner's conditions to be causally related to his June 21, 2013 accident, the Commission does not find their opinions persuasive because their opinions were not based on Petitioner's complete medical history, which included his August 2012 accident.

Although the Arbitrator awarded Petitioner all of his requested medical expenses incurred through arbitration, the Commission reverses the Arbitrator's award of medical expenses related to Petitioner's cervical spine, thoracic spine, shoulders, scapular area and chest conditions. The treatment Petitioner received for those conditions was not causally related to his June 21, 2013 accident. In addition, the Commission finds that much of the treatment provided to Petitioner for his lumbar spine and radiculopathy by the doctors at New Life Medical Center and to the treaters to whom they referred Petitioner, was excessive and unnecessary, based on the Utilization Review reports in evidence. Although Petitioner was billed over $7,100.00 for prescription medications from Windy City Rx between January 2014 and March 2014 (PX18), months later he reported at Advocate Condell Medical Center that he had never taken anything for pain (PX8).

The Commission modifies the Arbitrator's award of medical expenses to include, with one exception noted below, only that treatment to Petitioner's lumbar spine, herniated lumbar discs and radiculopathy, between June 21, 2013 and the June 9, 2017 date of arbitration.

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The exception is that the Commission declines to award Petitioner the medical expenses for those treatments and medications which were non-certified in the above-noted Utilization Review reports dated July 29, 2013, August 7, 2013, and September 19, 2013. The Commission finds that the treatment and medications that were non-certified in those Utilization Review reports, were not be reasonable or necessary to treat Petitioner's causally related lumbar spine condition. The Commission hereby vacates the Arbitrator's award of those medical expenses.

With regard to the issue of temporary total disability benefits, the Commission finds that Petitioner was authorized off work between June 21, 2013 and June 9, 2017. Although Respondent suggests that during that period, Petitioner was working for his cousin's house-cleaning business, and offered video surveillance showing Petitioner accompanying his cousin to her client's residences, the Commission does not find that to be proof that Petitioner was performing work. The video does not show Petitioner performing any actual cleaning tasks, only entering the residences. Petitioner's testimony that he performed no work for his cousin's business, and that the money and other purchases he received from his cousin were unrelated to any work, was unrefuted. The Commission finds that this testimony of Petitioner was credible and was not contradicted by Respondent's video.

Based on the foregoing, the Commission affirms the Arbitrator's award of 207 weeks of TTD benefits, although from June 22, 2013 (not June 21, 2013) through June 9, 2017. The Commission also affirms the award of prospective medical care consisting of lumbar fusion surgery, and remands this case back to the Arbitrator for further proceedings consistent with this Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 5, 2017, relating to Petitioner's claim no. 13 WC 21456, 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 for 207 weeks is affirmed, and that Respondent shall pay Petitioner the sum of $330.00 per week, commencing June 22, 2013 through June 9, 2017, 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 award of medical benefits is modified. Respondent shall pay Petitioner only those reasonable and necessary medical expenses incurred in treating Petitioner's lumbar spine and radiculopathy conditions between June 21, 2013 and June 9, 2017, except for those expenses incurred for treatment and medications which were found non-certified pursuant to Respondent's Utilization Review reports dated July 29, 2013 (RX6), August 7, 2013 (RX7), and September 19, 2013 (RX8). The Commission finds those treatments and medications that were non-certified in those reports to not be reasonable and necessary, and the Commission reverses the Arbitrator's award of those medical expenses.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care consisting of lumbar fusion surgery is affirmed.

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. 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 - 2019

o-06/20/19
mp/mcp
68

Marc Parker

Barbara N. Flores

CONCURRENCE IN PART AND DISSENT IN PART

I respectfully concur in part and dissent in part from the Decision of the majority. Petitioner sustained an injury after falling. He claimed injuries to his lumbar spine, cervical spine, thoracic spine, shoulders, scapular area, and chest. The Arbitrator specifically found that Petitioner's lumbar condition was causally related to his accident but did not specifically find whether the other conditions were so related. Nevertheless, the Arbitrator awarded all medical expenses submitted, including for treatment for areas other than the lumbar spine, and ordered Respondent to authorize and pay for prospective lumbar surgery. He also awarded temporary total disability benefits of 207 weeks, through the date of arbitration

The majority modified the Decision of the Arbitrator finding that Petitioner only proved that his lumbar condition was causally related to his accident, vacating the medical expenses associated with treatment for areas other than Petitioner's lumbar spine, vacating medical expenses that were not certified by utilization reviews, and affirming the Arbitrator's award for prospective medical treatment for Petitioner's lumbar spine. The majority also affirmed the Arbitrator's award of 207 weeks of temporary total disability benefits.

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I concur with the Decision of the majority that Petitioner did not prove the alleged conditions of ill-being in areas other than his lumbar spine were causally connected to his accident, in vacating the medical expenses associated with treatment for any body parts other than the lumbar spine, and in vacating the medical expenses not certified under utilization review. However, I dissent from the decision of the majority in awarding medical treatment for Petitioner's lumbar spine and of temporary total disability benefits after October 18, 2013, as well as the award of prospective medical treatment.

Respondent's Section 12 medical examiner, Dr. Hennessy, examined Petitioner, reviewed his records, and issued a report on October 13, 2013. Dr. Hennessy considered the objective finding in Petitioner's lumbar MRI were relatively minor with no herniations. Dr. Hennessy also found Petitioner exhibited various nonorganic pain responses, such as "stocking glove" symptoms, give-way weakness, and reporting symptoms in excess of, and not explained by, any objective findings. After his records review and examination, Dr. Hennessy opined that Petitioner was at maximum medical improvement and could return to work with no restrictions.

In arriving at their decisions, both the Arbitrator and the majority discounted the report and testimony of Dr. Hennessy as being unpersuasive. On the contrary, I find Dr. Hennessy's report and testimony extremely persuasive. In addition, I have serious reservations concerning Petitioner's credibility based on Dr. Hennessy's findings of his symptom magnification and nonorganic pain behavior, as well as his unfounded allegation of injuries to multiple body parts and overtreatment as found by the majority. Based on the report of Dr. Hennessy, I would have terminated all benefits as of the date of his report, October 18, 2013.

For the reasons stated above, I concur with the Decision of the majority that Petitioner did not prove the alleged conditions of ill-being in areas other than his lumbar spine were causally connected to his accident, in vacating the medical expenses associated with treatment for any body parts other than the lumbar spine, and in vacating the medical expenses not certified under utilization review. However, I respectfully dissent from the decision of the majority in awarding medical treatment for Petitioner's lumbar spine and of temporary total disability benefits after October 18, 2013, as well as the award of prospective medical treatment.

Deborah L. Simpson

Deborah L. Simpson

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

ULLOA, AMADO
Employee/Petitioner

Case# **13WC021451**

13WC021456

PSSI
Employer/Respondent

19IWCC0422

On 9/5/2017, 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 1.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE, JAMES P LAW OFFICE
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123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF Wil)

☐ 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)

Amado Ulloa
Employee/Petitioner

v.

PSSI
Employer/Respondent

19IWCC0422

Case # **13** WC **21451**

Consolidated cases: **13 WC 21456**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison** Arbitrator of the Commission, in the city of **Woodstock, Illinois**, on **June 9, 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 accidents, **September 11, 2012 and June 21, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

Timely notice of these accidents *were* given to Respondent.

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

In the year preceding the injury, Petitioner earned $**20,800.00**; the average weekly wage was $**400.00**

On the date of accidents, Petitioner was **33** years of age, ***single*** with **4** 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 $**6,563.89 for TTD**, $**0** for maintenance, and $**3,588.29** for other benefits (medical), for a total credit of $**10,152.18**

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, the following expenses: Vista Medical Center, $2,012.67; New Life Medical Center $17,465.00; Dr. Gregory Thurston $4,858.00; Pain Care Specialists $451.00; Illinois Orthopedic Network $6,022.48; American Ctr. For Spine $2,130.00; Elmhurst Orthopedics $1,010.00; Advocate Condell Med. Ctr. $2,184.75; American MRI $3,400.00; Chicago Medical Imaging $2,536.44; Oak Brook Imaging $2,500.00; Pinnacle Interventional Pain $2,385.00; Delaware Place MRI $1,835.01; Metro Anesthesia $4,230.08; Oak Brook Surg. Ctr. $42,960.00; Injured Workers' Pharmacy $921.23; Windy City Medical $7,149.90; TrySIS $3,359.61
as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize the lumbar fusion as recommended by Drs. Erickson, Dixon, and Koutsky.

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 207 weeks, commencing 6/21/13 through 6/9/17, as provided in Section 8(b) of the Act.

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

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

STATEMENT OF INTEREST RATE

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

Signature of Arbitrator

8/30/17
Date

SEP - 5 2017

STATEMENT OF FACTS:

19IWCC0422

Petitioner testified that in September 2012, he was an employee of Respondent, PSSI. He had been employed between a year and a half and two years as of that time. His job was to clean machines in a factory, specifically freezers, a cheese machine, and a salsa machine. The job involves disassemble machines and clean them.

In August 2012, Petitioner was cleaning a sauce machine. The general procedure is to disassemble the machine, place the pieces in a tank which cleans the pieces. The tank is heavy and is on wheels. The wheels were reportedly damaged on one side. Petitioner testified that he felt pain in his shoulder while pushing the tank in August 2012. He did not seek any medical treatment at that time.

Petitioner testified that on September 11, 2012, he was again pushing the tank. He indicated that he had a tingling sensation at the back of his shoulders as well as chest pain. Petitioner provided that the pain was such that he could not move the tank "to my area." Petitioner said he could no longer tolerate the pain. Petitioner stated he advised his supervisor, Jose, who took him to Vista Medical Center.

Records submitted show Petitioner was seen on September 11, 2012, at Vista Medical Center with a chief complaint of left sided chest pain. The history indicated that Petitioner "was moving a heavy tank three weeks ago and felt pain on the left side of his chest. He continued working and tried to work the pain out. This morning while he bent forward to put his boots on he felt a sharp pain [u]nderneath hi[s] left rib. He was then taken by his supervisor here for evaluation and management..." Petitioner was diagnosed with acute left sided chest wall/left shoulder pain/spasm. He was given home exercises, Ibuprofen and Cyclobenzaprine. Also, twenty-pound lifting restrictions were imposed. (PX 1)

Petitioner returned to Vista Medical Center on September 18, 2012. Petitioner reported that his chest pain was gone, but his left shoulder pain remained. A cortisone injection was recommended and performed. His restrictions were also continued. At his return visit on September 21, 2012, Petitioner reported very mild tightness in his back. He could perform daily living activities without difficulty. Petitioner was discharged from care and released to full duty work. (PX 1)

Petitioner continued working for PSSI until June 21, 2013. On that date, he was working in a different area. Petitioner testified that after disassembling a sauce machine, he crossed the hallway, and slipped and fell on the floor, which was frozen over. Petitioner stated he landed on his back. He tried to get up, and fell to his knees. Petitioner indicated that Pedro Grande, a coworker, witnessed the incident. Pedro assisted Petitioner and sat him next to a machine. Petitioner stated that although his "whole back and buttocks hurt" after the incident, he and Pedro finished the work shift that day.

Petitioner testified that after work, he proceeded to Vista Medical Center. Records submitted show Petitioner's handwritten history indicated that he fell due to ice, and had buttock and groin pain. A pain diagram completed by Petitioner indicates buttock and groin pain. The typewritten history indicated that he had upper back and chest pain as he had in September 2012. He had upper back pain radiating to the front of his chest and up his neck. The history also notes that he slipped on wet floor at work and strained his right groin. Petitioner was diagnosed with upper back, mid scapular pain spasm – left>right; right groin strain. Light duty restrictions and medication were issued. (PX 1)

Petitioner testified that he was unhappy with his treatment at Vista. As a result, he reported to New Life Medical Center the same day. The New Life records note a history of accident that day slipping and falling on an icy floor while carrying a hose in order to wash a machine. Petitioner's chief complaints were low back pain with leg pain; right testicular pain and numbness; and bilateral scapular area pain. After an examination, Dr. Carrion of New Life diagnosed 1.) lumbar strain, 2.) low back pain, 3.) lumbar radiculopathy, and 4.) muscle spasms (scapular and back). Conservative treatment commenced in the form of chiropractic therapy with Dr. Carrion. The doctor also took Petitioner off work and ordered a lumbar spine MRI. (PX 2)

An MRI scan of Petitioner's lumbar spine was completed the next day, June 22, 2013. This revealed a right central disc herniation at L5-S1, as well as a broad-based herniation at L4-5 compromising the spinal canal. (PX 2) Based on the MRI films, Dr. Carrion referred Petitioner to Dr. Krishna Chunduri. Petitioner presented to Dr. Chunduri on June 26, 2013, with complaints of pain in the low back radiating down both of his lower extremities. Dr. Chunduri noted a history of two accidents occurring in August 2012 and June 2013. Dr. Chunduri diagnosed L4-5, L5-S1 disc herniation with bilateral radiculitis. The doctor recommended epidural steroid injections as well as continued physical therapy care. Dr. Chunduri also opined that the diagnoses were causally related to the work injury. (PX 2, PX 3)

Dr. Chunduri performed right sided epidural steroid injections on July 25, 2013 and August 22, 2013. An EMG performed between the two examinations was positive for mild-moderate right lumbar radiculitis involving the L5 and S1 dermatomes. On August 29, 2013, Dr. Chunduri noted the injections did not provide significant relief. Dr. Chunduri referred Petitioner to Dr. Robert Erickson for a surgical consultation. (PX 4)

Petitioner was seen by Dr. Erickson on October 4, 2013. Petitioner provided an history of work accidents in August 2012 and June 2013. Dr. Erickson assessed lumbar spondylosis and recommended continued physical therapy. The doctor also wanted to directly review the MRI films and considered somatosensory evoked potential testing of the lower extremities. (PX 4, PX 6) On February 3, 2014, Dr. Erickson noted that he reviewed the MRI which he indicated showed disc changes at L4-5 and L5-S1. The doctor indicated that he wanted to re-evaluate with a new MRI. (PX 6)

Petitioner underwent the MRI on February 14, 2014. (PX 4) On February 25, 2014, Dr. Erickson recorded that he reviewed the scans from June 22, 2013 and February 14, 2014. The doctor provided that both scans show a diffused herniation at L4-5 associated with bilateral recess stenosis and associated Modic changes at that segment. He also noted there was a smaller right paracentral disk herniation at L5-S1. Dr. Erickson assessed lumbar disk disease with mechanical back pain and radiculopathy. The doctor recommended lumbar decompression at L4-5, and possibly L5-S1 as well. The doctor added that the proposed surgical treatment should be regarded as a result of the August 17, 2012 injury. (PX 4)

On April 16, 2014, Dr. Erickson recommended clinical evoked potential testing of the lower extremities. The test was performed the same day and was positive at L5 and S1 bilaterally. Dr. Erickson continued his surgical recommendation. The doctor also added that because of the mechanical aspect of Petitioner's pain, he might be a candidate for diagnostic discography prior to the procedure. Petitioner was continued off work. (PX 4, PX 6)

The lumbar discogram was performed by Dr. Neeraj Jain on April 23, 2014. According to Dr. Jain, Petitioner had discogenic pain at L5-S1 with the control levels at L2-3 and L3-4. The doctor also noted Petitioner had disconcordant non discogenic pain at L4-5. In summary, Dr. Jain felt Petitioner had a positive discogram L5-S1. (PX 16)

Records submitted show Petitioner received no medical treatment from Spring 2014 until Spring 2015, when he was seen again by Dr. Chunduri on May 22, 2015. Dr. Chunduri noted that Petitioner had not treated since he saw Dr. Erickson who had recommended surgery one year prior. Petitioner reported that his back and left leg pain had gotten worse. Dr. Chunduri kept Petitioner off work and recommended a new lumbar MRI, which when performed on May 29, 2015 demonstrated a broad disc herniation on the left at L4-5, and a broad disc protrusion with left greater than right neural foraminal narrowing at L5-S1 with a 7 o'clock peripheral annular tear. (PX 4)

Based on the films, Dr. Chunduri referred Petitioner to Dr. Geoffrey Dixon, who saw Petitioner on June 19, 2015. Dr. Dixon reviewed the MRI indicating same revealed a herniated disk at L4-5, slightly eccentric to the left as well as one at L5-S1 slight eccentric to the right. Dr. Dixon recommended an EMG of both lower extremities to determine to what extent each nerve root was effected. (PX 4)

The recommended EMG was performed on June 25, 2015, which indicated mild-moderate bilateral lumbar radiculitis in the L5 and S1 dermatomes, left greater than right. On July 20, 2015, Dr. Dixon noted the EMG was consistent with L5-S1 radiculopathy, left greater than right. The doctor provided that a discogram with CT would be appropriate to determine the appropriate surgical procedure. (PX 4) On October 9, 2015, Petitioner presented the prior discogram of April 2014. Dr. Dixon felt same clearly demonstrated significant disk annular tear at L5-S1 with extravasation of dye into the epidural space. The doctor discussed surgical options of a L4-5 and L5-S1 decompression versus a fusion. He recommended a consultation with Dr. Kevin Koutsky to determine if decompression or fusion would be a better option. (PX 4)

On December 7, 2015, Petitioner saw Dr. Koutsky. After performing an examination and reviewing the diagnostic test from February 2014, April 2014 and June 2015, Dr. Koutsky assessed 1.) lumbar radiculopathy L4-5, discogenic pain and 2.) lumbar radiculopathy, bilateral, L5-S1, discogenic pain. The doctor determined that decompression and fusion would be the best option, and recommended the same at L4-S1. (PX 7)

Petitioner returned to Dr. Chunduri on December 31, 2015. The doctor noted Petitioner continued to have a disk herniation causing pain and paraesthesias that required surgery. The doctor continued medication management pending surgery. (PX 4)

Petitioner testified at trial that he wishes to undergo the lumbar fusion procedure. He has trouble sleeping. He is able to do chores, but he has difficulty bending. He cannot sit for long periods of time. He cannot lift significant weight.

At Respondent's request, Petitioner was evaluated by Dr. Ryon Hennessey pursuant to Section 12 of the Act. (RX 2 and 3) Dr. Hennessey performed a physical examination and reviewed Petitioner's medical records on October 18, 2013. He prepared a report with his findings dated October 31, 2013. (RX 3) Dr. Hennessey's evidence deposition was taken on December 10, 2014. (RX 2) Dr. Hennessey testified that Petitioner suffered nothing more than a cervical strain and scapular strain for the alleged August 7, 2012, injury. Dr. Hennessey indicated MMI was reached on September 22, 2012. In regards to the June 21, 2013, alleged accident, the doctor opined that Petitioner did not sustain any aggravation, exacerbation, or acceleration of any previous injury to the cervical spine, bilateral shoulders, thoracic spine, or bilateral scapular regions. Dr. Hennessey opined that there was no evidence that any injury occurred to his lumbar spine, as the MRI findings did not support the subjective complaints. Dr. Hennessey evaluated the June 22, 2013, MRI and found the L4-L5 level had a decreased disc height. At the L5-S1 level, there was a right disc bulge without any herniation. Dr. Hennessey testified further that Petitioner was at maximum medical improvement, did not require any future treatment, and could return to work full duty at the time of his examination. Dr. Hennessey testified that his physical examination did not correlate with Petitioner's diffuse subjective pain complaints; thus, Petitioner did not require treatment or diagnostic testing.

Respondent introduced into evidence five utilization review reports performed on Petitioner's medical treatment. (RX 6-10) Utilization review declined to certify additional physical therapy, MRI, compound medication, back brace, or L4-L5 and L5-S1 foraminal decompression with facet fusion at L4-L5 and L5-S1. (RX 6-9) It did certify six chiropractic treatments but found the additional sessions to be unreasonable and unnecessary. (RX 10)

Respondent also presented a video, submitted and received as Respondent's Exhibit 5. This showed Petitioner primarily sitting and to a lesser degree walking. It does depict Petitioner entering a truck labeled Cleaning By Luna. Petitioner explained that Cleaning By Luna is a house cleaning service owned by his cousin and her husband, Mr. Florenzo Garcia. Petitioner stated that he sometimes accompanies them on cleaning jobs to relieve boredom. Mr. Garcia testified that Petitioner sometimes accompanies them on cleaning jobs to relieve boredom. He provided that Petitioner has never worked for the company nor has Petitioner ever received any monies from the company.

With respect to (C) DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner suffered two accidents arising out of and in the course of his employment with Respondent. The Arbitrator finds Petitioner's testimony to be credible and consistent with his statements to his treating physicians.

Petitioner testified that on September 11, 2012, he suffered an accident at work while pushing a tank. This had happened once before in the previous month. He felt pain in his chest and left shoulder, which eventually subsided after about a week of treatment. Respondent presented no evidence or testimony to contradict this testimony. Therefore, the Arbitrator finds Petitioner suffered an accident arising out of and in the course of his employment with Respondent on September 11, 2012.

Petitioner also testified to an injury occurring on June 21, 2013. On that date, he slipped and fell on a frozen floor while carrying a hose to his machine. He landed on his buttocks, and fell again when he attempted to get up. He was helped up by a coworker, Pedro Grande, who helped Petitioner finish his work. Petitioner was seen the same day at Vista Health and New Life Medical Center, where he gave consistent histories. Respondent presented no evidence or testimony to refute Petitioner's account. Therefore, the Arbitrator finds Petitioner suffered an accident arising out of and in the course of his employment with Respondent on June 21, 2013.

With respect to (D) WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, the Arbitrator finds as follows:

The Arbitrator finds timely notice was given to Respondent in both accidents. In the September 2012 incident, Petitioner was taken to Vista Health the same day as the alleged accident, September 11, 2012. As noted by the September 11, 2012 record of Vista Medical Center, "...[h]e was then taken by his supervisor here for evaluation and management..." Petitioner was taken by Respondent to Vista Health. Therefore, Respondent had some notice of something occurring.

In the June 2013 incident, Petitioner was taken by his employer to Vista the same day as well, and an Application was on file July 2, 2013, well within the 45 day requirement. Therefore, the Arbitrator finds that timely notice was given to Respondent in both cases.

With respect to (F) IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, the Arbitrator finds as follows:

The Arbitrator finds Petitioner's present condition, namely lumbar herniated discs with radiculopathy, to be causally related to the work accident. The Arbitrator finds Petitioner's testimony to be credible, as well as the opinions of his treating physicians. The Arbitrator does not find the testimony of Dr. Ryon Hennessy to be persuasive on this issue.

Dr. Robert Erickson testified that Petitioner requires surgical intervention. Dr. Dixon and Dr. Koutsky have confirmed this recommendation. There is no evidence to suggest that Petitioner had lumbar symptomology prior to the June 2013 work accident.

Dr. Hennessy disagreed with the diagnosis, stating that L4-5 had some decreased hydration, and that L5-S1 had a disc bulge, but that this was not a herniation and did not displace the right S1 nerve root. (RX 2, pp. 42-43) Dr. Hennessy acknowledged the right S1 radiculopathy on EMG, but discounted this as inconsistent with Petitioner's symptoms, despite the diagnosis of the treating physicians. (RX 2, p. 53) He agreed that the discogram was positive and concordant at L5-S1, but again, states that this is not consistent with Petitioner's symptoms. (RX 2, p.57) Finally, Dr. Hennessy also acknowledged the positive SSEP testing but again, stated only that Petitioner's symptoms did not correlate with the positive diagnostic testing. (RX 2, p.58)

The Arbitrator does not find the testimony of Dr. Hennessy to be persuasive on the issue of causal connection. Dr. Hennessy examined Petitioner on one occasion, and based his entire opinion on Petitioner's complaints of "stocking-glove" symptomology at that appointment. He did not address the physical examinations of Dr. Carrion, Dr. Erickson, Dr. Dixon, and Dr. Koutsky, which do not discuss "stocking-glove" symptoms. Therefore, the Arbitrator finds that Petitioner's lumbar disc herniations at L4-S1 are causally related to his work accident.

With respect to (J) WERE THE MEDICAL SERVICES PROVIDED REASONABLE AND NECESSARY, the Arbitrator finds as follows:

The Arbitrator finds that the medical services provided to Petitioner have largely been reasonable and necessary. Petitioner has undergone conservative care consisting of physical therapy, injections, and medication management. Respondent has provided evidence to refute the opinions of the treating physicians. Respondent's Exhibit 6 is a Utilization Review denying physical therapy, MRI scans, and medication. With respect to physical therapy, the denial is predicated upon a diagnosis of lumbar sprain/strain. This is not Petitioner's diagnosis. Therefore, the Arbitrator does not find the UR persuasive with respect to physical therapy. The lumbar MRI is denied as not being recommended until at least one month of conservative care has been completed. This, then, is merely a question of timing. The Arbitrator does not find this persuasive, as the MRI could simply have been done a month later. Therefore, the Arbitrator does not find the UR persuasive with respect to the June 2013 lumbar MRI. Finally, the UR denied compounded medication because NSAIDs and Tylenol had failed in the past. Those medications were presumably taken orally, and this is a topical cream, which is a different application. Therefore, the Arbitrator does not find the UR persuasive with respect to the compounded medication.

Respondent's Exhibit 7 is a Utilization Review denying physical therapy (left shoulder), compounded medication, and a left shoulder MRI. The physical therapy denial is based on a positive Speed's test, which would indicate a biceps tendon or labral problem, and physical therapy would be of no further help. The Arbitrator finds it is reasonable to continue conservative care prior to proceeding with surgical intervention. Compounded medication is denied because this is a chronic case, rather than an acute case. The Arbitrator finds that is reasonable to provide pain relief regardless of its chronic or acute nature. Finally, the left shoulder MRI

was certified. Therefore, the Arbitrator does not find Respondent's 7 persuasive with respect to left shoulder PT and medication.

Respondent's Exhibit 8 is a Utilization Review denying a back brace. This was denied because lumbar supports are not recommended for prevention, but recommended for treatment. The Arbitrator notes Petitioner was already injured, and thus this is for treatment. Therefore, the Arbitrator does not find Respondent's Exhibit 8 persuasive.

Respondent's Exhibit 10 is a Utilization Review regarding chiropractic care. Six sessions were certified, and further sessions were noncertified. The Arbitrator finds it is reasonable to attempt conservative care prior to more invasive procedures, and thus does not find Respondent's Exhibit 10 persuasive on this issue.

Based on the foregoing, the Arbitrator awards the medical billing submitted by Petitioner at trial.

With respect to (K) IS THE PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL, the Arbitrator finds as follows:

Having found for Petitioner on the issues of accident and causal connection, the Arbitrator finds that Petitioner is entitled to prospective medical care, specifically a L4-S1 lumbar fusion. Dr. Erickson, Dr. Dixon, and Dr. Koutsky all agree that this is reasonable, necessary, and causally related. Respondent's Exhibit 9 is a Utilization Review denying L4-S1 decompression and facet fusion as recommended by Dr. Erickson, Dixon, and Koutsky. Denial was based on the record being unclear as to whether facet blocks had been attempted, as well as a lack of specific evidence of radiculopathy. The Arbitrator notes Dr. Erickson, Dr. Dixon, and Dr. Koutsky's references to radicular symptoms, as well as attempted epidural steroid injections. The Arbitrator also notes the positive EMG, SSEP, and discogram. Therefore, the Arbitrator does not find Respondent's Exhibit 9 to be credible or persuasive. The Arbitrator awards the lumbar fusion.

With respect to (L) WHAT TEMPORARY BENEFITS (TTD) ARE IN DISPUTE, the Arbitrator finds as follows:

Petitioner claims entitlement to TTD benefits from June 21, 2013 through the date of trial, June 9, 2017. Respondent has paid benefits through November 3, 2013. The Arbitrator finds that Petitioner is entitled to TTD benefits from June 21, 2013 through the date of hearing, June 9, 2017. The Arbitrator bases this finding on the opinions of Petitioner's treating physicians, who have kept him off work pending lumbar fusion.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randall E. Clover,

Petitioner,

vs.

NO: 15 WC 25562
19IWCC0423

IDHS/Chester Mental Health Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses and prospective medical treatment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts said Decision, which is attached hereto and made a part hereof.

The Commission notes that while the Arbitrator claims in the body of his decision that he makes no conclusions on the remaining issues, including causation, under "Findings" on p.2 of his form decision he found that "Petitioner's current condition of ill-being is not causally related to the accident". (See Arb.Dec.).

In order to address this apparent inconsistency, the Commission modifies the decision of the Arbitrator to find that in addition to failing to prove that he sustained accidental injuries arising out of and in the course of his employment on 6/10/15, Petitioner also failed to prove that his current condition of ill-being is causally related to the alleged accident in question. This is based not only on the Commission's finding of no accident but also on the opinion of treating orthopedic surgeon Dr. Barr who noted that, absent Petitioner's verbal history, "[t]he meniscal tear would be an unresolved question in my mind that I would feel that I didn't have enough information to go on. All the other elements of his MRI findings I would consider to be

degenerative or chronic." (PX4, p.25). Furthermore, Dr. Barr acknowledged that it would affect his causation opinion, and potentially change it, if Mr. Clover had prior complaints or treatment with respect to his left knee. (PX4, pp.24-25).

Petitioner, for his part, was less than candid when asked whether he had experienced any prior problems with his left knee, noting more than once that he could not recall. The Commission finds this hard to believe, given the moderate to severe osteoarthritis noted by way of MRI as well as Dr. Barr's comment that it would not have surprised him if Petitioner had some symptoms in his left knee prior to the date of the alleged accident. (PX4, pp.11).

Accordingly, the Commission finds that Petitioner failed to prove both that he sustained accidental injuries arising out of and in the course of his employment 6/10/15 and that his current condition of ill-being is causally related to said alleged accident. Accordingly, Petitioner's claim for compensation is hereby denied.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 8/21/18 is modified, as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for compensation is hereby denied.

DATED: AUG 8 - 2019
o:6/11/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

CLOVER, RANDALL E
Employee/Petitioner

Case# **15WC025562**

IDHS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

19IWCC0423

On 8/21/2018, 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 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

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

AUG 21 2018

DONALD A. DARIA, Acting Secretary
Illinois Workers' Compensation Commission

19IWCC0423

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)

Randall E. Clover
Employee/Petitioner

v.

IDHS/Chester Mental Health Center
Employer/Respondent

Case # 15 WC 25562

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on July 20, 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. ☒ 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 _____

Electronic Filing

FINDINGS

On the date of accident, June 10, 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 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 $67,836.27; the average weekly wage was $1,304.54.

On the date of accident, Petitioner was 50 years of age, married with 0 dependent child(ren).

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

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

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

ORDER

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

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

August 13, 2018
Date

AUG 21 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 by Respondent on June 10, 2015. According to the Application, Petitioner was running to an emergency call to assist another employee and sustained an injury to his left knee (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a therapy aide. At trial, Petitioner testified that on June 10, 2015, he was working the 11:00 AM to 7:00 PM shift. At approximately 7:00 PM, there was a "code red" which Petitioner stated was an event in which assistance was needed. Petitioner responded to the "code red" by running down the hall. As Petitioner was running down the hall, he heard and felt a "pop" in his left knee. By the time he reached the area where the assistance had been requested, the situation had resolved. Petitioner left Respondent's facility shortly thereafter.

Respondent tendered into evidence the Employee's Notice of Injury form that was completed and signed by Petitioner the following day, June 11, 2015. According to that document, Petitioner was in the process of exiting unit F to go home at the end of his shift when he heard the code red over a two way radio. Petitioner then ran to unit A and his left knee popped in the cross hallway between unit A and unit F. Petitioner noted that he did not report the accident on the date it occurred because it was a pop in the knee and he did not think it was significant. Petitioner also noted that when he got home, his left knee began to hurt very much and he could not get out of a chair without great difficulty. Petitioner indicated that on June 11, 2015, he could not bend the knee very far without experiencing a great deal of pain (Respondent's Exhibit 1).

Respondent also tendered into evidence the Employer's First Report of Injury prepared by Jennifer Boisselle on June 12, 2015. According to that report, Petitioner was running with his left knee popped and, by the time he reached the doorway, Petitioner could only walk (Respondent's Exhibit 1).

Further, Respondent tendered into evidence a Supervisor's Report of Injury or Illness dated June 15, 2015. The Arbitrator could not read the signature; however, the report indicated that the supervisor was not aware of any details of Petitioner's accident. A witness report prepared and signed by Kevin Hayne, another therapy aide, dated June 23, 2015, noted that he was in the restroom at the time of the incident and did not see anything happen (Respondent's Exhibit 1).

Petitioner sought medical treatment the following day, June 11, 2015; however, the treatment appeared to be unrelated, Petitioner was seen by Alexis Lorinskas, a Physician Assistant associated with Southern Illinois Dermatology, for irritant dermatitis. The record did not contain any reference to Petitioner having any left knee symptoms (Petitioner's Exhibit 1).

Petitioner was evaluated by Patricia Boudet, a Physician Assistant, on June 12, 2015, for left knee symptoms. According to PA Boudet's record of that date, Petitioner strained his knee while running after patient at work, but it did not start hurting until a few days after. PA Boudet ordered an x-ray of the left knee (Petitioner's Exhibit 2).

X-rays of Petitioner's left knee were obtained on June 12, 2015. According the radiologist, they revealed arthritis with slight osteopenia and marginal osteophytes (Petitioner's Exhibit 2).

Petitioner was seen by Cheryl Ellis, a Nurse Practitioner, on June 18, 2015. According to her record of that date, Petitioner injured his left knee on June 10 while running in response to a code red when he sustained a "popping injury." NP Ellis ordered an MRI scan of Petitioner's left knee (Petitioner's Exhibit 1).

The MRI was performed on June 22, 2015. According to the radiologist, the MRI revealed a complex tear of the posterior horn of the medial meniscus as well as tricompartmental osteoarthritis (Petitioner's Exhibit 1).

Petitioner was subsequently evaluated by Dr. Richard Barr, an orthopedic surgeon, on November 10, 2015. According to Dr. Barr's record of that date, Petitioner injured his left knee on June 10, 2015, when running in response to an incident involving a violent patient. Petitioner felt a "pop" in his left knee at the time of the accident. Dr. Barr noted the findings of the MRI scan and diagnosed Petitioner with a chronic medial meniscus tear with moderate/severe arthritis of the left knee. Dr. Barr administered a cortisone injection and opined that a significant amount of Petitioner's pain may have been related to the arthritis as opposed to the meniscal tear (Petitioner's Exhibit 3).

Dr. Barr again saw Petitioner on December 8, 2015. At that time, he discussed various treatment options with Petitioner (Petitioner's Exhibit 3).

Dr. Barr subsequently saw Petitioner on July 11, 2017. Dr. Barr noted Petitioner had also been treated for a right knee injury. Dr. Barr again discussed treatment options in regard to Petitioner's left knee and suggested he undergo arthroscopic surgery (Petitioner's Exhibit 3).

Dr. Barr was deposed on April 15, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Barr's testimony was consistent with his medical records and he reaffirmed the statements contained therein. Dr. Barr testified Petitioner informed him that he sustained a work-related accident which caused a sudden onset of left knee pain. Dr. Barr's impression was that Petitioner had a chronic medial meniscal tear which was based, in part, on the fact that the accident had occurred several months prior to his evaluation in November, 2015 (Petitioner's Exhibit 4; pp 6-8).

Dr. Barr testified that the accident was the probable cause of the meniscal tear, although Petitioner had an arthritic condition that pre-existed the accident of June 10, 2015 (Petitioner's Exhibit 4; pp 10-11).

On cross-examination, Dr. Barr agreed that if the history Petitioner had provided to him was not accurate, that it could cause him to change his causation opinion. Further, Dr. Barr acknowledged that it was possible that a meniscal tear as noted in the MRI could have occurred degeneratively (Petitioner's Exhibit 4; pp 20, 25).

At trial, Petitioner testified he had just undergone total knee replacement surgery of the right knee and had been off work for some time. When cross-examined, Petitioner was asked about the condition of his left knee prior to the accident, whether he had any medical treatment for left knee problems, whether he was ever previously diagnosed with arthritis, whether he had any prior workers' compensation claims for left knee injuries, etc. Petitioner's answer to virtually all of the aforementioned questions was "I don't recall."

Michelle Dashka, testified on behalf of Respondent when this case was tried. Dashka was the workers' comp coordinator at the time of the accident, but had retired when this case was tried.

Dashka testified that she had a conversation with Petitioner on June 10, 2015, in Petitioner's capacity as a union representative. The conversation pertained to another employee who injured his knee while running from one area of the facility to another in response to an emergency situation. The purpose of Petitioner discussing this with Dashka was to determine if the accident involving the other employee was going to be found to be compensable. Dashka stated that the conversation took place sometime earlier in the day, prior to Petitioner's alleged accident. Ultimately, it was determined that the other employee's accident was compensable.

Conclusion of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment by Respondent on June 10, 2015.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the accident of June 10, 2015, lacked credibility for a variety of reasons.

The same day of the alleged accident, June 10, 2015, Petitioner met with Michelle Dashka, the workers' comp coordinator, in his capacity as a union representative. The discussion pertained to another employee who sustained an injury under circumstances virtually identical to those subsequently alleged by the Petitioner, namely, sustaining a knee injury while running in response to an emergency.

At trial, when Petitioner was questioned about whether he had any prior left knee symptoms, treatment, diagnosis of arthritis, workers' compensation claims, etc., Petitioner expressed what appeared to be a total loss of memory by stating "I don't recall."

The initial medical treatment Petitioner sought the day after the accident, June 11, 2015, was for irritant dermatitis. At trial, Petitioner testified that he had a significant amount of pain in his left knee and could not bend it very far on that date; however, he did not seek medical treatment for his left knee symptoms, but treatment for a skin condition. Further, there was no reference to Petitioner having left knee pain in the medical record of that date.

At trial, Petitioner testified that he sustained a "pop" in his left knee while running in response to a code red. When Petitioner first reported left knee symptoms to a medical provider on June 12, 2015, he gave a different history, stating he had strained his left knee while running after a patient. Further, Petitioner stated that the onset of left knee symptoms occurred a few days later, not later that same day or the following day.

The X-rays and MRI obtained on June 12 and June 22, 2015, respectively, clearly revealed Petitioner had arthritis in the left knee. Dr. Barr agreed that condition predated the accident. Further, Dr. Barr agreed that the torn meniscus could have occurred degeneratively.

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

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie Bruno,

Petitioner,

vs. NO: 17 WC 2918

Conifer Care Continuom Solutions, LLC,

Respondent.

19IWCC0424

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causation 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

Petitioner, a 52-year old third-party medical billing follow-up rep, testified that she has worked for Respondent for two years and eight or nine months, and that she works at a desk in a cubicle. (T.8-9). Petitioner testified that on 7/12/16 she "… went to use the restroom, and injured [her] shoulder." (T.9-10). She noted that she was in a stall and that "[w]hen I went to flush the toilet, the way I flush the toilet – this is going to be a little embarrassing – when I pushed down, it didn't flush. So it was like I went to push a little harder, and that's when the sharp pain had occurred behind my [right] shoulder and all the way down to my elbow." (T.10). She indicated that she was "[i]n a squatting position" at the time and that she reached behind her with her right arm. (T.10-11). She explained that "… the position that the handle was positioned, when I pushed, it basically was almost at the bottom. So it wasn't like – I took my hand. I pushed, and I had to push a little harder; and then it flushed." (T.11). She noted that there had

been issues with this particular toilet "... from the first date that I started working there." (T.11).

Petitioner testified that she "... actually just got up from my cubicle to go see my supervisor, and then en route to going back to her desk, which was in the back of the building, I stopped into the ladies' restroom." (T.11). She noted that she was on the clock, and that she had to swipe to get into the building. (T.12). She agreed that it [the area where she was] is an employee-only area and that the general public couldn't be there. (T.12). She stated that there are four stalls in the restroom and that she was using the third stall. (T.12). She indicated that she had personal knowledge that some of her co-workers were aware of this problem. (T.12-13). She was shown PX1, statements by ten of her co-workers regarding the issue with the toilet in the bathroom. (T.13).

In a statement dated 3/31/17, Elda Miskowicz noted that "[t]he third bathroom at the above listed has a handle that is not at a 45 degree angle. The handle to flush was not as easy to use as the rest of the toilet handles in the other stalls. I started working at 8201 W. 183rd Street address in June 2015 and the toilet handle in the third stall always had to be pushed down with more strength. At first I thought it didn't worked [*sic*] when I pushed down on it but I realized I didn't push down on the handle hard enough. It has always been an effort to use that handle since the time I was there until the time our department moved out to another Conifer facility on December 15, 2016." (PX1).

In a statement dated 3/28/17, Rebekah Toepfer noted that she recalled "... many issues with the bathroom at the Conifer building located at 8201 W. 183rd Street, Suite E, Tinley Park, IL 60487. The third stall had a toilet with a handle that was difficult to push down taking much force to do this. The bathrooms, in general, were not pleasant to be in nor did they work half of the time." (PX1).

In an undated statement, Jackie Washington-Stuart noted "... many issues in the washroom at Conifers 8201 West 183rd [S]treet [S]uite E Tinley Park[,] Illinois location. In July 2016 the third stall had a handle that was difficult to push. Sometimes you would need to push it down multiple times before it would flush. That stall and the others were often out of order." (PX1).

In a statement dated 3/28/17, Yulinda Bogan noted "... issues in July 2016 in the Conifer washroom at the 8201 [W]. 183rd [S]treet [S]uite E, Tinley Park location. The toilet in the third stall seemed to never have enough water for the toilet to flush properly." (PX1).

In a statement dated 3/28/17, Tiffany Lewis noted "... the toilet in the third stall at the [C]onifer location at 8201 [W]. 183rd [S]treet [S]uite E being hard to flush. The handle did not flush like other toilets and most times you had to push down multiple times." (PX1).

In an undated statement, Misty Nelson recalled "... there being an issue with the toilets in the previous building around July 2016. On several occasions the bathrooms were out of order and the toilet was even replaced at one point. The toilet in the third stall was harder to flush than any of the other toilets and sometimes you had to push the handle more than once and with more force. Often this stall was the focus on all of the bathroom issues in that building." (PX1).

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In an undated statement, Shawn Bishop noted that she recalled "... back in September 2016 when I arrived at the building in question that there was always some issue in the bathroom mainly the middle stall where the toilet would not flush or would take several attempts to flush. I also recall that it was out of order the majority of the time." (PX1).

In an undated statement, Pamela Hansen noted that she "... started in that office in August of 2016 and recall avoiding the third stall; in fact it was out of order most of the time. It was difficult to flush and sometimes you had to do it more than once. Those washrooms were so bad they had to have a company come out and tear up the floor to fix it, we were even sent home early one rainy day due to the issues in those washrooms." (PX1).

In a statement dated 3/28/17, Asha Taylor noted that "... the 3rd stall in the bathroom was difficult to flush in July 2016. It required several attempts to flush." (PX1).

In a statement emailed to Petitioner on 3/28/17, Tiffany Spearson noted that "[i]n the third stall of the bathrooms in our Tinley West building AKA Tinley 2 the handle was a lot harder to push down then the other stalls, sometimes it would require a second or third flush to make sure it works. We were always having bathroom issues in that building where the plumber has came [*sic*] out multiple times and it still was not fixed. Eventually we all moved to the Tinley 3 building before the bathroom situation was ever resolved." (PX1).

Petitioner testified that following the incident she reported the accident to her supervisor, Lori Fugate. (T.14). She indicated that she believed a report was eventually filled out approximately two weeks later by her director, Ashley Collota. (T.14).

Petitioner indicated that she did not seek medical attention on the day of the incident (7/12/16), but eventually visited Dr. Blair Rhode on 7/29/16. (T.15). She noted that she had seen Dr. Rhode in the past as the result of a previous work-related injury to her right shoulder in 2009. (T.15-16). Petitioner stated that she was injured at that time while walking into the building where she worked. (T.16). She indicated that she was released for that injury in 2010, and denied having any issues with her right shoulder or performing her job between 2010 and 2016. (T.16-17). When asked what kind of treatment she had for this prior injury, Petitioner replied: "I received an injection in my shoulder, and then I was actually referred for my lower back. So he [Dr. Rhode] referred me to another physician." (T.17). She indicated that her issue with her shoulder resolved with the injection. (T.17).

In an Orland Park Orthopedics note dated 7/29/16, Dr. Rhode recorded that "[t]he patient presents for evaluation of a work-related right shoulder injury sustained July 12, 2016. She states that she was attempting to flush a toilet while at work with a posterior outstretched hand performing a downward motion when she experienced a ripping sensation in the lateral aspect of her right shoulder. She states that the flush mechanism on the toilet is poorly functioning. She continues to experience lateral shoulder pain with weakness to forward reach an [*sic*] overhead lift. She is unable to elevate her arm past neutral. The patient previously has treated with Orland Park [O]rthopedics for right shoulder pain for which she was managed with an injection and home exercise program. She states that she was doing fine until her work related event on July 12, 2016." (PX2). Following his examination, Dr. Rhode noted that he suspected that the patient

sustained a rotator cuff tear secondary to "... flushing a malfunctioning toilet with an outstretched posteriorward reaching arm" and that she had early symptoms of a frozen shoulder. (PX2). Dr. Rhode "... institute[d] aggressive passive physical therapy" and ordered an MRI of the right shoulder. (PX2). Petitioner was instructed to continue her full duty work and follow up after the MRI. (PX2).

An MRI of the right shoulder performed on 8/3/16 revealed 1) distal subscapularis tendinopathy, mild posterior supraspinatus bursal surface degeneration/tendinitis, no retracted rotator cuff tear seen; 2) mild degenerative irregularity anterior-inferior labrum without labral tear seen; 3) maintained glenohumeral articular surfaces; and 4) mild degenerative osteoarthritis at the acromioclavicular joint accompanied by a laterally sloping acromion with supraspinatus abutment. (Dr. Rhode dep., PX2).

In an IME report dated 12/8/16, Dr. Brian Forsythe stated that "[a]t this time, the claimant's subjective complaints are not supported by the objective findings. The claimant demonstrated moderate symptom magnification during physical examination. Her MRI demonstrates no structural pathology. Her mechanism of injury was not of sufficient magnitude to cause any structural pathology. There is no clinical evidence of frozen shoulder on today's examination." (Dr. Forsythe Dep. RX2). His diagnosis was "... resolved right shoulder strain. Her prognosis is good." (Id.). He also noted that "[t]here are no clear preexisting conditions of the claimant's right shoulder related to the 07/12/2016 injury." (Id.). In addition, he stated that "... the claimant is currently working full duty without restrictions. I recommend that she continue to work full duty without restrictions." (Id.). Finally, Dr. Forsythe indicated that "... the claimant has achieved maximum medical improvement for the right shoulder... [and] [t]here is no disability associated with the 07/12/2016 work injury." (Id.).

Petitioner indicated that she was still able to work during this time and that she has not missed any work as a result of the injury besides doctors' appointments. (T.18). She agreed that she followed up with Dr. Rhode on 8/8/16 at which time he again recommended physical therapy and reviewed the MRI. (T.18-19). She also agreed that she has attended physical therapy two days a week at Orland Park Orthopedics from 8/10/16 to the present, and that she is still performing full-duty work. (T.19). Furthermore, she agreed that she followed up with Dr. Rhode on 9/12/16, 10/10/16 and 11/7/16. (T.19-20). She noted that Dr. Rhode administered an injection to her right shoulder on 10/10/16 which helped, and that she had another injection on 11/15/16. (T.20).

Petitioner agreed that Dr. Rhode discussed with her the possibility of surgery for her shoulder. (T.21). She agreed that she has been following up with Dr. Rhode once a month and doing physical therapy twice a week since that time. (T.21). She noted that she has yet to receive approval to have the surgery through workers' compensation, and that she still wishes to have the surgery performed. (T.22). She also indicated that her medical bills had been paid by workers' compensation "up to a certain point" and that some have not been paid. (T.23).

Petitioner indicated that prior to July of 2016 she never had a recommendation for right shoulder surgery or for treatment outside the injection performed by Dr. Rhode. (T.23). She noted that she continues to work for Respondent, and that she has "... a tray that pulls out from

under the desk so the keyboard is on my lap… [T]hey've made accommodations that way, and I have a different chair so the tray can fit all the way; so this way, my elbows stay at my side, and I can work that way, instead of being up on top of a desk because that was making it worse." (T.23-24). She stated that he has difficulty "somewhat" in performing her job currently, and that she did not have difficulty performing it prior to this injury. (T.24). She denied falling or suffering any other injury to her shoulder since 7/12/16. (T.24).

On cross examination, Petitioner indicated that she is right-handed. (T.25). When asked why she chose to use the third stall on the day in question, despite knowing about the difficulty in flushing the toilet, Petitioner responded: "I really needed to use the restroom, and the other three were taken." (T.25-26). She indicated that the incident occurred in the late morning and not during lunchtime. (T.26). She noted that she believed 60 or 70 people worked in the building, and that the women had access to just this bathroom. (T.26). When asked whether the injury was due to a single flush, Petitioner responded: "Yeah. I pushed, but then like had to push further down. I don't know exactly how to explain that." (T.26). When asked why she waited two and a half weeks to seek treatment for her shoulder, she noted that "I really thought it would just heal on its own." (T.28).

Petitioner acknowledged that she filed a workers' compensation claim for her right shoulder following another work injury in 2009. (T.27). She denied having any hobbies outside of work, and noted that she really hasn't worked out since the injury. (T.28).

On redirect, Petitioner explained that in the prior injury "[t]here was a puddle on the marble floor coming into the main foyer. People had seen it. It was on video and everything. My manager at the time said we had to fill out an incident [report]. I never actually thought it was [an accident] because I wasn't on the clock yet. They kept insisting one thing. Well then once everything started and treatment started, it ended up being a personal injury… So it was filed. It was denied, the Work Comp; and then it was taken care of by the personal injury. The bills were paid that way." (T.28). She indicated that the case was settled. (T.29-30).

Board certified orthopedic surgeon Dr. Blair Rhode testified that he first saw Petitioner with respect to her current work-related condition on 7/29/16. (PX3, p.8). He noted that he had previously seen her on 1/4/10 for treatment relative to her hip and right shoulder sustained when she fell walking into a building on marble tile on 12/21/09. (PX3, p.8). Dr. Rhode stated that Petitioner's right shoulder pain was ultimately resolved at that time, and she was released to full duty work and at MMI with a normal shoulder exam, with 5 out of 5 strength, on 11/8/10. (PX3, pp.9,11). He indicated that Petitioner did not return for medical care for the right shoulder until the current injury in 2016. (PX3, p.9).

Dr. Rhode noted that Petitioner had previously had an MRI of the right shoulder on 1/7/10 which revealed tendinitis of the proximal intra-articular portion of the bicep tendon with no evidence for rotator cuff tear. (PX3, p.10).

Dr. Rhode recorded that the patient "… sustained a work-related right shoulder injury on July 12th, 2016. She was attempting to flush a toilet while at work with what she described as a posterior outstretched hand performing a downward motion when she felt a ripping sensation

along the lateral aspect of her shoulder. She stated that the flush mechanism on the toilet was poorly functioning." (PX3, pp.10-11). Upon examination Dr. Rhode noted a positive impingement sign and some loss of motion, and diagnosed "... early frozen shoulder as well as an injury to her rotator cuff either ... rotator tendinitis or rotator cuff tear." (PX3, pp.12-13). He noted that a subsequent MRI of the right shoulder performed on 8/3/16 "... demonstrated tendinopathy to the insertion of the tendon. No frank rotator cuff tear." (PX3, p.14).

Dr. Rhode testified that on 11/7/16 he discussed surgical options with the patient, which he suspected would entail a subacromial decompression and possible rotator cuff repair depending on what is seen at the time of surgery. (PX3, p.16). He did not believe that authorization had been provided as of the date of his testimony. (PX3, p.18). He noted that Petitioner had been essentially following up with him every month, and that she continues to have mild motion loss, pain with end range and strength loss. (PX3, pp.17-18). He indicated that they had been able to maintain the patient full duty with self-limitation, that she had received three injections and undergone a significant amount of physical therapy, and that at this point "... my belief is there's not much we can offer her short of surgery or live with it." (PX3, p.19).

When asked his opinion as to the cause of Petitioner's right shoulder condition, Dr. Rhode testified as follows: "Albeit an uncommon mechanism, what was described to me by the patient was that she was essentially reaching behind her in an awkward position pushing down on the lever of – of a malfunctioning toilet. You know, so there's a tremendous amount of lever force that the patient was generating specifically because of the posterior reach and the – and the length of the lever arm, so to speak. And then at that time, she experienced sudden onset lateral shoulder pain, which would be consistent to pathology to the rotator cuff. Based upon that – and also upon the fact that I had previously seen and treated the patient for a right shoulder issue that previously resolved, it's my opinion that the right shoulder pathology is causally connected to that event." (PX3, p.20).

Dr. Rhode indicated that he had compared the MRIs and that "... both of them demonstrated intact rotator cuff so this is not an issue that the patient has a full thickness rotator cuff tear but there is an interval change relative to the tendinopathy present – the 2010 study being essentially normal with the exception of that bicipital tendinitis. I don't think that the patient currently has any residual from the biceps tendon. This is all rotator cuff. (PX3, p.21).

Dr. Rhode opined that Petitioner's treatment to date has been reasonable and necessary, although he acknowledged that "... she's become an outlier [in terms of physical therapy] based upon the fact that she can't get definitive treatment so we continue with physical therapy to maintain motion." (PX3, p.21). He noted that he continues to recommend surgery. (PX3, p.22).

On cross examination, Dr. Rhode agreed that he had not treated another patient who was injured in such a fashion, noting "[w]ho hurts their shoulder flushing a toilet?" (PX3, p.23). However, while he agreed it was an uncommon event, he stated that it was a common mechanism for a rotator cuff injury – namely, trying to create a long lever by extending the arm in an awkward position. (PX3, p.23). When asked how many times Petitioner said she had to flush, Dr. Rhode indicated that he believed "... it was a single event. Unless it was taco Tuesday." (T.24). He also stated that "I don't know the common practice of a female to flush a

toilet but I assume she was sitting on the toilet still at the time she was reaching back." (PX3, p.24).

Dr. Rhode indicated he believed his diagnosis following the initial work injury in 2009 was rotator cuff strain, while also conceding that he may have made a diagnosis of early frozen shoulder as well "... on the index visit." (PX3, p.24). He indicated that he agreed with the radiologist's interpretation of the 8/3/16 MRI, noting "... there's no evidence of a full thickness rotator cuff tear on MRI." (PX3, p.26). In comparing the two MRIs, Dr. Rhode noted that "... there was an interval change. There was increased signal within the supraspinatus as well as subscapularis tendon." (PX3, pp.26-27). He also noted it was "possible" that those interval changes represent the normal degenerative process in a middle-aged woman. (PX3, p.27).

Dr. Rhode testified that he did not agree with Dr. Forsythe's opinion to the effect that Petitioner's subjective complaints were not supported by the objective findings, noting that Dr. Forsythe's objective assessment of the patient's loss of strength was even greater than his own finding along these lines. (PX3, p.27).

Board certified orthopedic surgeon Dr. Brian Forsythe testified that he examined Petitioner at the request of Respondent on 12/8/16. (RX1, p.6). At that time Dr. Forsythe recorded that on 7/12/16 "... she injured her right shoulder reaching behind her back and flushing a toilet. She described an onset of hot, sharp pain down her arm." (RX1, p.6). He indicated Petitioner did not tell him how many times she flushed the toilet, and that "[t]hroughout the examination she manifested moderate symptom magnification with guarding with active and passive range of motion and descriptions of nonanatomic and nonlocalizing tenderness to palpation." (RX1, pp.6,8). He also stated that "[t]here were some slight inconsistencies because I could get her to elevate to 140 degrees at one point and then 160 degrees later. So there were some mild inconsistencies." (RX1, p.8).

Dr. Forsythe indicated that he reviewed the MRI films dated 8/3/16 and "... generally agreed with the radiologist's interpretation. There was some distal subscapularis tendinopathy. There was some mild posterior supraspinatus bursal surface degeneration/tendinitis. There was no evidence of any full-thickness articular tearing or retraction of the rotator cuff. There was a little bit of fibrillation of the anterior inferior labral tissues without any frank labral tear. The cartilage surfaces were intact. There was mild AC joint degenerative arthritis and a lateral downsloping acromion with mild supraspinatus abutment, both of which are chronic findings and sort of minimum range for a 52-year-old patient. So, in my opinion, there weren't any traumatic lesions or pathology whatsoever, and this was sort of what you would expect for a 52-year-old patient with respect to MRI findings." (RX1, pp.9-10). He also noted that he obtained x-rays of the right shoulder which he characterized as "completely normal." (RX1, pp.10-11).

Following his examination and review of the records, Dr. Forsythe opined that Petitioner had "... sustained a right shoulder strain which had resolved, and that her prognosis was good because I couldn't appreciate any objective pathology." (RX1, p.11). In addition, Dr. Forsythe "... felt that treatment had been appropriate, necessary, and related to the work injury, and at this juncture there was no indication for any further treatment." (RX1, p.11). When asked the basis for this opinion, Dr. Forsythe stated that he "... was giving the claimant the benefit of the doubt

to even sort of acknowledge that there was a work injury. When I saw her, none of her subjective complaints were supported by objective findings. So at the time that I saw her, she essentially had a normal examination, in my opinion, which was masked by some symptom magnification. So, as I didn't have the privilege of seeing her immediately after the alleged injury, I gave her the benefit of the doubt and said, 'Okay, she could have strained her shoulder.' But when I saw her, there was no objective pathology; thus, I postulated that – concluded that her alleged injury had resolved." (RX1, pp.11-12). He also noted that "... clearly, there was no surgical indication or condition structurally that was related to flushing a toilet." (RX1, p.12).

Dr. Forsythe noted that he had seen more than 10,000 new patients over the course of his practice and that he had never treated a patient that injured their shoulder flushing a toilet. (RX1, pp.12-13). He indicated that he does not recommend any additional treatment for Petitioner, and that he disagrees with Dr. Rhode's recommendation for subacromial decompression surgery, noting that "... when I examined her, her subjective complaints were not supported by objective findings. She had moderate symptom magnification meaning that she was cooperative with range of motion testing. When I did perform provocative maneuvers, all of her responses were nonspecific, nonanatomic, and she had nonlocalizing tenderness to palpation. So she really didn't have any clinical presentation that was consistent with any diagnosis which I could indicate for surgery." (RX1, p.13). He noted that he did not impose any work restrictions and was of the opinion that "... she was fine to resume work without restrictions." (RX1, pp.13-14).

On cross examination, Dr. Forsythe indicated that he performs probably over 200, 250 independent medical examinations per year, although he could not say how many of those were at the request of the defense. (RX1, p.14). He stated that it was not safe to say that Petitioner's right shoulder range of motion was diminished at the time of his physical examination, noting that "... I had 160 degrees of scaption at one point during the examination. She had 65 degrees of external rotation, and she had internal rotation to L3. So she had normal scaption. She had normal external rotation. She did have internal rotation to L3, which was somewhat diminished. That's internal rotation, which is not consistent with an impingement deficit. And it's also notable that she was guarding with all motions, meaning that she wasn't fully cooperative. So if someone is not being fully cooperative, you'd expect one of the ranges to be diminished. But two of the ranges that I tested were normal, and those would be the ones most specific for rotator cuff pathology as well as adhesive capsulitis, or a frozen shoulder, which at some point might have been mentioned. She had absolutely no symptomatology consistent with a severe impingement or a rotator – or an adhesive capsulitis." (RX1, p.15).

Dr. Forsythe indicated that he did not review any medical records other those mentioned in his report. (RX1, p.16). He agreed that his testimony was that he did not believe that the mechanism of injury was of sufficient magnitude to cause any structural pathology. (RX1, p.16). When asked if he was aware of the forces involved in the accident, Dr. Forsythe replied: "[w]hat I was told was that she reached behind her back and flushed a toilet... And in terms of the forces involved with flushing a toilet, I would [be] happy to hear what your impressions are." (RX1, p.16). He noted that he was basing his opinion on his "... personal knowledge of having flushed a toilet several times a day for the last, you know, 35 years in a variety of towns, states, countries, and locations. So I would estimate that in my lifetime I've flushed more than 30- -- you know, a toilet more than 30,000 times." (RX1, p.17). He stated that "[q]uite a few" of those

were malfunctioning, noting that "... I think that everybody in the course of their lifetime has flushed malfunctioning toilets." (RX1, p.17). He indicated that "[a]ll [Petitioner] described was reaching behind her back. So, yes, I'm aware of the forces involved. She reached behind her back and flushed the toilet. My understanding of toilets being flushed is that you're pushing downwards; is that correct?" (RX1, p.19). He testified that he did not specifically know how much foot pounds of force this particular toilet required in order to flush, and "guess[ed]" that Petitioner was right-hand dominant "... because 90 percent of the population is." (RX1, p.20).

Dr. Forsythe noted that he was not aware of any previous conditions that Petitioner may have had with her shoulder, given that she did not report any and in light of the fact that he did not review any records outside those contained in his report. (RX1, p.20). He agreed that reviewing those records would "actually" be helpful, noting that "[i]f you presented outside medical records predating the date of injury, it might suggest that she had a preexisting shoulder problem. So if I could evaluate that as a potential situation for her, it would be helpful." (RX1, p.20). However, he did not believe that this would change his opinion, noting that "... I've already reviewed all of her current documentation relating to this alleged work injury, and nothing substantiated or supported that a significant injury was sustained beyond a strain." (RX1, p.21).

On redirect, Dr. Forsythe noted that he had treated approximately 200 plumbers over the course of his practice, and that none of them complained of a left [*sic*] shoulder injury due to flushing a malfunctioning toilet mechanism. (RX1, p.22).

Conclusions of Law

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that she has suffered a disabling injury which arose out of and in the course of her employment. *Sisbro, Inc. v. Industrial Commission*, 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, meaning that, generally, the injury must occur within the time and space boundaries of the employment. *Sisbro*, 207 Ill. 2d at 203. However, under the personal comfort doctrine, the course of employment is not considered broken by certain acts relating to the personal comfort of the employee. *Eagle Discount Supermarket v. Industrial Commission*, 82 Ill. 2d 331, 339, 412 N.E.2d 492, 45 Ill. Dec. 141 (1980).

An injury "arises out of" employment when "the injury had its origin in some risk connected with, or incidental to, the employment and the accidental injury." *Sisbro*, 207 Ill. 2d at 203. There are three (3) 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. *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 371 Ill. Dec. 384, 990 N.E.2d 284 (4th Dist. 2013). 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 a risk to a greater degree

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than the general public. *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 990 N.E.2d 284, 371 Ill.Dec. 384 (4th Dist. 2013). The increased risk may be either qualitative (i.e. 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 members of the general public by virtue of his employment). *Metropolitan Water Reclamation Dist. of Greater Chicago v. Ill. Workers' Comp. Comm'n*, 407 Ill.App.3d 1010, 1014, 944 N.E.2d 800, 348 Ill.Dec. 559 (2011).

In the present case, in using the restroom facilities provided by Respondent, Petitioner's actions clearly fell within the personal comfort doctrine. In addition, there is absolutely no evidence to suggest that Petitioner availed herself of these facilities in an unreasonable or unforeseen manner so as to remove herself from the course and scope of her employment. Indeed, Petitioner did nothing more than reach behind her to flush a toilet with a malfunctioning handle – a fact that was corroborated by no less than ten other witnesses. (PX1). Therefore, the Commission finds that Petitioner was "in the course" of her employment at the time of the alleged accident.

In terms of "arising out of", the Commission finds that the act of reaching behind her to flush a recalcitrant toilet involved a neutral risk, one that members of the general public are commonly exposed to. The dissent tries to characterize the risk at issue as a personal one, but it was by no means unique to the Petitioner. While the act of "answering nature's call", as it were, is most assuredly a private one, it is also one that every human being necessarily performs on a daily basis. As such, the question of compensability comes down to whether Petitioner was exposed to a risk of injury to a greater extent than a member of the general public, either from a quantitative or a qualitative standpoint. Along these lines, the Commission finds that from a quantitative standpoint, Petitioner was exposed to a greater risk of injury due to her employment given the frequency with which she was forced to utilize the facilities in question, and the toilet with the malfunctioning handle in particular, compared to members of the general public. Indeed, to a certain extent, the malfunctioning toilet represented an employment risk, given the element of control and Respondent's failure to properly maintain the premises – especially in light of the fact that the facility in question was in an area not open to the general public and was the only bathroom women had access to. (T.12, 26).

Therefore, based on the above, and the record taken as a whole, the Commission reverses the decision of the Arbitrator and finds that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries that both arose out of and in the course of her employment on 7/12/16.

Furthermore, the Commission finds that Petitioner provided proper and adequate notice of the accident to her employer within the dictates of §6(c) of the Act based on Petitioner's unrefuted testimony that she reported the incident to her supervisor, Lori Fugate, and that she believed a report was eventually filled out approximately two weeks later by her director, Ashley Collota. (T.14).

The Commission further finds that Petitioner's current condition of ill-being is causally related to the accident on July 12, 2016 based on the chain of events as well as the opinion of Dr. Rhode. Petitioner credibly testified that she had previously treated with Dr. Rhode for a right

shoulder injury in 2009, for which she received an injection and returned to full duty work. (T.15-17). She noted that the issue with her shoulder resolved with the injection and that she had no problems with her right shoulder or performing her job between 2010 and 2016. (T.16-17). Petitioner also indicated that prior to July of 2016 she never had a recommendation for right shoulder surgery or for treatment outside the injection performed by Dr. Rhode. (T.23).

For his part, Dr. Rhode noted that he had previously seen Petitioner on 1/4/10 for treatment relative to her hip and right shoulder sustained when she fell walking into a building on marble tile on 12/21/09. (PX3, p.8). Dr. Rhode stated that Petitioner's right shoulder pain was ultimately resolved at that time, and she was released to full duty work and at MMI with a normal shoulder exam, with 5 out of 5 strength, on 11/8/10. (PX3, pp.9,11). He indicated that Petitioner did not return for medical care for the right shoulder until the current injury in 2016. (PX3, p.9). When asked his opinion as to the cause of Petitioner's right shoulder condition, Dr. Rhode testified that while the mechanism of injury was uncommon "... what was described to me by the patient was that she was essentially reaching behind her in an awkward position pushing down on the lever of ... a malfunctioning toilet. You know, so there's a tremendous amount of lever force that the patient was generating specifically because of the posterior reach and the – and the length of the lever arm, so to speak. And then at that time, she experienced sudden onset lateral shoulder pain, which would be consistent to pathology to the rotator cuff. Based upon that – and also upon the fact that I had previously seen and treated the patient for a right shoulder issue that previously resolved, it's my opinion that the right shoulder pathology is causally connected to that event." (PX3, p.20). Along these lines, the Commission finds the opinion of Dr. Rhode to be more persuasive than that offered by Respondent's §12 examiner, Dr. Forsythe.

In addition, the Commission notes that there is absolutely no evidence that Petitioner's condition was so far gone that any activity would have resulted in the injury in question. Indeed, the evidence shows that Petitioner had not treated for her right shoulder since her release at MMI by Dr. Rhode almost six years earlier, on 11/8/10. Accordingly, the Commission finds that Petitioner's current condition of ill-being relative to her right shoulder is causally related to the accident on 7/12/16.

Furthermore, the Commission finds that Petitioner is entitled to prospective medical care and treatment as recommended by Dr. Rhode, including diagnostic arthroscopic surgery entailing a subacromial decompression and possible rotator cuff repair depending on what is seen at the time of surgery. (PX3). This finding is based on the opinion of Dr. Rhode as to the reasonableness and necessity of said treatment as well as the Commission's previous determination as to accident and causation.

In sum, Petitioner testified about the condition of the lavatory in question, which was supported by no less than ten female employees. This evidence was unrebutted by Respondent. Petitioner testified that she gave immediate notice to her supervisor Ms. Fugate. Ms. Fugate did not testify, nor did Ms. Collata. As for the mechanism of injury from the physician's perspectives, the Commission has thoughtfully determined which physician is more persuasive considering that of Dr. Forsythe, who examined Petitioner six years post-accident and reasoned that the injury could not have happened to Petitioner because it never happened to his patients,

19IWCC0424

and Dr. Rhode, who reasoned that the mechanism of injury was embarrassing, but possible, given that Petitioner's arm was extended and forced downward behind her. The Commission finds that Petitioner has established that she sustained a compensable injury at work in consideration of the entirety of the record and the narrow, ignominious facts in this case.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated February 26, 2018 is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the current treatment recommendations of Dr. Rhode, including diagnostic arthroscopic surgery, pursuant to §8(a) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury 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 $10,000.00. 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 8 - 2019
o:06/18/19
TJT/pmo
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D. Douglas McCarthy

Barbara N. Flores

19IWCC0424

DISSENT

When rendering a decision, it is incumbent on the finder of fact not to take leave of his or her senses and most assuredly common sense. Petitioner testified she flushed a toilet injuring her shoulder resulting in a traumatic tear of the rotator cuff as well as a frozen shoulder as indicated by her treating physician. The Arbitrator found such implausible, and Petitioner not credible both findings to which I concur. See *Elliot v. the Industrial Commission*, 303 Ill. App. 3d 185, 188, 707 N.E.2d 228 (1999) ("Even before there can be a consideration of whether an accidental injury arose out of employment, claimant must prove there was an accidental injury"). The Arbitrator noted the "accident" was unwitnessed. No documentation was provided evidencing Petitioner reported this unwitnessed "accident." Moreover, the Arbitrator highlighted Petitioner's 17-day delay in treatment, and when Petitioner finally obtained treatment, she provided a history of experiencing a ripping sensation at the time of "accident" yet nonetheless waited 17 days to seek medical treatment. Finally, Petitioner was familiar with Dr. Rhode as he treated her in the past for shoulder pathology in the same shoulder. The majority without providing the requisite analysis finds in opposition and presumably now finds Petitioner credible. See *R & D Thiel v. Illinois Workers' Compensation Commission*, 398 Ill. App. 3d 858, 923 N.E.2d 870 (2010). Therefore, I respectfully dissent.

Even if Petitioner's testimony is accepted in totality, her claim fails. "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. [citations omitted]. 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). "Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements expressed by the legislature in the Act"). "To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro* at 203. Petitioner's incident occurred while she was in the course of her employment, but such incident did not arise out of her employment.

Accident

The majority utilizes a neutral risk analysis finding Petitioner's risk of injury while flushing the toilet was quantitatively increased given Petitioner "was forced to utilize the facilities in question, and the toilet with the malfunctioning handle in particular." *Supra*, p. 10, ¶ 2. The majority then goes a step further finding Petitioner's injury under an employment risk analysis. As the Court recently held in *McAllister v. Illinois Workers' Compensation Commission*,

> Thus, supreme court precedent makes clear that an injury should be deemed to have resulted from an employment risk when the risk causing the injury originates from one of the following three types of acts—acts (1) the claimant was instructed to perform by his employer, (2) claimant had a common law or statutory duty to perform, or (3) that were incidental to the claimant's employment. 2019 IL App (1st) 162747WC, ¶ 42.

Applying this standard, Petitioner's act of flushing the toilet was not an employment risk. There is no evidence 1) Petitioner was instructed by Respondent to utilize the toilet; 2) Petitioner had a common law or statutory duty to use the toilet; or 3) Petitioner's use of the toilet was incidental to her assigned duties. "[O]ur supreme court instructs that '[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.' (Emphasis added.) *Orsini*, 117 Ill. 2d at 45." *Id.* at ¶ 46. Petitioner is not a plumber; she works in a cubicle processing medical bills. T. 8-9. Petitioner's use of the toilet, malfunction or not, is simply not an employment risk. Nor is it a quantitatively increased neutral risk.

The majority finds Petitioner's risk of injury quantitatively increased but cites to no evidence requiring Petitioner to utilize this particular toilet. In fact, the evidence establishes that three other toilets besides the offending toilet were available for use. T. 12. More importantly, the majority cites to absolutely no evidence that the recalcitrant toilet was actually defective. Petitioner testified "I pushed, and I had to push a little harder; and then it flushed." T. 11. Petitioner reiterated her testimony stating, "I pushed, but then like had to push further down." T. 26. Petitioner flushed twice with the second attempt requiring more effort. The ten written statements submitted by Petitioner confirm this particular toilet at times required more than one attempt to flush. PX1. Such anecdotes merely prove this toilet functioned differently than those found in the other restroom stalls not that it was defective or imperiled Petitioner in anyway.

Petitioner's act of flushing for a second time with increased effort does not qualify as an employment risk nor a quantitatively increased neutral risk. Petitioner's accident did not arise out of her employment.

Causal Relationship

Assuming *arguendo* such risk exists, Petitioner failed to prove a causal relationship. Again, as recently noted by the Appellate Court in *McAllister v. Illinois Workers' Compensation Commission*,

> In other words, even if a claimant can establish an accident originating from an employment-related risk, he or she must still establish a causal connection between that accident and the resulting condition of ill-being. Certainly, where the evidence presented at arbitration supports a finding that the risk of injury was due to a degenerated physical condition, or was otherwise solely personal to the employee, recovery can and should be denied. 2019 IL App (1st) 162747WC, ¶ 67.

The Court further highlighted the Supreme Court's holding in *Sisbro* "whether 'any normal daily activity is an overexertion' or whether 'the activity engaged in presented risks no greater than those to which the general public is exposed' are matters to be considered when deciding whether a sufficient causal connection between the injury and the employment has been established in the first instance." *Id.* at ¶ 43. Using the restroom and flushing a toilet is the quintessential act of daily living. If the mere act of flushing a toilet does not qualify, I am at a loss as to what does.

After waiting 17 days to seek treatment, Petitioner presents to Dr. Rhode on July 29, 2017 at which time she is assessed with a rotator cuff tear and a frozen shoulder. An injection is

provided, and an MRI recommended. Moreover, Petitioner suffered from a previous right shoulder condition which required treatment. PX2. Petitioner's shoulder condition had deteriorated to such a point, any activity would have led to 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).

For the reasons stated above, I respectfully dissent.

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Heilmann,
Petitioner,

vs. No. 15 WC 37524

19IWCC0425

Advanced Geothermal Plumbing
& Heating, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

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

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 8, 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.

19IWCC0425

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

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

Bond for 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 8 - 2019

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp-wj
06-20-19
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

HEILMANN SR, ROBERT
Employee/Petitioner

Case# **15WC037524**

ADVANCED GEOTHERMAL PLUMBING & HEATING LLC
Employer/Respondent

19IWCC0425

On 12/8/2017, 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 1.45% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
JOHN P CAMPBELL
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

19IWCC0425

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert Heilmann, Sr.
Employee/Petitioner

v.

Advanced Geothermal Plumbing & Heating LLC
Employer/Respondent

Case # **15** WC **37524**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **September 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. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **November 13, 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 $**39,559.00**; the average weekly wage was $**760.75**.

On the date of accident, Petitioner was **51** 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 $**26,372.86** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**26,372.86**.

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 $507.17/week for 98 weeks, commencing November 14, 2015 through September 29, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $26,372.86 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $28,637.34 to Instant Care Equipment Leasing, $55,806.30 to Elmwood Park Same Day Surgery Center, $14,794.20 to Workers' Compensation Rx Solutions, $3,207.20 to Metro Health Solutions, $660.00 to Midwest Orthopedics at RUSH, and $627.12 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Singh including a C5-6 fusion surgery with decompression or other reasonable and necessary care.

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

December 5, 2017
Date

ICArbDec19(b)

DEC 8 - 2017

Statement of Facts

Petitioner Robert Heilmann testified that he was employed by Respondent Advanced Geothermal Plumbing & Heating as a plumbing laborer. He testified he has worked for Respondent in the past on various jobs. The Form 45 admitted as PX 1 indicates he had been employed by Respondent since August 15, 2015. Petitioner testified his job involved heavy lifting including carrying plumbing supplies to and from job sites. On November 13, 2015, Petitioner was carrying a sink and countertop up stairs when he lost his footing a fell down the flight of stairs, landing on his neck and right shoulder. The injury was reported to Respondent and Petitioner was taken to Presence St. Joseph Hospital (PX 1). The Emergency Department records note the history of accident with pain complaints in the right neck and shoulder. Petitioner had a CT scan of the cervical spine which noted a chronic fracture of the spinous process of C2 unchanged from a previous MRI on 9/6/14 and multilevel cervical spondylosis (PX 3). Petitioner testified he had a prior neck injury 2005, but had no treatment since that time. Petitioner testified that the 2014 MRI was performed in conjunction with an angiogram and was not related to any symptoms in his neck. He worked in plumbing as a laborer from 2005 until the accident performing labor intensive duties.

Petitioner sought treatment from Dr. Mehta beginning November 18, 2015. Petitioner reported the history of accident. He denied any prior pain issues. He reported pain in the right neck and right shoulder with radiation into the right extremity. He complained of right shoulder pain with weakness going down the right arm and 10/10 pain in the neck. Dr. Mehta assessed neck pain, shoulder pain and radicular complaints down the right arm. He recommended an MRI of the right shoulder and initiating physical therapy. He stated that due to the radicular complaints, Petitioner may benefit from intervention in the future if he does not improve. Dr. Mehta stated Petitioner should be off work (PX 4).

The right shoulder MRI taken December 1, 2015 noted the rotator cuff appeared intact. There was rotator cuff tendonitis and/or bursitis and AC inferior hypertrophic spurring probably with some impingement (PX 4). Petitioner saw Dr. Arpan Patel on December 8, 2015. His assessment was signs and symptoms suggestive of right rotator cuff tendinitis. He notes the impingement syndrome is likely unrelated to the fall as the impingement is occurring secondary to spurring. The bursitis and tendonitis likely is acute. He also states that Petitioner's cervical neck pain is secondary to myofascial inflammation and contusion. He does not seem to have any significant radicular symptoms. The CT scan did not show any acute findings. He notes that if cervical issues do not resolve, a cervical MRI would be considered. He scheduled a right shoulder injection and sent Petitioner for an orthopedic evaluation. He started physical therapy for the neck and shoulder. He prescribed medications and noted Petitioner has been on Norco for two years for arthritis. He continued Petitioner off work (PX 4).

Petitioner began physical therapy at Athletico on December 11, 2015. He underwent the shoulder injection on December 15, 2015. Petitioner saw Dr. Silver for his shoulder on December 19, 2015. He noted one day of relief from the injection. Dr. Silver diagnosed rotator cuff impingement. He recommended arthroscopic surgery. He prescribed continuing physical therapy, Meloxicam for swelling, Protonix for gastrointestinal protection, Hydrocodone for pain and Ultram (PX 4). Petitioner underwent arthroscopic surgery to his right shoulder on January 12, 2016. Dr. Silver performed a subacromial decompression, lysis of adhesions, distal clavicle resection, synovectomy and debridement. Post operatively, Dr. Silver prescribed a 42 day rental of a Game Ready cold compression device and A CPM device. Petitioner had follow up with Dr. Silver for the shoulder only. Dr. Silver renewed the prescriptions on January 20, 2016. Petitioner was released to restricted work on

March 2, 2016 and released to unrestricted work with respect to the shoulder only on April 18, 2016. Petitioner was discharged from physical therapy on April 19, 2016 (PX 4).

Petitioner continued treatment for his neck with Dr. Patel and Dr. Mehta. On January 6, 2016, Dr. Patel diagnosed cervicalgia and myofascial pain. He stated Petitioner has persistent neck pain which appears to be primarily related to aggravation of underlying spondylosis as well as myofascial spasming and pain. He recommended continuing therapy and medication and scheduled Petitioner for follow up after his shoulder surgery (PX 4). On February 9, 2016, Petitioner reported his neck pain continued. He told Dr. Patel that he underwent facet joint injections in 2005 approximately every 3 months. He feels his pain is similar to that. Dr. Patel states that because Petitioner is only 3 weeks post shoulder surgery, he will hold off on intervention. He notes that Petitioner will follow up in a month for trigger point injections and if no improvement he will be a candidate for facet joint injections at C5, C6 and C7. On March 18, 2016, Dr. Patel performed trigger point injections over the right cervical paraspinal muscles. On April 8, 2016, Dr. Patel reported Petitioner did not gain any improvement following the trigger point injections. Petitioner was scheduled for facet joint injections at C5-6 and C6-7. Dr. Mehta performed the injections on April 19, 2016. On May 6, 2016, Dr. Patel records that Petitioner had three days of significant improvement following the injections but then returned to baseline. Dr. Patel notes a history of chronic neck pain which was under control until the injury. He referred Petitioner to a spine surgeon for further evaluation (PX 4).

On May 17, 2016, Petitioner saw Dr. George Miz on referral from Dr. Patel. Dr. Miz noted the history of accident and complaints of cervical pain radiating into the trapezius and shoulder areas. He has no pain distal but experiences intermittent paresthesia in the right hand. His physical examination noted tenderness with restricted range of motion particularly toward the right due to pain. Spurling's test is negative. Reflexes and motor examination are symmetric. Sensory exam is intact. His impression was cervical radiculitis. He recommended an EMG and MRI of the cervical spine (PX 4). The May 18, 2016 cervical MRI impression was a 3-4 mm disc protrusion at C3-C4 and bulging discs at C4-C5, C5-C6, and C6-C7 (RX 10). The May 27, 2016 EMG impression was mild to moderate C8 radiculitis (PX 4). On June 2, 2016, Dr. Miz read the MRI as showing disc degeneration from C3-C7. He noted a mild disc bulge at C3-4 but no foraminal stenosis. At C4-5, he has bilateral foraminal narrowing right somewhat worse that the left. At C5-6, he has foraminal stenosis markedly worse on the right than the left. At C6-7, he has minimal foraminal or central stenosis. His impression is multiple level degenerative disc disease and more axial than radicular symptoms. Dr. Miz states that in his opinion, Petitioner is not a good surgical candidate. He recommends that he pursue non-operative management with his pain specialist. He states he has no disagreement with the plan for radiofrequency ablation (RX 5). Petitioner testified that he discussed disc replacement surgery with Dr. Miz.

On June 3, 2016, Petitioner saw Dr. Patel. He stated that he did not want to have surgery. Dr. Patel recommended a right paramedian C4-5 cervical epidural steroid injection. He continued Petitioner's light duty restrictions (PX 4). Petitioner had the epidural performed on June 21, 2016 with Dr. Mehta. The diagnosis listed on the procedure report was cervical degenerative disc disease, cervical disc protrusion, cervical stenosis and cervical radiculopathy (PX 4).

On June 23, 2016 Petitioner saw Dr. Miz. He noted that the ESI provided some benefit. He states that the EMG was found to be consistent with C8 radiculopathy. He notes that there is no evidence of any root compression at the C6-7 or C7-T1 level that he can connect to the C8 finding. He restates his opinion that Petitioner was not a surgical candidate and returned Petitioner for continued interventional pain management (RX 6).

On July 15, 2016, Dr. Patel noted that Petitioner had 100% relief for two weeks from the ESI with gradual reduction to about 50% improvement. He states the MRI reports disc protrusions at C3-4, C4-5, C5-6 and C6-7 with indentation of the thecal sac. He notes the EMG reporting mild to moderate right cervical radiculitis. He states that although he believes the cervical radiculopathy is most problematic and the likely pain generator, he believes that the remaining pain is facet mediated. He scheduled diagnostic medial branch blocks to determine if the C5-6 and C6-7 facet joint is resulting in continued neck pain. The medial branch blocks at C5, C6 and C7 were performed on August 9, 2016. On August 23, 2016 Dr. Mehta noted 100% pain relief for 8 hours with the nerve blocks and recommended radiofrequency ablations at C5, C6 and C7. Radiofrequency ablations were performed on September 6, 2016. Petitioner saw Dr. Patel on September 21, 2016. Petitioner stated that his range of motion improved, but that he continued to have pain in his neck and paresthesia down his arm. Dr. Mehta notes the paresthesia is not in the C8 distribution.

On September 28, 2016, Petitioner was seen by Dr. Jesse Butler for Section 12 examination at Respondent's request (RX 2). Dr. Butler took Petitioner's history and reviewed the treating medical records. His physical examination recorded normal strength, reflexes and sensation. Range of motion noted normal flexion, 30 degrees of extension and 60 degrees of rotation. Foraminal compression/Spurling's test was negative. He read the MRI as showing degenerative findings with disc height loss at all levels from C3-4 to C6-7. He diagnosed disc degeneration with cervical strain. The condition is related to the accident. He states Petitioner has subjective complaints of mechanical neck pain without significant radiculopathy. He does not find that Petitioner is exaggerating his complaints. No additional treatment is needed and Petitioner will reach maximum medical improvement within 6 weeks. Petitioner does not require long term work restrictions (RX 2). Dr. Butler prepared an impairment rating of 1% whole person (RX 3).

Petitioner saw Dr. Patel on October 26, 2016. He notes that Dr. Butler did not feel that Petitioner needed any specific work restrictions or additional treatment. Petitioner reported improvement after the radiofrequency ablation. Petitioner's residual symptoms are stiffness and pain in the right posterolateral neck as well as some tingling that radiates into the right arm. Dr. Patel assessed neck pain likely related to discogenic etiology as well as spondylosis. Overall his pain is much improved although he still has persistent axial pain likely related to myofascial symptoms. Dr. Patel recommended trigger point injections. On November 8, 2016, Petitioner requested a second opinion prior to undergoing any further injections (PX 4).

On November 16, 2016, Petitioner was seen by Dr. Kern Singh at Midwest Orthopedics at Rush (PX 5). Dr. Singh recorded Petitioner's history and noted continued pain and numbness down the right arm. On physical examination he noted 5- strength in the right biceps and wrist extensor. He read the MRI as showing a right sided C5-6 disc herniation. Dr. Singh recommended a single level fusion at C5-C6. He notes the Petitioner exhibited no Waddell findings. His symptoms, the MRI finding and weakness in the biceps and wrist extensor are anatomic pain complaints (PX 5). On December 6, 2016, Dr. Mehta agreed with Dr. Singh's recommendation and deferred to him for the surgical intervention (PX 4).

On February 13, 2017, Dr. Singh authored a report after reviewing the notes of Dr. Miz and Dr. Butler (PX 6). Dr. Singh continues to recommend a single level fusion at C5-C6 based on Petitioner's motor weakness in the wrist extensor on the right and positive Spurling's test. He opines that the condition is related to the accident as an aggravation of a pre-existing degenerative condition in the fall (PX 6). On March 13, 2017, Dr. Butler authored a report after reviewing Dr. Singh's report (RX 4). Dr. Butler disagreed with Dr. Singh's surgical recommendation noting that he did not find that there was documentation of a C6 radiculopathy until Singh's

evaluation. He reviewed the MRI and noted the asymmetric right sided spur at C5-6. He did not believe that there is a reliable option for surgical treatment (RX 4).

Dr. Singh testified by evidence deposition taken on June 7, 2017 (PX 7). He testified to his reading of the MRI showing degenerative changes throughout the cervical spine and a right-sided C5-6 disc herniation. He noted the EMG interpretation was a C8 radiculopathy. The radiculopathy correlates with the MRI, but the distribution is inconsistent. He believes this is a false positive as to the level concerned. He testified the interpretation by the EMG-ographer was erroneous. There is no pathology to explain a C8 radiculopathy. His physical examination noted half a grade weakness in his biceps and wrist extensor which is the C5-6 distribution. Spurling's sign was positive. Sensory loss into the index, thumb and long finger is consistent with the C5-6 distribution. He diagnosed degenerative spondylosis and a right sided C5-6 herniated disc and recommended a fusion surgery with decompression. The degenerative spondylosis was pre-existing. The disc herniation was causally related to the injury. Dr. Singh testified he reviewed the Petitioner's prior medical treatment records through Dr. Butler's IME report. He reviewed Dr. Miz records independently (PX 7).

Dr. Butler testified by evidence deposition taken August 30, 2017 (RX 1). He testified to his September 28, 2016 examination including review of the treating records described in his report. His physical examination had near normal range of motion with a negative Spurling's. He testified to his reading of the MRI showing degenerative changes from C3-4 to C6-7 with no cord compression or significant foraminal stenosis, particularly at the C5-6 level. He disagreed with the diagnosis of classic C6 radiculopathy. There was primarily axial neck pain. Absent a classic radicular pain that correlated with the EMG and MRI findings, surgery was not reasonable or necessary. Typically, C6 radiculopathy would manifest as pain that would radiate from the neck into the biceps, thumb, index and long fingers. Petitioner did not manifest these symptoms on a consistent basis. Dr. Miz diagnosed radiculopathy, but did not find correlation between the EMG and MRI findings. Dr. Miz noted numbness and tingling down the arm. Fusion would be warranted if there are MRI findings and subjective radicular complaints that correlate with that level (RX 1).

Dr. Butler testified that Petitioner reported pain and disability at very high levels despite his presentation of not being in that degree of pain. There were no over-findings of symptom magnification. Petitioner's subjective complaints of posterior neck pain without radiating complaints into the upper extremities were correlated with the objective finding of degenerative disc disease and the history of the fall down the stairs that served as a strain of the underlying degenerative issues. Dr. Butler opined that Petitioner did not need any further treatment and did not require work restrictions. He testified to his methodology in reaching his impairment evaluation of 1% whole person (RX 1).

Petitioner testified that he cannot do any heavy activities or lifting. He has pain and numbness into his hand since the day he fell. He testified he would have the surgery proposed by Dr. Singh if it were authorized.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. Petitioner

suffered an undisputed accident on November 13, 2015, when he lost his footing a fell down the flight of stairs, landing on his neck and right shoulder. Petitioner sought immediate medical care for his neck and right shoulder. The causal connection of the right shoulder condition has not been disputed. Petitioner saw Dr. Silver for his shoulder on December 19, 2015. He diagnosed rotator cuff impingement and recommended arthroscopic surgery. Petitioner underwent arthroscopic surgery to his right shoulder on January 12, 2016. Petitioner was released to unrestricted work with respect to the shoulder only on April 18, 2016. The Respondent is disputing the ongoing causal connection of Petitioner's neck and related right arm complaints and disputing the causal connection of the surgical recommendation by Dr. Singh.

Petitioner testified and the medical histories confirm he had a prior neck problem and treatment in 2005. Dr. Butler diagnosed disc degeneration with cervical strain. He read the MRI as showing degenerative findings with disc height loss at all levels from C3-4 to C6-7. Dr. Singh agreed that the degenerative spondylosis was pre-existing. He opines that the condition is related to the accident as an aggravation of a pre-existing degenerative condition in the fall. A claimant bears the burden of showing that a preexisting condition was aggravated by his employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Lawless v. Industrial Comm'n*, 96 Ill. 2d 260, 269 (1983).

Dr. Singh has recommended a C5-6 decompression and fusion for a diagnosed disc herniation with C6 radicular symptoms. He bases this on his reading of the MRI showing a C5-6 disc herniation, the EMG interpretation of radiculopathy, Petitioner's complaints of radiating pain, and weakness in his biceps and wrist extensor which is the C5-6 distribution. Dr. Mehta agrees. On June 23, 2016, Dr. Miz noted that the EMG was found to be consistent with C8 radiculopathy. He notes that there is no evidence of any root compression at the C6-7 or C7-T1 level that he can connect to the C8 finding. He opines that Petitioner was not a surgical candidate and returned Petitioner for continued interventional pain management. Dr. Butler testified his reading of the MRI showing degenerative changes from C3-4 to C6-7 with no cord compression or significant foraminal stenosis, particularly at the C5-6 level. He disagreed with the diagnosis of classic C6 radiculopathy. There was primarily axial neck pain. Absent a classic radicular pain that correlated with the EMG and MRI findings, surgery was not reasonable or necessary.

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, particularly medical opinion evidence. *Berry v. Industrial Comm'n,* 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n,* 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Comm'n,* 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). 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.

Having evaluated the medical opinions in light of all the evidence presented, the Arbitrator finds the opinions of Dr. Singh more persuasive. The Arbitrator had the opportunity to view Petitioner's testimony and concurs with both Dr. Singh and Dr. Butler that he exhibited no signs of symptom magnification or exaggeration. While he had prior neck treatment in 2005, there is no evidence that he had intervening treatment in the 10 years before the accident. Petitioner had been performing heavy, physical labor. Following the accident, Petitioner's complaints have been consistent of neck pain and intermittent radiating pain in the right arm with numbness and tingling. On November 18, 2015, Dr. Mehta assessed neck pain, shoulder pain and radicular complaints down the right arm. On May 17, 2016, Dr. Miz noted complaints of cervical pain radiating into the trapezius and shoulder areas. His impression was cervical radiculitis. The EMG noted radiculopathy. Dr. Singh's explanation of the disparate radicular level found on EMG is reasonable to the Arbitrator. Dr. Patel states the MRI reports disc protrusions at C3-4, C4-5, C5-6 and C6-7 with indentation of the thecal sac. He notes the EMG reporting mild to moderate right cervical radiculitis. Dr. Patel assessed neck pain likely related to discogenic etiology. He states that although he believes the cervical radiculopathy is most problematic and the likely pain generator, he believes that the remaining pain is facet mediated.

Dr. Miz read the MRI as showing foraminal stenosis markedly worse on the right than the left at C5-6. While Dr. Butler disputes the diagnosis of C6 radiculopathy and the need for surgery, he also noted in his March 13, 2017 report that he reviewed the MRI and noted the asymmetric right sided spur at C5-6. Based upon the inconsistent level of radiculopathy noted on EMG, Dr. Mix recommended ongoing pain management to address Petitioner's condition. The Arbitrator notes that Petitioner has undergone multiple injections as well as the radiofrequency ablation and continues to experience ongoing symptoms. Dr. Butler disagreed with Dr. Singh's surgical recommendation based upon his lack of objective signs of C6 radiculopathy on his physical examination. He agrees that Dr. Singh's findings are consistent with C6 radiculopathy. The totality of the medical evidence documents ongoing complaints radiating into the right arm with multiple treating medical opinions of radiculitis, and discogenic pain as well as findings on the MRI to support Dr. Singh's clinical findings of C6 radiculopathy. Conservative care and pain management have failed to resolve Petitioner's credible symptoms.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that his condition of ill being in the right shoulder and neck is causally connected to the accident sustained on November 13, 2015.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Petitioner is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner is entitled to reasonable and necessary medical care for his condition of ill being in the right shoulder and neck. Petitioner submitted outstanding medical bills totaling $103,732.16 as PX 2. The outstanding bills include charges related to both the right shoulder and neck. Respondent submitted RX 9 showing medical payments made. Respondent also admitted RX 8 documenting the non-certification of certain medications and durable equipment. No fee schedule analysis pursuant to Section 8.2 was offered.

While Respondent has not disputed the causal connection of Petitioner's condition of ill being in the right shoulder, Respondent denied charges from Instant Care Equipment Leasing for the 42 day rental of the Game

Ready cooling unit and a portion of the rental for the CPM. They also denied charges from Workers' Compensation Rx Solutions for medication prescribed by Dr. Silver. Dr. Silver's records include detail as to the purpose of each of the medications prescribed, specifically noting the medical necessity due to the work injury. The prescription forms signed by Dr. Silver for the CPM and cooling unit include a specific letter of medical necessity stating the equipment is reasonable and necessary and designed to reduce post operative edema, swelling, and pain. Respondent's submitted non-certification recommendations note that the Physician Advisor was unable to recommend the non-certified services and medications, but did not include the guidelines used or the clinical reasons used. The Arbitrator is unable to assess the basis for the non-certification and therefore finds Dr. Silver's statements of reasonableness and necessity persuasive.

With respect to the treatment for the neck, based upon the Arbitrator's finding with respect to Causal Connection, Respondent would be responsible to pay for reasonable and necessary treatment for this condition of ill being. The Arbitrator has reviewed the bills from Metro Health Solutions and Prescription Partners for medications prescribed by Dr. Patel and Dr. Mehta, bills from Elmwood Park Same Day Surgery Center for the multiple injections and services performed, and Dr. Singh's bill for his office visit on November 16, 2016. The Arbitrator finds this treatment reasonable, necessary and causally related. The Arbitrator notes payments made by Respondent to Elmwood Park Same Day Surgery Center and adjustment to the bill by this provider. The Arbitrator makes no finding as to whether the balance billing exceeds the provisions of Section 8.2.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $28,637.34 to Instant Care Equipment Leasing, $55,806.30 to Elmwood Park Same Day Surgery Center, $14,794.20 to Workers' Compensation Rx Solutions, $3,207.20 to Metro Health Solutions, $660.00 to Midwest Orthopedics at RUSH, and $627.12 to Prescription Partners, as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Petitioner is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. Petitioner has received all reasonable and necessary care for his condition of ill being in the right shoulder and was released from care as of April, 2016. No further treatment for the shoulder has been recommended.

Based upon the Arbitrator's finding with respect to Causal Connection, Petitioner is entitled to any ongoing reasonable and necessary medical care for his condition of ill being in the neck and radiating pain into the right arm. As more fully discussed in the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds the opinions of Dr. Singh, supported by Dr. Mehta persuasive. Dr. Singh has recommended a C5-6 fusion surgery with decompression. Petitioner has testified that he wishes to undergo surgery if it is authorized.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he his entitled to prospective medical care. Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Singh including a C5-6 a fusion surgery with decompression or other reasonable and necessary care.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Section 8(b) of the Workers' Compensation Act provides weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. The dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement.

Petitioner has not returned to work since the accident and has not been released to return to work by any of his treating doctors. As more fully discussed in the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds the opinions of Dr. Singh persuasive. Dr. Singh does not find Petitioner at maximum medical improvement and has recommended additional treatment including a C5-6 fusion with decompression. This surgery has not yet been performed. Pursuant to the Arbitrator's finding with respect to Prospective Medical, the Arbitrator has found this recommended treatment reasonable and necessary and has ordered Respondent to authorize and pay for this care. The Petitioner remains entitled to temporary compensation as of the date of hearing herein.

Based upon the record as a whole and the Arbitrator's findings with respect to Causal Connection and Prospective Medical, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is entitled to temporary total disability benefits for 98 weeks, commencing November 14, 2015 through September 29, 2017, being the date of hearing, as provided in Section 8(b) of the Act. Per the stipulation of the parties and RX 9, Respondent shall be given a credit of $26,372.86 for temporary total disability benefits that have been paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bradley Hill,

Petitioner,

vs. NO. 16WC 008561

State of Illinois/Illinois Department of Transportation,

Respondent.

19IWCC0426

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2019 is hereby affirmed and adopted.

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

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

19IWCC0426

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

DATED: AUG 8 - 2019
SJM/sj
o-7/17/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

DISSENT

I find the evidence in this case supports an award of 20% loss of use of the person-as-a-whole. Petitioner sustained an injury to his back resulting in an L3-L4, L4-L5, and L5-SI laminectomy. While the procedure provided some relief, the evidence establishes that Petitioner still experiences pain and stiffness in his low back for which he takes Meloxicam. His injury has had a negative impact on his activities of daily living and has caused a disruption in his sleep. Because of his ongoing pain, Dr. David Raskas discussed the possibility of an L3-L4, L4-L5, and L5-SI fusion. While I agree with the weight assigned by the Arbitrator to the five factors listed under Section 8.1(b), I believe the severity of the injury coupled with Petitioner's ongoing pain and the possibility of a three-level fusion warrants an increase in the permanency award to 20% loss of use of the person-as-a-whole.

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HILL, BRADLEY
Employee/Petitioner

Case# **16WC008561**

19IWCC0426

STATE OF IL/ IDOT
Employer/Respondent

On 2/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.44% shall accrue from the date listed above to the day before the 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 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 -5 2019

Brendan O'Rourke, Assistant 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

Bradley Hill
Employee/Petitioner

v.

State of IL/IDOT
Employer/Respondent

Case # 16 WC 08561

Consolidated cases: n/a

19IWCC0426

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 8, 2019. By stipulation, the parties agree:

On the date of accident, January 22, 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 $74,244.00; the average weekly wage was $1,427.77.

At the time of injury, Petitioner was 45 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 $19,173.77 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $19,173.77. At trial, the parties stipulated TTD benefits had been paid in full.

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 87.5 weeks because the injuries sustained caused the 17 1/2 % loss of use of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from May 4, 2018, through January 8, 2019, 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

January 26, 2019
Date

FEB 5 - 2019

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on January 22, 2016. According to the Application, Petitioner "Fell" and sustained injuries to the back and body as a whole (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated that medical bills and temporary total disability benefits had been paid in full and the only disputed issue was the nature and extent of disability (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a highway maintainer. Petitioner's job duties included driving/operating heavy machinery, loading machines, dragging chains, prolonged walking, etc. Petitioner testified that on January 22, 2016, he fell off of a track hoe machine and injured his back.

Petitioner initially sought medical treatment at Franklin Hospital on January 22, 2016. Petitioner provided a history of the accident and complained of pain in the thoracic and lumbar areas of the spine. CT scans of the thoracic and lumbar spine were performed at that time.

A CT scan of the thoracic spine revealed a possible avulsion fracture at T1, but was otherwise normal. The CT scan of the lumbar spine revealed annular bulges at multiple levels of the lumbar spine. Petitioner was prescribed medication, authorized to be off work and directed to see his family physician (Petitioner's Exhibit 3).

Petitioner was subsequently seen by Dr. Jack Keller, his family physician, on January 26, 2016. Petitioner informed Dr. Keller of the work injury and complained of low back pain with pain in both legs, more on the right than left. Dr. Keller noted the abnormal findings of the lumbar CT scan and ordered an MRI of the lumbar spine as well as physical therapy (Petitioner's Exhibit 3). The MRI was scheduled for February 19, 2016, but was not performed because it was not authorized by Respondent. Petitioner did not receive physical therapy at that time either because it was also not authorized by Respondent.

Petitioner was subsequently evaluated by Dr. David Raskas, an orthopedic surgeon, on February 17, 2016. At that time, Petitioner complained of back pain that radiated into both buttocks/thighs. Dr. Raskas opined Petitioner had severe low back pain and bilateral leg pain. He ordered an MRI scan of the lumbar spine (Petitioner's Exhibit 5).

The MRI was performed on February 17, 2016. According to the radiologist, there were small disc protrusions at L2-L3 and L3-L4 and a large central disc protrusion at L5-S1. Dr. Raskas reviewed the MRI and his reading was consistent with that of the radiologist (Petitioner's Exhibits 5 and 6).

Dr. Raskas saw Petitioner on February 23, 2016, and Petitioner continued to complain of low back and bilateral leg pain. Dr. Raskas opined Petitioner had herniated discs at L4-L5 and L5-S1 as well as a spondylolisthesis. He recommended Petitioner undergo epidural steroid injections (Petitioner's Exhibit 5).

Petitioner was subsequently seen by Dr. Patricia Hurford, a pain management physician. Dr. Hurford administered epidural steroid injections on February 23, and March 1, 2016, at L4-L5 and L5-S1, respectively (Petitioner's Exhibits 5 and 7).

When Petitioner was seen by Dr. Raskas on March 18, and April 19, 2016, Petitioner advised the injections had helped in regard to his leg symptoms. However, Petitioner continued to complain of chronic low back pain (Petitioner's Exhibit 5).

Dr. Raskas again saw Petitioner on June 10, 2016. At that time, Dr. Raskas recommended Petitioner undergo an MRI of the thoracic spine (Petitioner's Exhibit 5).

The MRI of Petitioner's thoracic spine was performed on July 17, 2016. According to the radiologist, the MRI revealed degenerative changes, but was otherwise benign (Petitioner's Exhibit 6).

Dr. Raskas saw Petitioner on July 19, 2016, and reviewed the MRI. He opined it revealed small disc herniations, but there was no significant cord compression. He opined surgery was not indicated for this condition, but recommended Petitioner undergo another epidural steroid injection (Petitioner's Exhibit 5).

Petitioner was seen by Dr. Hurford on August 9, 2016. At that time, Dr. Hurford administered an epidural steroid injection at L5-S1 (Petitioner's Exhibit 7).

Dr. Raskas saw Petitioner on October 11, 2016. At that time, Petitioner advised the injection had given him relief from his pain symptoms for a couple of weeks, but that he continued to have back and leg pain. Dr. Raskas recommended Petitioner undergo a CT myelogram (Petitioner's Exhibit 5).

The CT myelogram was performed on December 8, 2016. According to the radiologist, it revealed disc level extradural defects and stenosis at multiple levels of the lumbar spine (Petitioner's Exhibit 9).

Dr. Raskas saw Petitioner on December 13, 2016, and reviewed the CT myelogram. Given the amount of conservative care Petitioner had received and the fact that he continued to have symptoms, Dr. Raskas suggested surgery as an option. At that time, Dr. Raskas recommended a laminectomy at L3-L4 and L4-L5 (Petitioner's Exhibit 5).

When Dr. Raskas saw Petitioner on March 21, 2017, Petitioner advised his condition was getting progressively worse. Dr. Raskas recommended Petitioner try to lose some weight, but noted he would schedule surgery for sometime in the middle of June (Petitioner's Exhibit 5).

Dr. Raskas performed surgery on June 21, 2017, and the procedure consisted of a three level laminectomy from L3 to L5. When Dr. Raskas saw Petitioner on July 11, 2017, Petitioner's back pain was markedly improved and he had no lower extremity symptoms. Dr. Raskas ordered physical therapy (Petitioner's Exhibit 5).

Dr. Raskas again saw Petitioner on August 18, and October 3, 2017. Petitioner advised his low back and leg conditions had improved, although he still has some stiffness in his back, primarily in the morning (Petitioner's Exhibit 5).

The last time Dr. Raskas saw Petitioner was May 4, 2018. Petitioner still had some complaints of back soreness for which he continued to take Meloxicam. Dr. Raskas opined Petitioner was at MMI, but that he might be a candidate for an L3 to S1 fusion sometime in the future. He also referred Petitioner to an internist for management of medications (Petitioner's Exhibit 5).

At trial, Petitioner testified he was able to return to work as a highway maintainer. Petitioner stated he still experiences pain and stiffness in his low back while at work; however, the symptoms are less intense when he is sitting while driving/operating machinery. When he performs other tasks such as loading machines, dragging chains, walking for prolonged periods of time, etc., his low back symptoms are more intense. Petitioner stated he has experienced sleep disruption and his hobby of hunting has been adversely impacted because of the injury.

Respondent tendered into evidence a copy of the Decision in another Illinois Workers' Compensation case, 13 WC 17829, involving the same Respondent. In that case, Petitioner claimed to have sustained a repetitive trauma injury to both hands that caused bilateral carpal tunnel syndrome. Arbitrator Paul Cellini heard the case and his Decision was entered on June 22, 2016. Arbitrator Cellini ruled against Petitioner and found he failed to sustain his burden of proof that he sustained an accidental injury arising out of and in the course of his employment by Respondent and likewise failed to prove his bilateral carpal tunnel syndrome was related to his work duties. In Arbitrator Cellini's Findings of Fact, he questioned the credibility of Petitioner's testimony and noted portions of Petitioner's testimony were inconsistent with the medical records. Respondent tendered this Exhibit primarily because of the latter finding (Respondent's Exhibit 3).

On cross-examination, Petitioner agreed he had not missed hunting season in the last three to five years. In regard to Dr. Raskas' exam of May 4, 2018, he agreed Dr. Raskas had noted Petitioner had a good range of motion. Petitioner also agreed he was disciplined by Respondent because he failed to complete a required ethics test.

Conclusions of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 17 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 worked as a highway maintainer and testified that his job duties included driving/operating heavy machinery, loading machines, dragging chains and prolonged walking. The Arbitrator gives this factor moderate weight.

Petitioner was 45 years old at the time of the accident. He has approximately 20 years before he will reach normal retirement age. Petitioner will have to live with the effects of the injury for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. Petitioner was able to return to work to his job as a highway maintainer. The Arbitrator gives this factor no weight.

As a result of the accident, Petitioner sustained an injury to his low back for which he received extensive conservative treatment. Ultimately, back surgery was required, specifically, a three level laminectomy. While Petitioner was able to return to work to his regular job, he continues to experience low back pain, especially at work when he performing tasks other than being seated and driving/operating heavy machinery. While Dr. Raskas opined Petitioner was at MMI as of May 4, 2018, he noted Petitioner would require ongoing use of medication and might require a fusion from L3 to S1 sometime in the future.

In regard to Petitioner's credibility, the Arbitrator notes Arbitrator Cellini found portions of Petitioner's testimony were inconsistent with the medical records; however, the Arbitrator did not make such a finding in this case. While Petitioner has apparently continued to engage in hunting, the Arbitrator notes Petitioner's testimony about his low back symptoms were consistent with his having undergone a three level laminectomy in the lumbar area of the spine. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY BUTLER,

Petitioner,

vs. NO: 15 WC 41670

CHOATE MENTAL HEALTH,
STATE OF ILLINOIS,

Respondent.

19IWCC0427

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability, nature and 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.

I. FINDINGS OF FACT

A. Background

Petitioner is a 35-year-old mental health technician I employed by Respondent on the date of accident. He was hired on June 17, 2013. Petitioner described his job duties to include assisting residents on the behavior intervention plan (BIP) unit with daily activities. He testified that he was capable of performing all of his job duties on the date of accident.

B. Accident and interim Medical Treatment 19IWCC0427

On December 9, 2013, Petitioner testified that the lead called for assistance over the radio as she was having some kind of altercation with a patient/resident during a one-on-one activity. He explained that the residents had to be assisted, within arm's length, with activities including showering, bathing, and eating. Petitioner testified that this particular resident was a problematic individual measuring about 6 feet tall, weighing approximately 220 pounds. Petitioner was the first to respond to the lead worker's call.

Petitioner explained that he walked into the living room type setting, which had a table located in the back corner with an old-style telephone on it that was plugged into the wall. Petitioner testified the lead was trying to direct the resident, and he assisted with redirecting the resident. Then, as Petitioner approached, the resident grabbed the telephone and struck Petitioner on the right side of his head by his eye with the base of the telephone.

Petitioner testified that he had immediate swelling and pretty intense pain. He developed a 'goose egg type knot' under his right eye and experienced a rather immediate headache with the impact. Petitioner viewed and identified the photographs contained in Petitioner's Exhibit 10 to be of him taken after the resident struck him with the phone. PX10 (December 9, 2013 photo and three December 9, 2013 photos). The photographs reflect swelling and bruising in varying degrees on the respective dates that the photographs were taken. Petitioner testified that the photos fairly and accurately depicted what his face looked like after being struck by the phone.

Petitioner immediately notified Respondent of the accident. The shift lead had been present and she contacted the shift supervisor who contacted the nurse who contacted the doctor. Petitioner testified they all came and assessed Petitioner. He was told to present to the emergency room, which he did.

The medical records reflect that Petitioner presented to the emergency room at Herrin Hospital on December 9, 2013. He underwent a CT scan of the head, sinus, facial, and nasal areas. Petitioner understood that he had sustained a blow-out fracture of his right eye orbital bone. He was referred to the St. Louis University Comprehensive Ophthalmology Clinic.

On December 12, 2013, Petitioner saw his primary care physician, Dr. Randall Pass, at Shawnee Health Care regarding his injuries. He suggested that Petitioner follow through with the emergency room referral.

On December 26, 2013, Petitioner saw Dr. Gabriela Espinoza at the St. Louis University Comprehensive Ophthalmology Clinic. Petitioner testified that at that time, "it felt like someone took the palm of their hand and just pressed into the area underneath the eye as hard as they possible could, and that pain would radiate into the temple." Petitioner also reported numbness to his gums and teeth, intense tingling, burning pains, severe headaches, twitching of the eye, and also, he had some light sensitivity. Dr. Espinoza examined Petitioner's eye and diagnosed him with an orbital fracture, post assault with phone at work. Petitioner also reported some blurred vision, but that went away over time. Petitioner was released without restrictions and advised to follow-up in six months.

Petitioner returned to Dr. Pass on March 20, 2013 for the eye and facial injuries. He ordered an MRI; which Petitioner underwent at the Marion CT Open MRI Center. The interpreting radiologist noted a right periorbital hematoma with suggestion of the right orbital fracture. Dr. Pass also referred Petitioner to Dr. Lori Guyton, a neurologist in Marion, Illinois.

On June 26, 2013, Petitioner returned to Dr. Espinoza who released him from care and indicated that Petitioner did not need surgery. Petitioner then had his initial visit with Dr. Guyton on July 14, 2013 and another follow up on October 8, 2014. Dr. Guyton prescribed Topomax, Baclofen, and Tramadol. Petitioner testified that the medications did help.

Petitioner also testified that he moved to Cape Girardeau area and his primary doctor referred him to a neurologist in that area, Dr. Godbey. Petitioner initially presented to Dr. Godbey on December 10, 2014 with similar complaints including the feeling of pressure he had previously reported during medical treatment. Petitioner also had an intense radiating pain that traveled into the nerve area, with numbness and a burning sensation, tingling, twitching of the eye followed by headaches, and light sensitivity. Dr. Godbey diagnosed Petitioner with pain secondary to trauma, fracture, migraine features and the same medications prescribed, although Petitioner testified that he believed the doctor increased Topamax at some point. Dr. Godbey also considered a CT scan to evaluate the fractures.

On February 4, 2015, Petitioner underwent the repeat CT of the head at Auburn Imaging, which was normal. Petitioner continued to follow up with Dr. Godbey at about 13 visits through June 15, 2018.

C. Section 12 Examination Report – Dr. Silverman

During his ongoing treatment, on May 22, 2017, Petitioner submitted to a Section 12 examination with a neurologist, Dr. Todd Silverman, at Respondent's request. Petitioner testified that his complaints at the time of Dr. Silverman's examination were pretty consistent and he still experienced all the complaints in the right side under his eye including pressure on the right, under the eye, gum/mouth numbness on the right side, twitching, sharp shooting pains, headaches, and light sensitivity. Dr. Silverman's report reflects that he performed a physical examination, took a history from Petitioner, and rendered opinions regarding the relatedness, if any, of Petitioner's condition of ill-being to the accident at work.

Dr. Silverman noted that Petitioner was assaulted with a telephone while employed by Respondent. He suffered a right orbital blow-out fracture, which had resolved, and had post-traumatic trigeminal neuralgia and post-traumatic migraine. Dr. Silverman noted that the latter two diagnoses caused Petitioner ongoing pain. Dr. Silverman stated that post-traumatic trigeminal neuralgia is well described as complication of orbital fractures and can result in chronic facial pain. The condition can also sensitize the trigeminovascular system, which is implicated in the etiology of migraine. Dr. Silverman indicated that objective findings on exam are not expected, and were not present. He did, however, note that Petitioner had tenderness to palpation and that the radiation into the gums is within the nerve distribution.

Dr. Silverman opined that all diagnoses are caused by the work-related injury. He stated that Petitioner is three and a half years post trauma, and it is clear that he requires ongoing treatment with medications for neuropathic pain. Lyrica has been successful and more likely than not will be needed lifelong. Dr. Silverman also noted that spontaneous resolution of symptoms is unpredictable and cannot reasonably be expected. Dr. Silverman stated that Petitioner was able to function without limitation on the current treatment and he placed Petitioner at maximum medical improvement. Dr. Silverman noted no pain behavior by Petitioner.

D. Further Medical Treatment and Additional Information

Petitioner last saw Dr. Godbey on June 15, 2018 reporting the same complaints as previously noted. Petitioner testified that he had some difficulties with Topomax and another medication with which he developed some mood swings, so that was suspended. He was prescribed Lyrica and the plan was to gradually increase until symptoms stopped or reduced. Once his symptoms started to reduce, they would wean him off the medication. Dr. Godbey diagnosed Petitioner with an injury to the trigeminal nerve and recommended the same medication regimen. He noted that Petitioner had a severe throbbing headache, severe headache with photophobia about a month prior, and ongoing pain and twitching. Dr. Godbey further noted that it had been four years since the original injury. He believed that Petitioner would require lifelong treatment for his pain with medications, and had reached maximum medical benefit. Petitioner was to return in six months.

On cross-examination, Petitioner testified that he explained the symptoms reported to Dr. Godbey and agreed that he reported severe headache and throbbing with photophobia that occurred a couple times per week. Petitioner testified that the headache severity varied from moderate to extreme. At that visit, Petitioner stated it was possible he was not experiencing very much pain as it did not occur every day.

Petitioner testified that he was still taking medications at the time of the arbitration hearing as he could never stop enough such that his pain stopped or completely went away. Petitioner indicated they had tried different medications over the 13 visits with Dr. Godbey, but settled on Lyrica, Baclofen, and Tramadol. Petitioner also testified that he had a follow up scheduled with Dr. Godbey in January of 2019 to be seen in six-month intervals for medication management.

Petitioner testified that he had no other conditions or injuries to his eye or facial area before or after December 9, 2013. He had no medical restrictions prior to the accident, and no prior or subsequent workers' compensation claims.

On cross examination, Petitioner testified that he had partially reviewed the medical records in evidence and believed that they were pretty accurate. Petitioner indicated that the pain and pressure identified in the records are two different things; he specified that it feels like there is pressure in the right eye area, under the eye, and that is followed by pain, which is a sharp shooting, pins-and-needles type, burning sensation. The pain does travel some and the numbness goes to his teeth and gum area, and travels to the right temple area that causes headaches.

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Regarding his current condition of ill-being, Petitioner testified that currently the only thing that is different is the consistency of the symptoms compared to before. He testified that the medication had been helping, but he does experience persistent pain at least two times per week. Petitioner also continues to experience the pressure under his eye area, intense burning, eye twitching, headache, gum numbness, and light sensitivity. Petitioner acknowledged that the pain he experiences now is not daily, but different things tend to trigger it like stressful environments, insufficient sleep, and sensitivity to light. Petitioner could not predict when his pain would next occur, but it does happen at least twice weekly and consistently. He explained that the pain level varies from minimal (4/10) to intense (8-9/10) with headaches. Petitioner testified that the eye twitching occurs a couple times a week with stress. He identified no other triggers for those spasms below his right eye in the upper cheek area, but cold weather seems to increase the pressure he feels in the right cheek area.

Petitioner testified that the numbness radiates into the upper gums and teeth area a couple of times per week. These symptoms also start with pressure that builds up and radiates until he has a headache. Petitioner testified that it always starts with a pressure-like sensation. As to light sensitivity, his current position requires him to work extensively on a computer throughout the day. He testified that he constantly stares at a screen and has to remove himself from the environment to reduce the light sensitivity effect so that it does not extend into a headache. At work he takes frequent breaks from the computer. Petitioner also testified that he limits his driving due to the light sensitivity as bright lights from other vehicles affect him. He limits night driving as it presented challenges. With family activities and activities of daily living, Petitioner removes himself from the environment depending on pain intensity.

Petitioner testified that he takes Lyrica three times in the morning and twice at night, which does help his symptoms. He explained that the medication helps with the burning sensations in the eye and right cheek area. Petitioner also takes Baclofen with extreme headaches and eye twitching, which helps and he takes that as needed. However, Baclofen causes him to get pretty drowsy and he has to make sure he eats something with it, or he gets nauseated. Petitioner testified that the Tramadol is also for headaches and intense pain, which he takes as needed. He also testified that he intended to continue to see Dr. Godbey as scheduled every six months for the injuries he had sustained.

On cross examination, Petitioner testified that he had partially reviewed the medical records in evidence and believed that they were pretty accurate. Petitioner indicated that the pain and pressure identified in the records are two different things; he specified that it feels like there is pressure in the right eye area, under the eye, and that is followed by pain, which is a sharp shooting, pins-and-needles type, burning sensation. The pain does travel some and the numbness goes to his teeth and gum area, and travels to the right temple area that causes headaches. The twitching in the eye is referred to as blepharospasm and that occurs at least twice per week lasting from a few seconds to minutes.

Petitioner testified that Dr. Godbey indicated that if after increasing the medications he still had the complications after six months then it was the trigeminal neuralgia causing his symptoms and pain; something he understood he would probably experience then for the rest of his life.

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E. Current Employment

Petitioner currently works for the State of Illinois, Department of Human Services, and has been so employed since March of 2016 on a day shift. Petitioner testified that he changed his job and no longer works for Respondent due, in part, to the stressful environment and lack of sleep associated with that job. Petitioner explained that he worked the second shift from 2:45 p.m. to 11:00 p.m. while employed by Respondent. He also testified that the night driving caused extreme headaches due to the light sensitivity, so he obtained a different position for the day shift that helped with that sensitivity to light exposure. Petitioner further testified that Respondent also required a lot of mandatory overtime, and if he worked a 16-hour shift he had about four hours of sleep with the drives.

Petitioner testified that he has missed work with his current employer due to his ongoing symptoms. In contrast, he testified that he missed work very frequently while employed by Respondent, and they even had him off work on FMLA, so he did not have to provide a medical slip whenever he was taking off work. In his new position, he does not miss work as frequently, but he can anticipate missing work several times per month.

On cross-examination, Petitioner testified that Dr. Pass had initially placed him on light duty work restrictions on December 12, 2013 and he believed that he was off work for about a month. Petitioner was then placed on the light duty, which Respondent could not accommodate. Petitioner had continued working full duty since his release although now for a different employer. Petitioner acknowledged that he made that decision to change jobs.

Petitioner also testified that he rarely had used a computer in his position with Respondent, whereas now he uses the computer 90% of the day. He testified that his current position is to determine eligibility for State services like SNAP and Medicaid. Unlike his position with Respondent, Petitioner testified that overtime is offered at his current position, but it is not mandatory, and he never takes advantage of the option. Petitioner testified that this is his choice, but increased hours caused more problems. Petitioner acknowledged that he has no medical restrictions relating to overtime work.

F. Deposition Testimony – Dr. Godbey

Dr. Andrew Godbey testified at an evidence deposition on January 31, 2018. He is board certified in neurology and has been in practice seven and a half years. Dr. Godbey testified that he specializes in neurological disorders and was licensed in June of 2005 in Missouri.

Dr. Godbey noted his review of Petitioner's prior treatment records and his own treatment of Petitioner. With regard to Petitioner's complaints, Dr. Godbey noted that Petitioner initially complained of numbness around the eye and maxilla and right side of his teeth. He also reported intermittent numbness of the right upper row of teeth and right eye pain that was described as pressure-like radiating to the maxilla and temple with associated light sensitivity. Petitioner noted chronic right eye pain and blepharospasms, as well as worsened pain with closing the eyes. He did not recall relieving factors. Petitioner described the pain at a level ranging from 4/10 to 8/10.

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Dr. Godbey noted that the pain was exacerbated one to two times per week and lasted 30-60 minutes with constant pain.

Dr. Godbey opined that the documented history of Petitioner's condition and injury was causally related to the accident of December 9, 2013. Dr. Godbey further opined that the diagnosed trigeminal neuralgia was caused by the work accident. As of April 28, 2017, Dr. Godbey found Petitioner to be at maximum medical improvement with a continued diagnosis of residual trigeminal neuralgia. He testified that Petitioner would be on life-long treatment for the pain with medications.

As of January 11, 2017, Dr. Godbey noted that Petitioner's medications were Baclofen, Lyrica, and Tramadol. Dr. Godbey last saw Petitioner on December 15, 2017 at which time he had the same complaints and continued on the same medications. Dr. Godbey testified that Petitioner's right trigeminal neuralgia was now chronic and due to the December 9, 2013 accident at work. He further testified that Petitioner would require medication monitoring throughout his life, and that Petitioner was scheduled for a follow up visit in six months.

II. ANALYSIS

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No

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

With regard to subsection (i), neither party submitted an AMA impairment report for consideration. Thus, the Commission gives no weight to this factor.

With regard to subsection (ii), Petitioner was employed as a mental health technician I at time of the accident. He was released to full duty without restrictions. Thus, the Commission gives greater weight to this factor.

With regard to subsection (iii), Petitioner was 30 years of age at the time of accident and a long life and long work-life expectancy. Petitioner has many work-life years with his ongoing pain and various symptoms, and neuralgia, and aggravating triggers, and also considering the ongoing, life-long medication management. Thus, the Commission gives greater weight to this factor.

With regard to subsection (iv), Petitioner gave unrebutted testimony regarding the stresses that his prior position with Respondent placed on him, increasing his symptomatology. As a result, Petitioner testified that he missed more time from work and he suffered increased onset of symptoms due to lack of sleep, nighttime driving, and a combination of both after working mandatory overtime. Petitioner explained that he voluntarily changed employment to work less hours on a day, as opposed to night, shift and avoid some potential aggravating triggers. He acknowledged that he now worked approximately 90% of the time in front of a computer but explained that he could remove himself from it as needed. Petitioner also acknowledged that he has the opportunity to work overtime at his current job but explained that he does not take advantage of it due to his ongoing symptoms. There is no indication that when Dr. Godbey released Petitioner back to full-duty, he did so with the understanding that Petitioner would return to his former employment with Respondent, or if he did so with understanding Petitioner would return to work at his new employer; that being less stressful. Notwithstanding, based on Petitioner's testimony, there is evidence that his future earnings capacity has been diminished, again, also considering his longer expected work life with Petitioner being 30 years old at the time of the accident and ongoing symptoms and pain management. Thus, the Commission gives some weight to this factor.

With regard to subsection (v), the record reflects that Petitioner sustained a right orbital fracture and developed post-traumatic trigeminal neuralgia and migraines as a result of his undisputed accident at work. He testified that he still suffers from ongoing symptoms at least two to three days per week, which he manages with environmental changes as well as regularly prescribed preventive medication and interventional pain medications taken as needed. Moreover, the medical records as a whole and the opinions of Dr. Godbey and Respondent's Section 12 examiner, Dr. Silverman, support the causal connection between Petitioner's multiple diagnoses and his ongoing subjective complaints. Petitioner's uncontroverted testimony regarding his ongoing symptoms, and the lifestyle and employment changes he had to make in order to lessen the onset and frequency of his symptoms, is also supported by the record as a whole. Petitioner

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testified that he limits potentially aggravating activities (i.e., night driving, sleep deprivation, light exposure), which is significant for a young individual in his 30's with decades of anticipated working years and life expectancy. It is notable that both Petitioner's treating physician and Respondent's Section 12 examiner believe that Petitioner will require some form of medication management to address now-chronic condition and his ongoing symptoms for life. Thus, the Commission gives greater weight to this factor.

Given the totality of the record, the Commission finds that the evidence and testimony warrant an increase of the award to 25% loss person as a whole, considering the above factors under Section 8.1(b), and, herein, modifies the award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $432.71 per week for a period of 125 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of 25% of Petitioner's 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 $54,200.00. 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 - 2019

Barbara N. Flores

BNF/jsf
7/11/19
045

Marc Parker

Commissioner Simpson dissenting

Dissent 19IWCC0427

I respectfully dissent from the Decision of the majority. Petitioner was an employee at Choate Mental Health Center and was struck by a patient with a telephone in the right side of his head/face. He developed post-traumatic trigeminal neuralgia and migraines with ongoing symptoms. The only issue on review was the nature and extent of Petitioner's permanent partial disability ("PPD"). The majority increased the PPD award from 17.5% of the person-as-a-whole to 25% person-as-a-whole. I would have affirmed and adopted the award of the Arbitrator.

The analyses of the Arbitrator and the majority on the issue of the nature and extent of Petitioner's permanent disability are very similar. In my opinion, the majority did not place sufficient weight on certain factors in the record. First, there were long gaps in treatment which neither Petitioner's treating doctor nor Respondent's Section 12 medical examiner could explain. These gaps suggest that at least during those periods of times, Petitioner's symptoms were not sufficiently severe to require treatment.

Second, Petitioner's treating doctor released him to work without restrictions and noted that he did not believe Petitioner's condition was disabling. While Petitioner chose to work in another job, he noted to another treating doctor that he believed that he could perform his duties with Respondent. Petitioner also testified that he voluntarily declined to work overtime. There was no other evidence of potential reduction in future earning potential. Therefore, the change of jobs and any potential diminution of income was a voluntary decision of Petitioner. In my opinion, the Commission placed too much weight on the possible loss of income.

Finally, the Arbitrator personally observed Petitioner. In my opinion her observations are a legitimate factor in assessing permanent partial disability that the Commission does not have on review, especially in this instance where a closed head injury is at issue. In this case, I see no reason why the Commission should substitute its impression of Petitioner's disability for that of the Arbitrator who was actually able to observe him in arriving at her award.

For the reasons stated above, I would have affirmed the PPD award of the Arbitrator. Therefore, I respectfully dissent.

Deborah L. Simpson

DLS/dw
O-7/11/19

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUTLER, TIMOTHY
Employee/Petitioner

Case# **15WC041670**

ST OF IL/CHOATE MENTAL HEALTH
Employer/Respondent

19IWCC0427

On 11/15/2018, 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 2.46% 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:

1459 LEVENHAGEN LAW FIRM PC
CHRISTOPHER T TUCKER
216 W POINTE DR SUITE B
SWANSEA, IL 62226

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

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

NOV 15 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

TIMOTHY BUTLER ,
Employee/Petitioner

v.

STATE OF IL / CHOATE MENTAL HEALTH ,
Employer/Respondent

Case # **15** WC **41670**

Consolidated cases: **N/A**

19IWCC0427

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 20, 2018**. By stipulation, the parties agree:

On the date of accident, **12/09/2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**17,308.26 (over 24 weeks)**, and the average weekly wage was $**721.18**.

At the time of injury, Petitioner was **30** years of age, ***married*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent. Respondent has stipulated that it will pay the causally related medical bills contained in PX 1, subject to the Medical Fee Schedule and the parties agreed that Respondent should receive credit for any medical bills previously paid, including any that may have been paid by Respondent's group medical plan for which credit is allowed under Section 8(j) of the Act.

Respondent shall be given a credit of $ **all TTD paid** for TTD, $**all TPD paid** for TPD, $ **0.00** for maintenance, and $ **0.00** 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 **$432.71 /week** for a further period of **87.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **17.5% loss of use of the body as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **April 28, 2017** through **September 20, 2018** , 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.

Nancy Lindsay
Signature of Arbitrator

Nov 12, 2018
Date

NOV 15 2018

Timothy Butler v. SOI/IllinoisChoate Mental Health, 15 WC 41670

FINDINGS OF FACT & CONCLUSIONS OF LAW regarding THE NATURE AND EXTENT OF PETITIONER'S INJURIES

The Arbitrator finds:

Petitioner, a Mental Health Tech I for Respondent, was involved in an undisputed accident on December 9, 2013 while working for Respondent. On that date, a patient/resident became upset, picked up a telephone and hit Petitioner in the right side of the face/eye with the phone. (RX 1, RX 2, AX 1)

Petitioner was seen in the emergency room at Herrin Hospital that same day complaining of a right eye injury and headache. The history revealed that Petitioner was at work at Choate Mental Health, and a client became aggressive and hit Petitioner with a telephone. Petitioner complained of headache and black right eye. His right eye was visibly swollen and bruised, and he complained of a headache to the right side. The "Review of Systems" stated that Petitioner was struck with a phone, had bruises, ecchymoses, facial trauma/pain on the right, head injuries/pain and facial injuries/lacerations. Right periocular swelling and ecchymosis were documented. CT scans were performed of Petitioner's brain and sinus/facial/nasal bones.

The CT scan of the facial bones findings revealed, "The floor of the right orbit is fractured over a transverse length of 8.9 mm. There is depression into the maxilla of 4.6 mm. No extraocular muscle entrapment appreciated. Fat does herniate into this fracture defect. No other fractures are detected. The soft tissues are prominent anterior to the right orbit." The doctor's impression was "1. Bullet fracture, right orbit. No entrapment of the extraocular muscles. 2. Right periorbital hematoma." (PX 4)

Petitioner's CT scan of the brain revealed, "The midline structures are central. The ventricles are neither dilated nor displaced. The brain attenuation with its gray-white matter interface is normal. No acute intracranial hemorrhage or extra-axial fluid collections are detected. The calvarium is intact. There is prominence of the right periorbital soft tissues and there is suggestion of a fracture of the right orbital floor. The paranasal sinuses mastoid air cells are clear." Impression was, "1. No acute intracranial process. 2. Right periorbital hematoma and suggestion of right orbital floor fracture." The final diagnoses were listed as an acute right orbital blow out fracture and headache. Petitioner was given prescriptions for Motrin, Ultram and Amoxil and ordered to follow up with Dr. Pass of St. Louis University Comprehensive Ophthalmology Clinic. , Petitioner was also given restrictions of no lifting over 10 pounds, and no interaction with patients where the possibility of a struggle or altercation might occur. (PX 4)

On December 10, 2013 Petitioner's wife spoke to Dr. Parvathi Rayudu of SLUCare Physician Group. By history, Petitioner had sustained an orbital fracture after being hit in the head with a phone the day before and had been seen at Herrin Hospital the evening before. Petitioner had some pain but no double vision, nausea, or vomiting that morning. His vision was slightly blurry the day before but was okay on the 10th. They were to be seen in the clinic in two weeks. In the

interim, should he develop worsening vision, double vision, restriction of EOM, nausea or vomiting, they should call back for an immediate evaluation. (PX 5)

On December 12, 2013 Petitioner was seen at his primary care facility, Shawnee Healthcare Marion, by Dr. Randall Pass. "The symptoms are reported as being moderate. Hit in R eye 12/9 at work – seen in Herrin ER – diagnosed with R orbital blowout fracture – off work since then – pain and swelling have decreased – has appt with optho in St louis 12/26." Petitioner's physical examination revealed bruising below his right eye. (PX 6)

Dr. Pass' assessment/plan was closed fracture of orbital floor (blow-out). He agreed Petitioner should be seen by the eye doctor in St. Louis as scheduled and agreed with work restrictions given the potential for attack/injury in his work at Choate. Dr. Pass felt Petitioner could resume light duty (no direct patient care) on Dec 17th, continuing until he was seen 12/26 in St Louis. Petitioner's pain was under control and his visual acuity seemed fine, which was reassuring. (PX 6)

On December 26, 2013 Petitioner was seen at SLUCare Physician Group by Dr. Gabriella Espinoza for evaluation s/p orbital fracture. Petitioner gave a consistent history of the accident. Initially he had some blurry vision but this had cleared up. He reported very minimal pain but some numbness from below the eye near the nose down to the gums. He was feeling "pins and needles pain" in this distribution and expressed worry about it. He denied any flashes of light or floaters. The earlier CT scan of Petitioner's facial bones performed on December 9, 2013 was reviewed. Petitioner was felt to have an orbital floor fracture of right orbit without clinical or radiographic evidence of entrapment He was, symptomatically, doing well without diplopia. On exam he had very mild enophthalmos, not currently bothersome to Petitioner. No surgical intervention was felt necessary at present. Petitioner was advised there was a possibility of late enophthalmos after the fracture and potential for surgery in the future. He was also told that the numbness might improve over the next few weeks to several months; however, he could not tell at that time if it would improve. They reviewed potential treatment for neuropathic pain should it persist beyond six weeks. Petitioner was advised to follow-up in six months with Dr. Espinosa to ensure appropriate healing and measure level of enophthalmos to make sure it does not progress, sooner if any problems. (PX 5)

On March 20, 2014 Petitioner followed with Rachel Sargent, PA-C at Shawnee Healthcare. Petitioner presented with a headache and right eye pain. He explained that his initial paresthesia had improved mid- January and things seemed to start getting better, but then he began experiencing shooting pains, discomfort and neuropathy, which had now been going on for over a month. He also complained of right eye and facial pain that was intermittent and occurred several times throughout the day. He denied any triggers; rather, the pain occured randomly. He denied any vision changes. Petitioner's wife was concerned that his eye seemed to have more enopthlamos than previously. The original CT showed no entrapment of the ocular muscles. He saw an opthlamologist in St. Louis who stated he might need treatment if no improvement in six weeks. Petitioner's examination revealed "normal touch sensation to facial nerve patterns bil. + tenderness to skin surrounding right eye and radiating to rt temporal region. Mild rt enophthalmos." Petitioner was assessed with a closed fracture of the orbital floor (blow-out). An MRI was ordered. They discussed the possible need for sooner follow-up pending the MRI results. He also was also diagnosed with facial neuropathy for which he was prescribed Gabapentin 300 mg a day x 1 day, then increased to bid. (PX 6)

On March 21, 2014 Petitioner underwent an open MRI of his facial structures. The impression was "Ethmoid sinusitis, otherwise normal pre and post gadolinium MRI of the facial structures. No abnormal enhancement identified." (PX 7)

On June 26, 2014 Petitioner returned to Dr. Espinosa. Petitioner described intermittent eye pain, 10/10 scale, which would turn into a headache located around temple area OD. He was taking Ibuprofen and Gabapentin to make the pain go away. He denied diplopia, dizziness, or nausea. Petitioner reported minimal numbness on right side of face and about his lip and stated his vision had remained stable, but he was now photosensitive at night and bright lights made his eyes water. He was not using eyedrops at this time. Petitioner had sustained a reaction to Bactrim and Keflex, causing a rash, but he wasn't sure which antibiotic caused a rash. He had never been on either antibiotic before. Petitioner reported having headaches 1-2 times a month, which would slowly resolve with the medications. Petitioner was prescribed Gabapentin for daily use but did not feel it that it helped. He had an appointment to see neurology in July (Dr. Lori Guyton in Herrin, Illinois). He reported that when he looked to the right for a prolonged period of time, it put a strain on his vision. However, it didn't hurt to look in that direction briefly and there was no diplopia. Dr. Espinosa's impression was that of an orbital fracture. Vision and movement were well, but he now had new light sensitivity at night while driving. His headaches were intermittent, but severe when they occurred. Dr. Espinosa's plan was for Petitioner to use glare reducing glasses and to follow up with neurology for the headaches. There were no ocular findings indicating a need for surgical intervention. Petitioner was assured that often the sense of straining he was noting would improve as he adjusted to it and turned his head more often. Excellent movement of the muscles was noted. No other treatment was indicated. (PX 5)

On July 14, 2014 Petitioner (who was referred by Rachel Sargent, PA-C) presented to Dr. Lori Guyton of Neurology of Southern Illinois, LTD. regarding his right eye pain and headaches. Petitioner provided a consistent history of his treatment to date. He reported that his vision was now back to normal. Currently he was having some sharp, shooting pain in the right eye, and in his head, extending from the eye to the occipital region which, usually, occurred together. At first it would happen now and then, and now it happened more frequently, but it was not as severe. His pain turned into a headache but without any nausea or vomiting. He had photophobia and phonophobia. His pain was a 6 on a scale of 0 to 10. Usually with the headache pain he did not have to go to bed. He was taking Ibuprofen rarely and he had tried 300 mg of Neurontin but stopped it. He was on Lysine for supplement. Petitioner reported that he had gone back to work and could do his job but felt pain constantly. His arms and legs were without problems. His numbness lasted for several months and then improved. He did not exercise currently. Dr. Guyton's impression was that Petitioner had sustained an orbital blowout fracture of the right eye with significant pain and facial numbness of the right eye region and his teeth. His vision was back to normal and his numbness had subsided. He had minimal subjective symptoms of numbness, on occasion. He currently had some sharp pain around his right eye (neuralgia) and had occasional headaches. Due to his frequent headaches and discomfort, the doctor recommend that he began a preventive medicine, Pamelor 10 mg qhs. He was told it would take several weeks to be of benefit. Dr. Guyton's diagnoses were numbness of the face, fracture of the lateral wall of orbit, and headache syndrome. Dr. Guyton's plan was to try Nortriptyline HCl 10 mg caps, 1 every day at bedtime. (PX 8)

On October 8, 2014 Petitioner returned to Dr. Guyton with the chief complaints of right eye

pain and headaches. Dr. Guyton noted that the Baclofen had helped with the spasms. Petitioner reported that the other day he had felt like someone was pressing up against his right jaw. Petitioner was unable to take the Pamelor due to symptoms of sleepiness at work and in the car. He did not have much sleepiness with the Baclofen. Dr. Guyton's impression remained unchanged. Petitioner's eye pain was occurring less frequently and he was encouraged to continue using the Baclofen. Dr. Guyton noted that Petitioner was moving to Cape Girardeau so no further follow up care would be provided. (PX 8)

On November 3, 2014 Rachel Sargent, PA-C of Shawnee Healthcare Marion referred Petitioner to Dr. Andrew Godbey as he could no longer see Dr. Guyton since he had moved to Cape. (PX 6)

On December 10, 2014 Petitioner was seen for the first time by Dr. Godbey. Petitioner reported 4/10 pain in his right eye and headache. Dr. Godbey noted Petitioner's history of being struck by a phone in his face on December 9, 2013 and suffering a right orbital floor fracture. He had intermittent numbness in his right upper row of teeth. Gabapentin 300 mg daily was ineffective. He had right eye pain described as pressure-like that radiated to his maxilla then to his temple and pain associated with photophobia. Petitioner reported that his eye pain was worsened by closing his eyes tightly and looking to his right. His pain intensity ranged from a 4-8/10 with constant pain with exacerbations lasting from 30 to 60 minutes. He had exacerbations 1-2x per week. Dr. Godbey's neurological examination was positive for frequent migraine headaches and paresthesia. Dr. Godbey noted Petitioner's pain had some migrainous features and he felt Petitioner was suffering from constant pain with intermittent exacerbations. Petitioner was to start Topamax and the doctor felt he might need another CT scan of the facial bones. (PX 2, Depo. Exh. #3)

On February 4, 2015 Petitioner underwent a CT scan of his orbits at Auburn Park Imaging. The Impression was: "1. No evidence of acute injury or destructive process involving the facial bones. Patient has a history of previous blowout fracture of the right orbit which appears well healed and in good alignment. 2. The contents of the orbits are unremarkable. 3. The paranasal sinuses, mastoid air cells, and middle ear cavities are clear. 4. The soft tissues of the face region appear unremarkable." (PX 9)

Petitioner continued to see Dr. Godbey on December 10, 2014, February 4, 2015, April 30, 2015, July 31, 2015, September 11, 2015, December 7, 2015, March 24, 2016, July 8, 2016, January 11, 2017, and April 28, 2017. (PX 2, Depo. Exh. #3 and PX 3)

Examination with Dr. Silverman

On May 22, 2017 Petitioner was seen by Respondent's Section 12 examiner Dr. Todd Silverman. Dr. Silverman examined Petitioner, reviewed records, and authored a report dated May 22, 2017. (RX 3) Dr. Silverman took a history of the accident and reviewed Petitioner's treatment since then with Petitioner. Surgery had not been required and subsequent x-rays revealed that the fracture had healed as expected. Petitioner had not suffered any residual vision loss or double vision. He returned to work after a couple weeks. Petitioner told the doctor that he subsequently took a different job with the State of Illinois, working now as a Human Services Case Worker, full-time, and without any restrictions. He could fulfill the obligations of his job and did not feel limited by any current symptoms, so long as he took his Lyrica to manage residual facial pain and headache. Petitioner's current complaints were intermittent, intense pressure-like pain over the right maxillary

area "like a hand pushing on my face really hard" which would radiate to the right upper jaw and last a few minutes. A residual headache could last hours. Petitioner reported that his headache was associated with photophobia, but no sonophobia, nausea or vomiting. He was initially treated with Topiramate, but it did not help. Gabapentin was tried but it caused sleepiness. He was now on Lyrica 150 mg twice daily which had been very helpful. He also used Tramadol, as needed, for his headaches. Before he began the Lyrica, Petitioner's headaches were occurring 4-5 times per week. On Lyrica, they occurred twice per week and were less intense. Petitioner also reported intermittent right eyelid twitching for which he took Baclofen, as needed. Finally, Petitioner advised he was having intermittent tingling over the right cheek which was better when using the Lyrica.

Dr. Silverman noted that Petitioner exhibited no pain behavior, symptom embellishment, give way weakness, or any inconsistency of effort. Petitioner's speech was fluent and the history he provided was orderly and concise with logical and goal-oriented thought processes. Petitioner was fullly oriented to location, time, and situation. (RX 3)

Dr. Silverman's report discussed Petitioner's medical history and employment history. The doctor's physical examination documented "mild tenderness to palpation over the right zygomatic arch." (RX 3) Petitioner's cranial nerves were also examined. His visual fields were full to confrontation. His pupils equal, round and reactive to direct and consensual light. Extraocular movements were full. Optic fundi normal with no papilledema. No ptosis. Petitioner's facial sensation was normal to light touch and temperature. His facial strength was normal. Petitioner's corneal reflexes were intact bilaterally as was his hearing. No nystagmus in primary position or lateral gaze was noted. Dr. Silverman also performed a motor exam and sensory exam both of which were normal. Coordination and deep tendon reflexes were normal. Petitioner's gait was normal.

Dr. Silverman reviewed records including the 12/09/13 Workers' Compensation Employees Notice of Injury, 12/09/13 Workers' Compensation Witness Report, 12/9/13 Herrin Hospital Emergency Room, 12/12/13 Shawnee Healthcare Marion/Dr. Christa Pestka, 12/26/13 Ophthalmology Evaluation/Dr. Gabriela Espinoza, 03/20/14 Shawnee Healthcare Marion/Rachel Sargent, PA-C, 03/21/14 Open MRI of facial structures with and without contrast, 06/26/14 SLUCare Ophthalmology follow-up with Dr. Espinoza, 07/12/14 Neurology Consultation with Dr. Lori Guyton, 12/10/14 Neurology consultation with Dr. Andrew Godbey, 02/04/05 Neurology follow-up with Dr. Godbey, 02/04/15 CT of orbits, 04/30/15 Neurology follow-up with Dr. Godbey, 07/31/15 Neurology follow-up with Dr. Godbey, 09/11/15 Neurology follow-up with Dr. Godbey, 12/07/15 Neurology follow-up with Dr. Godbey, 07/08/16 Neurology follow-up with Dr. Godbey, 01/11/17 Neurology follow-up with Dr. Godbey, and 04/28/17 Neurology follow-up with Dr. Godbey. (RX 3)

Dr. Silverman agreed that Petitioner had suffered a right orbital blowout fracture, which was a type of facial bone fracture. The fracture has healed, but he had residual right facial pain and headaches that would require ongoing management with medication, currently Lyrica. Dr. Silverman attributed Petitioner's ongoing complaints to the resolved right orbital blowout fracture, post-traumatic trigeminal neuralgia, and post-traumatic migraines. The latter two diagnoses were the cause of Petitioner's ongoing pain syndrome. Dr. Silverman explained that post-traumatic trigeminal neuralgia is a well-described complication of orbital fractures and can result in chronic facial pain. It can also sensitize the trigeminovascular system, which is implicated in the etiology of migraine. Objective findings on neurological examination were not expected and, in this case, were not present. Petitioner did, however, have tenderness to palpation over the right zygomatic arch, within the trigeminal nerve distribution (V2), with radiation of pain to the right upper gingiva (gums), which is

within the distribution of the injured nerve. 19IWCC0427

Dr. Silverman was of the opinion that the aforementioned three diagnoses were caused by the work-related injury on 12/09/13. All medical treatment to date had been reasonable and necessary. He did not feel any further diagnostic studies were indicated. Petitioner was now 3.5 years out from the injury and it was clear that he required ongoing treatment with medication for neuropathic pain. Lyrica twice daily has been successful, to date, and the doctor felt he would, more than likely, need it lifelong. Spontaneous resolution of his symptoms would be entirely unpredictable and could not reasonably be expected at this point. The doctor felt Petition was able to function without limitation on current treatment and was at maximum medical improvement (MMI).

Additional Medical Treatment

Petitioner continued to see Dr. Godbey on August 11, 2017, and December 15, 2017. (PX 2, Depo. Exh. #3 and PX 3)

Dr. Godbey's Deposition

Dr. Andrew Godbey testified by deposition taken on January 31, 2018. (PX 2) Dr. Godbey is board-certified in neurology. (PX 2, p. 4). He specializes in neurologic disorders. (PX 2, p. 4-5) Dr. Godbey testified consistent with his office notes discussed herein. In addition, he testified that within a reasonable degree of medical certainty that the injuries and conditions he diagnosed Petitioner with were caused by the work accident of December 9, 2013.

Dr. Godbey was asked to explain what an orbital floor fracture was, and he testified, "So your eye is encased in bone. An orbital floor fracture is the bottom underneath the eye. There is fracturing of the bone that's underneath the eye, so that's the floor fracture and was fractured and broken, and there was significant swelling which is typical. You break something, you have some swelling". (PX 2, p. 14) It was a right orbital floor fracture." (PX 2, p. 14-15)

Dr. Godbey testified that photophobia is sensitivity to light, and Petitioner had that sensitivity. (PX 2, p. 15)

Dr. Godbey testified that "Blepharospasm, that's twitching of the eye. Twitching of the muscles around the eye". (PX 2, p. 15)

Dr. Godbey explained Topamax was prescribed for prevention of pain and to treat migraines. (PX 2, pp. 15-16)

Dr. Godbey testified that the February 4, 2015 CT scan showed no evidence of acute injury and everything had healed. (PX 2, p. 17)

Dr. Godbey further testified that he next saw Petitioner on July 31, 2015. He confirmed that Petitioner was weaned off of Topamax due to word-finding difficulties which was a side effect of that medication. (PX 2, p. 17) Dr. Godbey documented Petitioner had intermittent pain in his right eye that was severely intense for ten to fifteen seconds followed by a right retro-orbital headache that radiated into his right upper gum that lasted two to three hours. (PX 2, p. 17-18) Petitioner was experiencing headaches about five times a week. Dr. Godbey switched medication by starting Petitioner "on gabapentin with is a medication we use primarily for nerve injury." (PX 2, p. 18)

Tramadol was prescribed as well for pain as needed. (PX 2, p. 18) Dr. Godbey testified, "Baclofen is used to treat the twitching of the eye muscles." (PX 2, p. 18)

Dr. Godbey testified that he re-examined Petitioner on September 11, 2015. Petitioner was having blepharospasms four to five times a week, lasting two to five minutes. His pain could last up to thirty minutes and was worse with stress and lack of sleep. (PX 2, P. 19) Dr. Godbey's diagnosis was eye pain, severe, worsening, and he decided to titrate Petitioner's medications to 600 milligrams three times a day for a total of 1800 milligrams per day. (PX 2, p. 19)

Dr. Godbey further testified that when he next saw Petitioner on December 7, 2015 Petitioner followed reported that his level of pain was seven over ten. (PX 2, p. 19-20) He also testified that he noted Petitioner had been having worsening pain when taking on more shifts at work. (PX 2, p. 20) During this visit, Dr. Godbey diagnosed Petitioner with trigeminal neuralgia, explaining that "The tri – so that's injury to the trigeminal nerve. The trigeminal nerve allows you to feel your face. It breaks into three branches. His centered around his eye, and with trigeminal neuralgia you'll get intermittent shock like pain. Whenever you injure a nerve, the nerve becomes hyperactive and it can cause, you know, shock-like pain to -- the trigeminal nerves can and since it centered around his eye where he had the injury, I diagnosed him with more of a traumatic trigeminal neuralgia given his description of his pain as intermittent stabbing – or intermittent pain." (PX 2, p. 20) Dr. Godbey agreed within a reasonable degree of medical certainty that his diagnosis of traumatic trigeminal neuralgia was caused by the work accident of December 9, 2013. (PX 2, p. 20-21)

Dr. Godbey further testified that when he saw Petitioner on March 24, 2016, Petitioner had developed severe lethargy and mood swings on the Gabapentin 800 milligram. (PX 2, p. 21) Dr. Godbey decided to transition Petitioner from Gabapentin to Lyrica. (PX 2, p. 21) Dr. Godbey was asked why he made that change and he testified, "Gabapentin initially was helpful, but he continued to have problems, so we increase. Typically, you increase to effect or side effect, and since he developed side effects and his pain continued, we decided -- I decided to switch to Lyrica which has been shown to be effective in traumatic nerve injuries." (PX 2, p. 21)

Dr. Godbey saw Petitioner on July 8, 2016 and on January 11, 2017. (PX 2, p. 21) On January 11, 2017 he restarted the Baclofen and Tramadol to help with the blepharospasms and the episodic pain. He also advised Petitioner to continue his current dose of Lyrica as a preventive medication for pain. (PX 2, p. 22)

Dr. Godbey testified that when he saw Petitioner again on April 28, 2017 he continued him on the same regimen. He thought Petitioner had reached MMI at that point since it had been three years after the accident. Dr. Godbey's diagnosis remained right trigeminal neuralgia. (PX 2, p. 22)

Dr. Godbey testified that as of August 11, 2017, he felt, within a reasonable degree of medical certainty, that Petitioner would require lifelong treatment for his pain with medications. (PX 2, p. 22-23)

Dr. Godbey testified that he again saw Petitioner on December 15, 2017 at which time Petitioner continued with many of the same complaints as were documented in his prior office visits. Dr. Godbey had Petitioner on Baclofen, Lyrica and Tramadol, and testified with a reasonable degree of medical certainty Petitioner would need those medications for life due to the accident of December 9, 2013. (PX 2, p. 23-24)

Dr. Godbey testified within a reasonable degree of medical certainty that Petitioner's diagnosis of right trigeminal neuralgia is chronic. (PX 2, p. 23-24)

Dr. Godbey set a six month follow-up visit for Petitioner. (PX 2, p. 24)

Dr. Godbey was asked if the treatment Petitioner received for his right eye head injuries, including the office visits, diagnostic tests and medications that had been prescribed for Petitioner, were reasonable and necessary in an effort to cure or relieve the symptoms Petitioner had experienced from the conditions he diagnosed he sustained in the work accident of December 9, 2013 and he confirmed that they were. (PX 2, p. 24-25)

On cross-examination Dr. Godbey confirmed he first saw Petitioner on December 10, 2014 about one year after the December 9, 2013 accident. (PX 2, p. 26) He was asked if that influenced how he treats a patient and he testified, "No – well, that is an open-ended statement. If I had seen him just after, then you would treat him a little differently. The diagnostics are more important, and then once it's been a year it's more focused on the management of those symptoms at that time. I did not see him at the beginning." (PX 2, p. 26-27)

Dr. Godbey was asked if, after reviewing Dr. Guyton's records with the treatment Petitioner had in the first year, he had any issues with the treatment he received, and he testified, "The issues I've had was that it had been a year and he had only been on one medication, you know, at least – two medications, one preventative medication, Topamax. He hadn't even started that one, so he had been treated for a year, but not much in regard to helping his pain." (PX 2, p. 26-27) Dr. Godbey's issues revolve primarily around the medication. He confirmed it's not something that he should have had surgery or something like that. (PX 2, p. 27)

Dr. Godbey's neurologic exam on December 10, 2014 revealed abnormal drooping of the eye. (PX 2, p. 28) His diagnosis was eye pain due to orbital blowout fracture. (PX 2, p. 28-29) The CT scan showed the fracture had resolved on its own. (PX 2, p. 29) He did not place any restrictions on Petitioner throughout the course of his treatment. (PX 2, p. 30)

Dr. Godbey was asked about surgery and he testified that the "decision to perform surgery is more to do with the contents of the globe, what the orbital bones surround. If the fracture caused injury to an eye muscle or there was concern that there will be – there's eye muscle damage, then there's more concern that you need to do surgery. If there's no injury to the eye itself or the contents within the orbit, then they choose conservative therapy watch and see if it heals on its own." (PX 2, p. 30-31)

Dr. Godbey further testified, "He continued to experience intermittent pain, but it wasn't disabling. He had been – he had responded to the Lyrica which I use as a preventative treatment and the Baclofen and Tramadol as needed. At that time I decided that he had reached maximum medical – what's that – improvement. He was – in my opinion, he was left with chronic pain. That's what we were treating with this regimen and my – I did not think he was going to improve much more and he seemed to be – okay, that's all." (PX 2, p. 34-35)

Dr. Godbey testified as to the meaning of intermittent pain and explained, "So with – so it comes and goes, so with traumatic trigeminal neuralgia and trigeminal neuralgia in general, it's not a constant pain. It comes and goes. Sometimes there are trigger. Some people, they brush their teeth, they get the shooting pain, air blowing on their face. Stress can trigger lots of different types of pain,

so he was left with traumatic trigeminal neuralgia with, you know, pain that comes and goes, and we're managing with preventative medication with Lyrica to try to calm those exacerbations down and then the tramadol and Baclofen to treat when he acutely experienced the pain or spasms in his eye. (PX 2, p. 35)

Dr. Godbey was asked whether Petitioner had any specific triggers, and he testified, "Reading through the records, the significant triggers were stress, fatigue. I think there was some with some weather changes, but I have to double check, but no other specific – yes, weather changes – no other specific triggers." (PX 2, p. 35)

Dr. Godbey was also asked if Petitioner's medications caused fatigue, and he responded, "More likely the Baclofen causes – is more likely to cause fatigue, but in reference to fatigue is if he, at least previous notes, overworked himself, he said he took on more shifts during Christmas – the holiday season and that caused his pain to worsen. (PX 2, p. 36)

Dr. Godbey did not review Dr. Todd Silverman's IME report dated May 22, 2017. (PX 2, p. 36-37) When told that Dr. Silverman had three diagnoses (the right orbital fracture now resolved, the posttraumatic trigeminal neuralgia, and the posttraumatic migraine) and Dr. Godbey agreed with those. (PX 2, p. 37) Dr. Godbey testified, "I focused more on the posttraumatic trigeminal neuralgia. His pain had some migrainous features, but the predominant treatment plan is for the trigeminal neuralgia." (PX 2, p. 37)

Dr. Godbey testified that in December of 2017 Petitioner was complaining of one severe headache, and continuing to experience intermittent burning, tingling in his right cheek and eye, temple and gums. (PX 2, p. 38)

Dr. Godbey was also asked about Petitioner's prognosis, and he testified, "It's been three years. He has been stable on his current regimen, but the fact that he continues to experience the pain give me hesitancy to say he will continue to improve or the pain will go away. When treating trigeminal neuralgia, other nerve injuries, the goal is to have pain freedom for at least two to three months, and then at that time you start thinking about weaning medications, but he never experienced a freedom and he is on a high-dose Lyrica, so I do not think he's going to reach pain freedom." (PX 2, p. 39)

Dr. Godbey explained that with trigeminal neuralgia one's pain will come and go. Therefore, sometimes when he saw Petitioner, Petitioner was not in severe pain at that moment. History becomes important. Dr. Godbey testified that Petitioner wasn't experiencing constant pain. Rather, he has exacerbations of pain that come and go. (PX 2, p. 40)

Dr. Godbey was asked whether the medications he currently has Petitioner on (Lyrica, Baclofen and Tramado), overlap in any way, and he testified, "Lyrica is meant for preventative medication that's safe to take daily. Baclofen is used as an as needed for the twitching of the eye, the blepharospasms, and tramadol is used as needed for the severe pain. It's not a medication I want him on every day, not tramadol, but the Lyrica is safe to take daily, not tramadol, but the Lyrica is safe to take daily. It's not a narcotic type pain medication. It's predominantly for prevention." (PX 2, 40-41)

Dr. Godbey was asked about how long Petitioner might need the Tramadol and Baclofen, and he testified, "I currently cannot predict how long he will need it. Given the three years he's been in

pain, my best medical guess would be he would require it lifelong." (PX 2, p. 41) That applies to all three medications. (PX 2, 41-42) Dr. Godbey also testified, "If the symptoms are no longer there, he doesn't need it. The Baclofen is meant for the eye twitching, and if he no longer experienced eye twitching, he could stop the Baclofen. The Tramadol is for the severe pain. If he does not need the Tramadol for the severe pain, he could go off that." (PX 2, p. 42) Dr. Godbey was asked what lifelong treatment entails, and he testified, "Management of medications. (PX 2, p. 42)

Dr. Godbey testified trigeminal neuralgia is chronic if it's been more than three months. (PX 2, p. 42)

Dr. Godbey confirmed a six-month time frame is typical for follow up when prescribing Lyrica, Baclofen and Tramadol. (PX 2, p. 43)

As of December of 2017, Dr. Godbey did not believe Mr. Butler's condition was not disabling. (PX 2, p. 43)

On redirect examination, Dr. Godbey agreed Petitioner's symptoms could wax and wane. (PX 2, p. 44) He agreed that there are a number of different triggers that can trigger Petitioner's trigeminal neuralgia and the pain that he experiences. Stress, stress at work, movements of the face – eating, drinking, and movement of the jaw are typical trigeminal neuralgia. "For [Petitioner] the only triggers were stress, lethargy and weather changes. (PX 2, p. 44)

Dr. Godbey was asked to assume that if the evidence showed that Petitioner had changed his job from a night shift to a day shift because he had trouble with driving at night because of the eye and the headlights caused him to have these blepharospasms, whether or not that would surprise him, and he testified it would not surprise him if he changed his shift. (PX 2, p. 44-45)

Dr. Godbey agreed a blowout fracture can have some measure of healing, but the residual in this type of injury would be the trigeminal neuralgia, irritation to the trigeminal nerve. (PX 2, p. 45)

Additional Medical Treatment

On June 15, 2018 Petitioner was again seen by Dr. Godbey. His chief complaint was traumatic right trigeminal neuralgia. Dr. Godbey noted that since his last visit, Petitioner had experienced a severe headache-throbbing, severe headache with photophobia that occurred a couple of times a week. He noticed the blepharospasm often. He denied any other worsening of his pain outside of the one severe headache. He continued to experience burning/tingling in his right cheek and right eye pressure that radiated to his gums/cheek and temple. He was tolerating Lyrica to 225 mg Qam and 150 mg Qpm. He was also taking Baclofen/Tramadol PRN, which he tried to take while at home due to lethargy. Petitioner was fatigued. Dr. Godbey's assessment was injury to right trigeminal nerve. He noted Petitioner had experienced improvement in his pain and blepharospasm with his current regimen of Lyrica and Baclofen/Tramadol, as needed. He was to call with any worsening symptoms. Dr. Godbey documented, "In regard to his workman's compensation, it has been over 4 years since his original injury. I think he will require lifelong treatment for his pain with his medications. He has reached maximum medical benefit. I cannot predict whether he will have resolution of his symptoms but given the continued need for treatment he will likely require lifelong treatment." (PX 3)

Petitioner's case proceeded to arbitration on September 20, 2018. Petitioner was the sole witness testifying at the hearing which centered solely on the nature and extent of his injury. Respondent stipulated that a finding could be entered regarding its liability for the medical bills.

Petitioner testified that he is 35 years old and on December 9, 2015 (sic 2013) he was employed by Respondent. Petitioner was hired by Respondent on June 17, 2013 and his job title on December 9, 2013 was Mental Health Technician I.

Petitioner's job duties on December 9, 2013 were to assist with the daily activities of the residents on the unit based on their behavior intervention plan, BIP. On December 9, 2013 Petitioner was capable of performing all his job duties.

Petitioner was asked what happened at work on December 9, 2013, and he explained that an individual (a patient/resident) was with a lead worker one-on-one and became agitated. The lead worker called for assistance because of the altercation and Petitioner was the first one to respond and assist. He walked into the room and walked towards the right corner where there was a table with an old-style telephone sitting on it. Petitioner and the lead worker were trying to redirect the resident when the resident grabbed the phone and struck him in the right region under his eye with the base of the telephone. Petitioner estimated the resident's height at six feet and his weight at about 220 lbs.

Petitioner testified that he had immediate swelling, and pretty intense pain. He immediately had like a goose egg type knot underneath his right eye. The headache was pretty immediate with the impact, and initially, that was all that I experienced initially.

Petitioner identified Petitioner's Exhibit 10 which were four pictures of himself, one of which was taken on December 9, 2013 and three that were taken on December 22, 2013. He testified that the pictures fairly and accurately depicted what his face looked like after being struck by the telephone on December 9, 2013.

Petitioner testified that he moved to Cape Girardeau and asked his primary care physician at Shawnee Health Care for referral to a neurologist in the Cape Girardeau area. Petitioner was referred to Dr. Godbey and initially saw him on December 10, 2014 in Cape Girardeau.

Petitioner testified that he has a follow up visit with Dr. Godbey in January of 2019 and sees him in six-month intervals. Dr. Godbey still prescribes him Lyrica, Baclofen and Tramadol.

Petitioner was asked to describe his current complaints relative to the injuries he sustained on December 9, 2013, and he testified, that they are "pretty much the same." The only difference he has noted is the consistency of the complaints. His medications have been working. At least a couple of times a week, sometimes more, he notices pain – a palm-like pressure under the eye, an intense burning, the twitching of the eye, the headaches, the numbness in the gum area, and the sensitivity to lights.

Petitioner testified that he doesn't have pain on a daily basis but different things tend to trigger it such as stressful environments, insufficient sleep, and light sensitivity. It does seem to happen on a weekly, consistent basis. The pain can vary from a "4/10" to an "8-9/10."

Petitioner testified that he experiences headaches at least twice a week, sometimes more, depending upon stress, lack of sleep and bright lights.

Petitioner testified his right eye twitches "a couple times a week." He seemed to think the twitching was triggered by stress and occurred in the right eye region, right below the right eye and the upper cheek region by the eye.

Petitioner testified that he has numbness radiating to the gums of his upper teeth on the right side that occurs a couple of times a week. It starts with a pressure feeling and then builds up and radiates into the teeth and goes up like a headache. Petitioner confirmed the area is the upper cheek area, between the top of the cheekbone, going into the corner of the eye and lower brow.

Petitioner testified that he currently works on a computer "pretty extensively" throughout the day and he is constantly staring at a computer screen. He will have to get up and leave so that he can get away from the light sensitivity. Petitioner limits the amount of driving he does due to the sensitivity to light, especially bright lights.

Petitioner testified he changed jobs from Choate to another employment due to the lack of sleep and stressful environment at Choate. He worked the second shift at Choate from 2:45 p.m. to 11:00 p.m. The night driving would cause extreme headaches from the light sensitivity. He took a different job which has allowed him to work the day shift and helped with the sensitivity to light exposure. At Choate he was required to work mandatory overtime which meant he wouldn't get enough sleep since the shifts could be sixteen hours long and he might be mandated to do two or three such shifts. Sometimes, he would only get four hours of sleep before having to report to work again. Petitioner went from Choate Mental Health to his current employer, the Department of Human Services, in March of 2016.

Petitioner testified that cold weather seems to increase the pressure he feels in his right cheek.

Petitioner was asked if there was anything that he can't do now because of his right eye and facial injuries that he could do before December 9, 2013 and he testified, that the nighttime driving presents challenges and he has to take frequent breaks at work to get away from the computer screen. He also notices changes in daily activities with his family as he can't participate like he did because he may be having intense pain.

Petitioner testified that he has had to miss some work with his new job because of his symptoms. At Choate, he was on FMLA to allow for him to take time off as needed. In his new job, he may be absent several times a month.

Petitioner takes Lyrica three times in the morning and two times in the afternoon to help with the burning sensations in the eye region, the right cheek area. Petitioner takes the Baclofen for the extreme headaches and twitching of the eye. It can make him drowsy and he has to take it with food to keep from getting nauseated. Petitioner testified it helps those conditions and he takes it as needed. The Tramadol helps with the headaches and intense pain and is taken as needed.

Petitioner denied having any workers' compensation claims either prior or subsequent to December 9, 2013. Petitioner has never had any medical restrictions prior to December 9, 2013.

On cross-examination Petitioner was asked whether the pressure and pain were two different

things, and he explained that they were. The pain is followed by pressure. The pressure is what he described as a "palm of the hand feeling" under his right eye and it is followed by a sharp shooting, pins and needle-like burning sensation/pain. The pain then travels down in to the right teeth and gum area and into his right temple causing the headaches.

Petitioner confirmed he gets severe headaches a couple times per week.

Petitioner acknowledged that he was taken off work by Dr. Pass initially approximately a month to a month and a half and then released to light duty. Petitioner is currently working full duty with a different employer.

Petitioner testified that his change in employment was a personal decision. Petitioner's work at Choate Mental Health Center rarely involved use of the computer. Petitioner's current position at DHS requires him to operate a computer about 90 percent of the day. Petitioner's current position involves determining eligibility for states services. Petitioner testified overtime is offered at his current position, but he never takes it because, in the past, increased hours had caused his symptoms to persist more aggressively. Petitioner confirmed, however, that he doesn't have doctor's restrictions in place stating he cannot work overtime.

Petitioner explained that the photographs found in Petitioner's Exhibit 10 were taken by his wife. Petitioner does not know why his wife took the pictures, and he did not tell his wife to take them.

Petitioner was asked why he has two addresses and he explained that he has a permanent address in Illinois but has temporarily re-secured a reside and he testified that he has a permanent address in Illinois but temporarily re-secured a residence that they are looking to fix up and sell and be closer to his children and their mother who is currently sick. It is easier for the children's mother to travel closer and have a relationship with her children. Petitioner testified that the DHS office is located in Murphysboro, Illinois. It is about 25 – 30 minutes from Herrin and about an hour from Cape. Petitioner testified that he is capable of traveling from location to location although some days present some difficulties.

Petitioner was asked about how often he takes Baclofen and Tramadol and he testified to eight or ten times per month. He rated his current pain level at a "4/10" or "pretty moderate."

The Arbitrator concludes:

Pursuant to Section 8.1b of the 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 preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining

the level of impairment.

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

With regard to (i) of Section 8.1(b) of the Act, the level of impairment, neither party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

With regard to (ii) of Section 8.1(b) of the Act, Petitioner's occupation, Petitioner was employed by Respondent as a Mental Health Technician at the time of his accident. He was released to return to that job without any restrictions. Petitioner has voluntarily found other employment with the State of Illinois Department of Human Services and began working there in March of 2016. The two jobs are very different as the former was more physical and involved evening shifts. His new position is sedentary and involves computer work for the majority of his day. He is now working a day shift. While Petitioner was released to return to his former job and has no permanent work restrictions, his reasoning for changing jobs was credible and consistent with the nature of his injuries. He has difficulty with light sensitivity while using a computer in his new position and needs to take frequent breaks. He had trouble with sleep, driving, and stress as a result of his former occupation. It appears that the decision to move from one job, with its consequences, has led to different consequences with the new job. In either job, the injuries he has sustained have had an impact. The Arbitrator gives weight to this factor.

With regard to (iii) of Section 8.1(b) of the Act, Petitioner's age at the time of his accident, the Arbitrator notes that Petitioner was 30 years old at the time of his accident and would be considered relatively young with a reasonably long work and life expectancy ahead of him. As such, one may reasonably infer that he will be living and working with the effects of his injury for a longer period of time than a much older member of the work force. The Arbitrator gives great weight to this factor.

With regard to (iv) of Section 8.1(b) of the Act, evidence of reduced earning capacity, the Arbitrator again notes that Petitioner was released with no restrictions. He has voluntarily chosen to decline overtime in his new position; however, he provided no testimony as to how much in earnings that meant. Additionally, he provided no direct evidence as to his current income from his new position and how it compares to his former one. Therefore, the Arbitrator assigns little weight to this factor.

With regard to (v) of Section 8.1(b) of the Act, evidence of disability as corroborated by Petitioner's treating medical records, Petitioner sustained an acute right orbital blow out fracture on December 9, 2013 after being violently struck by a resident with the base of a telephone. He has also been diagnosed and treated for post-traumatic trigeminal neuralgia and post-traumatic

migraines, the latter two of which are the cause of Petitioner's ongoing pain syndrome. His right orbital floor fracture resolved albeit with residual facial pain and headaches. Petitioner's testimony regarding his current complaints (pressure under the eye, intense burning, twitching of the eye, headaches, numbness in the gum area, and sensitivity to lights) and the activities or circumstances that trigger them was corroborated by the treating medical records. Additionally, Petitioner is on three medications which, for all intents and purposes, will most likely be taken for life. He has follow up visits with Dr. Godbey every six months. Petitioner tried different medications during his 13 visits with Dr. Godbey and has settled with Lyrica, Baclofen and Tramadol. Petitioner has a follow up visit with Dr. Godbey in January 2019 and sees him in 6-month intervals.

Petitioner gave examples of activity modifications he has made since the accident, including nighttime driving challenges, taking frequent breaks at work because of having to look at the computer screens, and removal from certain daily activities with his family. Petitioner has sensitivity to weather changes as cold weather seems to increase pressure in his right cheek area. Petitioner was a very credible witness.

Petitioner's medical records provide consistent corroboration of his ongoing physical complaints arising from the work accident. Petitioner's current treating physician Dr. Godbey testified persuasively as to Petitioner's diagnoses, ongoing complaints and need for lifetime treatment, which includes the medications Lyrica, Baclofen and Tramadol.

While not a treating medical doctor, Respondent's Section 12 examiner, Dr. Silverman, agreed with Dr. Godbey's diagnoses and the need for lifetime medical treatment associated with the work injuries Petitioner sustained on December 9, 2013.

Based upon the foregoing the Arbitrator finds that Petitioner has sustained permanent partial disability to the extent of 17.5% man as a whole.

****

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

BRIAN HOLLENBECK,

Petitioner,

vs. NO: 15 WC 010904

RUSCO MANUFACTURING CO.,

Respondent.

19IWCC0428

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent of his 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 Decision of the Arbitrator is modified only to increase the benefits conferred to Petitioner under §8(e) of the Act from 35% loss use of the left foot to 40% loss use of the left foot. The Decision of the Arbitrator accurately recited Petitioner's testimony about the lingering effects his accident and injury to his left foot have to both his professional and personal life, but the Commission does not believe the award tendered in the Decision of the Arbitrator is adequate compensation. The Commission is particularly sympathetic to Petitioner experiencing pain when simply walking and his need to be vigilant to the positioning of his right foot to avoid any missteps that could result in him falling.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $693.10 per week for a period of 56-5/7 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

19IWCC0428

the sum of $338.34 per week for a period of 15-1/7 weeks, that being the period of temporary partial disability under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $623.85 per week for a period of 66.8 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 40% loss use of Petitioner's left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,347.00 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.

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 12 2019
DLS/mav
O: 07/09/19
46

Deborah L. Simpson

Deborah L. Simpson

Thomas J. Tyrrell

Thomas J. Tyrrell

Maria Elena Portela

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOLLENBECK, BRIAN E
Employee/Petitioner

Case# **15WC010904**

RUSCO MANUFACTURING INC
Employer/Respondent

19IWCC0428

On 11/9/2018, 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 2.45% 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:

0529 TUITE LAW
GREGORY E TUITE
PO BOX 59
ROCKFORD, IL 61105

5001 GAIDO & FINTZEN
MALLORY ZIMET
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

19IWCC0428

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

BRIAN E. HOLLENBECK
Employee/Petitioner

v.

RUSCO MANUFACTURING INC.
Employer/Respondent

Case # 15 WC 19904

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Glaub**, Arbitrator of the Commission, in the city of **Rockford**, on **9/18/2018**. 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 **3/13/2015**, 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 **$54,067.00**; the average weekly wage was **$1,039.75**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **2** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$39,308.68** for TTD, **$5,123.52** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$44,432.20**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $1,347.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $693.10/week for 56 5/7 weeks, commencing 3/14/15 through 4/13/16, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $338.34/week for 15 1/7 weeks, commencing 4/16/16 through 7/14/16 and 8/20/17 through 10/8/17, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $623.85/week for 58.45 weeks, because the injuries sustained caused the 35% loss of the left foot, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

November 8, 2018
Date

NOV 9 - 2018

Brian E. Hollenbeck vs. Rusco Manufacturing, Inc.
IWCC # 15 WC 10904

19IWCC0428

STATEMENT OF FACTS

On March 13, 2015, Mr. Hollenbeck was employed by Rusco Manufacturing as a machine operator. On the date of injury, Petitioner was working in the large machine area. At the time, he and another coworker were attempting to move a large gear blank using straps and a forklift. Unfortunately, one of the straps broke causing the gear to fall and land on top of Petitioner's right foot. A supervisor was called to the scene. Petitioner was taken to the supervisor's office where an accident report was completed. Mr. Hollenbeck was then transported to Physicians Immediate Care. (PX 2/6). Petitioner's foot was examined by Dr. Stranig and x-rays were taken. Petitioner was directed to seek further treatment that day with Dr. Blint, an orthopedic surgeon. After evaluating Petitioner's foot, Dr. Blint recommended surgery. He also took Petitioner off work.

Petitioner returned to Dr. Blint three days later in follow-up. A CT scan of the right foot was recommended. The scan was performed on March 18, 2015 and revealed the following:

1. "Comminuted although not significantly displaced fractures involving the base of the second and third tarsal bones articular surfaces at the LisFranc joint.

2. Additional diaphyseal fracture is identified involving the fourth and fifth metatarsal bones, as described above. Minimal displacement of the fifth metatarsal bone fracture. (PX 4/263)."

After the CT scan, Dr. Blint recommended an open reduction and internal fixation of the right LisFranc and percutaneous pinning of the third, fourth and fifth metatarsals. (PX 4/254). That surgery was performed on March 31, 2015 at St. Anthony Hospital. (PX 3/7). The surgery confirmed the diagnosis of:

- "Right LisFranc fracture – dislocation status post crush injury with disruption of medial/ intermediate cuneiform, disruption of LisFranc ligamentous complex;

- fracture of the right fifth metatarsal;
- fracture of the right fourth metatarsal."

Petitioner saw Dr. Blint in follow-up throughout the spring and summer of 2015. The K wires were removed on May 14, 2015. Physical therapy was initiated on May 27, 2015 at Orthopedic Rehab Specialists. (PX 5). On July 9, 2015 Dr. Blint recommended wearing compression stockings, continuing physical therapy, elevating the leg, and using ice. Dr. Blint then saw Petitioner on a monthly basis through the rest of 2015. He continued to keep Petitioner off work and recommended continued physical therapy.

On January 13, 2016, Respondent sent Petitioner to Dr. Jeffrey Senail for a Section 12 evaluation. (RX 1). Dr. Senail confirmed the causal relationship between the condition of Petitioner's right foot in the work injury. He also stated that treatment had been reasonable and necessary. He did not believe that Petitioner needed further physical therapy and that he could return to work on a graduated schedule. He did not believe that Petitioner had reached maximum medical improvement and stated further that he may require further medical care.

Petitioner continued to see Dr. Blint subsequent to the Section 12 evaluation. He recommended that Petitioner continue with work hardening and indicated that he still could not return to work. On March 28, 2016, Dr. Blint stated that Petitioner could work five hours a day for five days a week for a period of four weeks. Petitioner did return to part-time work on April 16, 2016.

Petitioner returned to Dr. Blint on May 23, 2016. At that time the doctor noted decreased range of motion due to stiffness. There was continued tenderness in the dorsal midfoot. Petitioner demonstrated a mild limp at the visit. Dr. Blint refilled Petitioner's anti-inflammatory medication, started Gabapentin, prescribed bilateral orthotics, and continued the work restrictions. On October 24, 2016 Dr. Blint examined Mr. Hollenbeck and recommended a functional capacity evaluation. This was not performed. Petitioner then went approximately three months without treatment.

Petitioner returned to Dr. Blint on February 9, 2017. At that time he complained of increased constant ache over the top of the foot in the medial aspect of the foot. He continued to demonstrate a mild limp. Dr. Blint recommended a topical anti-inflammatory medication and an MRI of the right foot. The MRI was performed on March 11, 2017 and moderate fatty atrophy of the abductor digiti minimi was noted. The radiologist indicated that the finding was concerning for Baxter's neuropathy. An EMG was recommended. The EMG did not demonstrate Baxter's neuropathy but was interpreted to show a mild length-dependent sensorimotor peripheral neuropathy. (PX 4/39).

Petitioner returned to Dr. Blint on August 24, 2017. Because of the ongoing pain in the top of the foot and medial aspect of the foot, as well as point tenderness over the screw heads, Dr. Blint recommended removal of the hardware. This was performed on September 20, 2017 at St. Anthony Hospital. (PX4/41). Petitioner was then provided with accommodated work through October 8, 2017. Petitioner was last seen by Dr. Blint on January 18, 2018. Dr. Blint recommended that he continue with the anti-inflammatory cream and return to see him in one year for an exam and x-rays.

Petitioner testified that he is no longer working for Respondent. He took a job as a machine operator for a different employer in June 2018. His maximum lifting without a crane is approximately 40 pounds. He is on his feet all day except during scheduled breaks. He testified that he is careful and is always aware of the location of his foot. If he makes a misstep he feels pain in the injured portion of his foot. This pain is also aggravated by normal walking and continuous motion. He notes that the pain increases during the course of the day and that he takes an anti-inflammatory before he goes to work. At home, he notes that he has difficulty going down the basement steps and occasionally goes down one by one. He no longer likes being barefoot and avoids grass and uneven surfaces. He also notices pain in the foot while playing with his children. He also continues to wear the compression socks that Dr. Blunt prescribed.

CONCLUSIONS OF LAW

In regard to Issue (F) **CAUSAL RELATIONSHIP**, the Arbitrator finds the following:

All of the evidence presented in this case support a finding of causal relationship between the accident and the condition treated by Dr. Blint. While Petitioner did testify to foot pain while in the Marine Corps in 1995, there is no evidence of any difficulty or medical treatment between that date and the work injury. Petitioner had a severe injury that led to multiple fractures of the right foot. Even Respondent's examining physician clearly stated that there was a causal relationship between the accident and the condition of ill being. There is no evidence of any intervening injury between the date of injury and the date of arbitration. Based upon the above the arbitrator finds that Petitioner's conditional bill being is causally related to the March 13, 2015 accident.

In regard to Issue (J) **UNPAID MEDICAL EXPENSES**, the Arbitrator finds the following:

Having found in Petitioner's favor on the issue of causal relationship the Arbitrator awards the following medical charges:

OSF St. Anthony Medical Center	$1200.00 x-rays taken during September 2017 surgery;
Rockford Radiology Associates	$66.00 radiology charges for above x-rays;
Rockford Radiology Associates	$64.00 radiology charges for March 13, 2015 ER;
Prescriptions	$17.12 post injury supplies.

The arbitrator awards $1347.00, to be paid pursuant to the Worker's Compensation fee schedule.

In regard to Issue (L) **WHAT IS THE NATURE AND EXTENT OF THE INJURY?**, the Arbitrator finds the following:

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.

Section 8.1 (b) also states, "No single 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 a physician must be examined. The term "impairment" in relation to the AMA Guides to the Evaluation of Permanent Impairment 6th edition is not synonymous with the term "disability" as it relates to the ultimate permanent partial disability award.

1. The reported level of impairment pursuant to the AMA Guidelines:

The arbitrator notes that no AMA impairment rating was offered at the time of hearing. Therefore, the arbitrator gives no weight to this factor.

2. The occupation of the employee:

Petitioner is currently employed as a machine operator for a different employer. He continues to perform duties similar to what he did for Respondent. He limits his individual lifting to 40 or 50 pounds and uses an overhead crane for anything heavier. The Arbitrator gives the appropriate weight to this factor.

3. The age of the employee at the time of the injury:

Petitioner was 38 years of age at the time of the injury. Based upon his relatively young age and his expected work life the Arbitrator notes that he must live and work with this disability for a number of working years. The Arbitrator gives the appropriate weight to this factor.

4. The employee's future earning capacity:

There is no evidence of any current or future reduced earning capacity contained in the record. The Arbitrator gives the appropriate weight to this factor.

5. The treating medical records:

These records provide evidence of disability as indicated by Commission decisions regarded as precedent pursuant to §19(e). The records document the almost two year period of recovery from the serious injury sustained by Mr. Hollenbeck. Because of the injury he missed over one year of work at the direction of Dr. Blint. Of particular significance is the final office note of Dr. Blint from January 18, 2018. (PX 4/17). At the time, Petitioner complained of continuing pain on the lateral aspect of his foot. He further noted tightness with walking. On a pain scale of 0 to 10, Mr. Hollenbeck reported a pain level of 2/10 at rest and 5/10 with activities. Current medications were Mobic and Gabapentin. Tenderness was noted medially and over the fourth and fifth metatarsals. Range of motion was within functional limits. Dr. Blint recommended that Petitioner continue to perform activities as tolerated and to avoid activities that cause pain. (PX4/18). He was told to follow-up in one year for x-rays. The medical records do indicate that after the petitioner's significant injury and treatment, he was released to full duty work. The Arbitrator gives the appropriate weight to the treating records.

The Arbitrator also finds the report of Dr. Senail, Respondents examining physician, to be significant. He noted that because of the nature of the injury Petitioner was at risk of developing chronic midfoot pain, degenerative arthrosis, and symptomatic hardware. The hardware was eventually removed by Dr. Blint. Dr. Senail also stated that with a LisFranc injury

patients can develop posttraumatic arthrosis which may necessitate an arthrodesis of the midfoot. (RX 1).

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single factor as the sole basis of disability.

Based on all of the above and after considering all of the factors set forth in Section 8.1(b), the Arbitrator finds that Petitioner has sustained 35% disability of the left foot pursuant to 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BENJAMIN ROBINSON,

Petitioner,

vs.

NO: 18 WC 03791

TYSON FOODS,

19IWCC0429

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, medical expenses, and permanent disability and being advised of the facts and law, views the evidence differently than the Arbitrator, reverses the Decision and awards compensation under the Illinois Workers' Compensation Act ("Act") as stated below.

Pursuant to the Application for Adjustment of Claim Petitioner filed with the Commission on February 6, 2018, an arbitration hearing was conducted on October 25, 2018 to decide Petitioner's claim that his employment with Respondent gave rise to him developing bilateral carpal tunnel on January 12, 2018. The arbitration hearing resulted in the presiding Arbitrator finding that Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent as well as that his current condition of ill-being is causally related to his employment with Respondent.

Petitioner began working for Respondent on December 27, 2017 as a materials supervisor and, as such, was initially detailed to the production side of Respondent's operation for a couple days where he placed "meat logs" weighing 26- to 28-pounds a piece into wheeled buckets. He performed this activity nine or ten-hour workdays with the workdays broken up by one-hour lunches and ten to fifteen-minute breaks. After a few days working on the production side, he transferred to the packing side where he moved pallets of Respondent's products by means of pallet jacks. The pallets were said to weigh as much as 1,700 pounds and, with the aid of two

other individuals, the pallets were pushed or pulled 50 to 75 feet. Petitioner transitioned from performing this task for two to three hours a day to five hours day. After, approximately one-and-a-half weeks of performing this activity, Petitioner began experiencing symptoms of carpal tunnel syndrome in both of his hands on or about January 12, 2018.

The Arbitrator noted how soon after Petitioner began working for Respondent he sought treatment for his wrists, noting in the Decision of the Arbitrator, the "crux of the dispute between the parties herein is whether Petitioner worked for Respondent long enough to, in fact, cause or aggravate his pre-existing carpal tunnel syndrome." The Arbitrator further noted Dr. Shawn Kutnik, who examined Petitioner at Respondent's request under Section 12 of the Act, testified, "Petitioner's exposure time was not enough to cause any chronic structural changes which would result in the development of carpal tunnel syndrome." The Arbitrator adopted this portion of Dr. Kutnik's testimony as one of her rationales for finding Petitioner did not sustain a compensable accident.

The Arbitrator drew attention to Petitioner's January 24, 2018 examination by Dr. Lowell Senintaffer, an examination in which Petitioner was recorded complaining of bilateral hand and forearm pain that had been present for several months. The Arbitrator found that history inconsistent with the history Petitioner gave Dr. Kutnik. Dr. Kutnik testified to Petitioner telling him that the pain and numbness in his hands began in January 2018. The Commission, in reviewing the evidence deposition of Dr. Senintaffer, found that he testified that Petitioner told him that his symptoms had been present for "many years." Based on Dr. Senintaffer's testimony, the Commission agrees that the history Petitioner provided Dr. Kutnik was inconsistent with the one he provided Dr. Senintaffer. The Commission, in finding Petitioner had symptoms of bilateral carpal tunnel syndrome prior to his employment with Respondent and misled Dr. Kutnik about this, does not find either to necessarily preclude Petitioner from being entitled to benefits under the Act.

Petitioner's symptoms of bilateral carpal tunnel syndrome prior to beginning work with Respondent confirms Dr. Kutnik's position that Petitioner's employment with Respondent did not cause his bilateral carpal tunnel syndrome. The question before the Commission now becomes whether Petitioner's employment with Respondent aggravated or accelerated his preexisting bilateral carpal tunnel syndrome.

The Arbitrator, as quoted above, suggested that there might be a minimum amount of time that an employee must work for an employer before that work could cause or aggravate preexisting carpal tunnel syndrome. In this immediate case, the Arbitrator found Petitioner having worked for Respondent for seventeen days to be too few to have made his complaints compensable under the Act. No explanation was offered as to how that conclusion was reached.

Dr. Kutnik, while concluding that Petitioner's work activities for Respondent did not cause his bilateral carpal tunnel syndrome, testified that he did not know what caused Petitioner's symptomatology to increase and thought that it probably was not a coincidence that Petitioner's symptoms worsened after Petitioner began working at a hand-intensive job. In the report Dr. Kutnik authored following his examination of Petitioner, he wrote that the work Petitioner performed "can result in an aggravation of the symptoms of carpal tunnel syndrome

...."

The Commission relies on the totality of the evidence presented in the case and concludes the evidence demonstrates Petitioner had preexisting bilateral carpal tunnel syndrome that was made worse by the work he performed for Respondent. The Commission finds, based on the evidence, that Petitioner sustained an accident to both hands that arose out of and in the course of his employment with Respondent on January 12, 2018.

Having addressed accident, the Commission turns its attention to the issue of whether Petitioner's accident was causally related to his need for the medical treatment he received and is causally related to any permanent disability Petitioner experiences. Dr. Kutnik, in his report, concluded "that the patient's bilateral carpal tunnel syndrome is not causally related to his work at Pierre [sic] Foods in that he had an exceptionally limited exposure time of only 2 weeks ...."

Dr. Kutnik's report and the Arbitrator speculate that, "Petitioner may have suffered a temporary increase in symptoms ... [and] the need for surgery was not causally related ...." This position does not deny the existence of a causal relationship between Petitioner's accident and his need for treatment, only surgical treatment. Despite this, no compensation for medical expenses were contemplated, not even the treatment provided while Petitioner was experiencing the "temporary increase in symptoms."

Petitioner's history of his condition, as recorded by Dr. Sensintaffer on January 24, 2018, indicated that he performed a very physical job that involved pushing and pulling and that the work exacerbated his symptoms. Dr. Sensinaffer noted, in the same record, that Petitioner's bilateral carpal tunnel syndrome was exacerbated by his job. Dr. Sensintaffer's note does not provide specific details as to what it was Petitioner did for Respondent, but what he recorded was not inaccurate. Furthermore, Dr. Sensitaffer concluding on January 24, 2018 that Petitioner's employment exacerbated his symptoms is more compelling than the evidence deposition testimony Dr. LeeBurton provided concerning causation.

Petitioner's treating medical records follow close enough in time to the date of his accident and his history and complaints as recorded in those records are consistent enough as to find them to be credible evidence demonstrating there to be a causal relationship between the injuries Petitioner sustained while working for Respondent and the medical treatment he received treating those injuries. Accordingly, the Commission finds Petitioner to be entitled to medical expenses as contemplated under Section 8(a) of the Act.

The Commission also finds Petitioner entitled to permanent partial disability benefits under Section 8(e) of the Act. He sustained an aggravation of his preexisting bilateral carpal tunnel syndrome that necessitated bilateral carpal tunnel releases which, by all accounts, appear to have greatly improved, if not, resolved the symptoms of which he complained.

The Act dictates, as Petitioner's accident occurred after September 1, 2011, that the criteria specified under Section 8.1(b) of the Act be used to establish permanent partial disability. Pursuant to Section 8.1(b), the Commission finds as follows:

(1) Neither party procured an impairment rating using AMA guidelines; Dr. Kutnik

opined Petitioner lost a 1% use of his right hand and a 1% use of his left hand that translated to a 1% whole person impairment rating; no evidence was offered that Dr. Kutnik's assessment comported with Section 8.1(a) of the Act; no weight is given to this factor.

(2) Petitioner was a warehouse supervisor at the time of his injury and is currently a shift manager with another employer; little weight is given to this factor.

(3) Petitioner was 43 years of age at the time of the accident and is in the middle of working career; some weight is given to this factor.

(4) No evidence was offered with respect to Petitioner's future earning capacity; no weight is given to this factor.

(5) There is some evidence of disability corroborated by the treating medical records; Petitioner's last visit to Dr. LeeBurton occurred on April 11, 2018; no refence was made to a physical examination being conducted; Petitioner was recorded as saying that a lot of his preoperative symptoms had resolved; a restriction of lifting no more than 8-pounds was to end at the beginning of May 2018; Petitioner's last visit to Dr. Sensintaffer occurred on May 8, 2018; Petitioner indicated that he had good grip strength with his right hand and less strength with the left hand and a little tightness involving his left wrist; physical examination did not appear to include Petitioner's hands or wrists; Petitioner offered a referral for occupational therapy; greater weight is placed on this factor.

No single enumerated factor is the sole determinant of Petitioner's disability. The Commission, on the bases of the factors considered under Section 8.1(b) and Petitioner's testimony of his hands being much better and his grip strength being better, concludes Petitioner sustained a 10% loss use of his right hand and a 12.5% loss use of his left hand as a result of the injuries sustained on January 12, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $519.22 per week for a period of 44.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 10% loss of use of Petitioner's right hand and the 12.5% loss of use of Petitioner's left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,223.11for 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum

of $27,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 12 2019
DLS/mav
O: 06/11/19
46

Deborah L. Simpson

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINSON, BENJAMIN
Employee/Petitioner

Case# **18WC003791**

TYSON FOODS
Employer/Respondent

19IWCC0429

On 12/11/2018, 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 2.48% 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:

4888 SHORT & DAUGHERTY TRIAL LAWYER
KEITH SHORT
325 MARKET ST
ALTON, IL 62002

0000 WIEDNER & McAULIFFE LTD
JULIE M TENUTO
8000 MARYLAND AE SUITE 550
ST LOUIS, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF **Madison**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Benjamin Robinson
Employee/Petitioner

v.

Tyson Foods
Employer/Respondent

Case # **18** WC **03791**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 25, 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. [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 **1/12/18**, 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 approximately four weeks preceding the injury, Petitioner earned $**2,250.00**; the average weekly wage was $**865.38**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

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

Respondent is entitled to a credit of $**0.00** for any medical bills paid by a group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident on January 12, 2018 which arose out of and in the course of his employment with Respondent or that his current condition of ill-being in his hands is causally related to his employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Harry Lindsay
(Signature of Arbitrator)

December 6, 2018
Date

ICArbDec p. 2

DEC 11 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to the medical records, Petitioner initially sought treatment for his bilateral hands on September 28, 2010 (RX5). He reported progressive weakening of his bilateral hands and the inability to grip or make a full fist with his right hand. He described progressive weakness, numbness, and pain to his bilateral hands for one month, as well as numbness to his fingertips and shooting pain to his elbow. Petitioner was diagnosed with bilateral tenosynovitis of the wrist/hand and bilateral idiopathic progressive polyneuropathy (RX5). He treated conservatively, was released from care on October 21, 2010, and advised to follow-up as needed (RX5).

There is no evidence in the record of any treatment to Petitioner's hands between October 21, 2010 and January 24, 2018.

Petitioner presented to Dr. Sensintaffer on January 24, 2018 (PX3). He complained of "bilateral hand and forearm pain, left worse than right "over the past several months." The doctor also noted "Extremity to arthritis." Petitioner reported that his pain was preceded by numbness and worse at night. He denied any trauma but the doctor did note that Petitioner worked in a very physical job pushing and pulling and that his symptoms were exacerbated by working. Petitioner was prescribed nighttime splints and given work restrictions. The doctor also noted that Petitioner had a supervisory job so "hopefully he could stay at work." A nerve conduction study was recommended. On physical examination Petitioner had a positive Tinel's sign on the right at the wrist but a negative Phalen's. On the left he had a positive Tinel's sign at the ulnar groove but all else was negative. (PX3).

Petitioner returned to Respondent on January 30, 2018 to turn in his work slip from Dr. Sensintaffer. That same day he also completed a Team Member Statement of Injury or Illness Form (RX2). On the Injury Form, Petitioner reported an injury to only his left hand occurring on January 12, 2018 while moving several pallets and materials into trailers. He didn't notice any pain until the next day. (RX2).

Petitioner signed his Application for Adjustment of Claim herein on January 31, 2018 alleging an injury to his left hand. (AX 2)

Dr. Sensintaffer referred Petitioner to Dr. LeeBurton who initially saw him on March 12, 2018. No mention of work was made, only a history of having been told many years ago that he had carpal tunnel syndrome. A recent EMG reportedly showed bilateral carpal tunnel syndrome.[1] Dr. Sensintaffer subsequently performed bilateral carpal tunnel release surgery on March 29, 2018 (PX1). Dr. LeeBurton released Petitioner from his care at full duty on April 11, 2018 and Dr. Sensintaffer released Petitioner from his care at full duty on May 8, 2018 (PX1, 2).

Deposition of Dr. Kutnik

Respondent offered the testimony of board-certified orthopedic surgeon Dr. Shawn Kutnik, who performed a Section 12 examination of Petitioner on August 27, 2018. Dr. Kutnik's evidence deposition was taken on September 25, 2018 (RX1). Dr. Kutnik testified that Petitioner reported pain and numbness in his hands which began in January of 2018 after pulling pallets and using a manual pallet jack at work (RX1, pg.7). At the time of his Section 12 examination, Petitioner had already undergone bilateral carpal tunnel releases and denied any specific complaints to Dr. Kutnik (RX1, pg.7-8). In conjunction with his examination, Dr. Kutnik was provided with Petitioner's medical records which pre-dated his alleged date of injury, as well as Dr. Sensintaffar's and Dr. LeeBurton's records (RX1, pg.9-10). Dr. Kutnik also reviewed a written job description (RX3) for Petitioner's position as a materials supervisor (RX1, pg.10).

Dr. Kutnik diagnosed Petitioner with prior carpal tunnel syndrome with good surgical result (RX1, pg.10-11). He testified Petitioner's employment with Respondent was not the cause of his bilateral carpal tunnel syndrome given Petitioner's limited exposure time of about two weeks before symptoms development, which in and of itself, is not enough to cause any chronic structural changes to result in carpal tunnel syndrome (RX1, pg.11). Dr. Kutnik described that the common denominator for the diagnosis of carpal tunnel syndrome is thickening of the ligament that rests over the top of the median nerve; that thickening is something that occurs as time progresses with repetitive microtrauma and absent surgery, the thickening of the ligament remains (RX1, pg.11, 24).

Dr. Kutnik testified there is a distinction between "symptoms" and "disease" (RX1, pg.17). "Symptoms" are simply a manifestation of a disease, whereas "disease" refers to the

[1] The EMG/NCS is not a part of the record.

underlying structural or chemical abnormalities (RX1, pg.23-24). While symptoms may increase with activity, an increase in symptoms is not the same as a progression or aggravation of the underlying disease or diagnosis (RX1, pg.17). Dr. Kutnik did not believe Petitioner's employment with Respondent caused any thickening of the ligament or structural changes in the body (RX1, pg.21-22). Dr. Kutnik explained that surgery is performed to treat the disease, not symptoms (RX1, pg.18). He testified "just because somebody's symptoms increase with certain activities or over time does not necessarily mean whatever they were doing at that point is what causes the disease to progress" (RX1, pg.24). While Dr. Kutnik acknowledged it was possible that lifting a moving a pallet jack can cause an increase in carpal tunnel symptoms, so could a normal activity of daily living such as sleeping (RX1, pg.25). Dr. Kutnik testified Petitioner merely suffered a temporary aggravation of symptoms and that the bilateral carpal tunnel release was not related to Petitioner's employment with Respondent (RX1, pg.25). Dr. Kutnik opined Petitioner had reached maximum medical improvement and did not require work restrictions (RX1, pg.12). He assigned an impairment rating of 1% of each upper extremity (RX1, pg.13).

Deposition of Dr. LeeBurton

Petitioner offered the testimony of the treating physician Dr. Timothy LeeBurton. Dr. LeeBurton's evidence deposition was taken on September 7, 2018 (PX1). Dr. LeeBurton is a board-eligible general orthopedist. On direct examination he testified in accordance with his office notes. Dr. LeeBurton first evaluated Petitioner on March 12, 2018 for bilateral hand complaints. He testified that Petitioner told him he'd been having carpal tunnel symptoms for many years. (PX 1, p. 7) Dr. LeeBurton diagnosed Petitioner with bilateral carpal tunnel syndrome and recommended surgery. The doctor testified that the EMG revealed severe bilateral carpal tunnel syndrome. His initial office note documents "I believe [Petitioner's] carpal tunnel could be related to his repetitive motions while working" (PX2). Dr. LeeBurton performed bilateral carpal tunnel releases on March 29, 2018. Dr. LeeBurton last saw Petitioner on April 11, 2018 at which time Petitioner stated a lot of his preoperative symptoms had resolved. Petitioner was released from Dr. LeeBurton's care that same day (PX1, pg.11).

Dr. LeeBurton acknowledged that he had very little information regarding Petitioner's job within his records. (PX 1, p. 13) His causation opinion was based on a hypothetical scenario posed by Petitioner's attorney at his deposition, over Respondent's objection. The hypothetical assumed Petitioner had evidence of carpal tunnel syndrome before he began working for

Respondent (PX1, pg.13). It further assumed Petitioner worked for Respondent for approximately 30 days during which time he did inventory control that included staging trucks, using a pallet mover and "stack[ing] them all day long with 27-to-30-pound bags, 15 to 20 at a time" (PX1, pg.13-14). The hypothetical also assumed Petitioner moved pallets of flour that weighed approximately 2,500 pounds and loaded them onto a pallet jack. It further assumed Petitioner performed those tasks "five days a week, ten hours a day" and his hands became symptomatic "after a month of doing this activity" (PX1, pg.14). Assuming those facts to be true, Dr. LeeBurton believed the work-related items "could have exacerbated [Petitioner's] carpal tunnel syndrome" (PX1, pg.15). He agreed Petitioner "could have" had evidence of carpal tunnel before he ever began working for Respondent (PX1, pg.15).

On cross-examination, Dr. LeeBurton acknowledged he was unsure of exactly when Petitioner was previously told he had carpal tunnel syndrome (PX1, pg.16-17). He did not review any of Petitioner's prior records which pre-dated his alleged date of injury, nor did he review Dr. Sensintaffer's records (PX1, pg.17). Dr. LeeBurton testified that carpal tunnel syndrome develops over a period of time and, in Petitioner's case, it was not caused by just one specific incident (PX1, pg.18). He did not know where Petitioner was working or Petitioner's job title at the time of his initial evaluation (PX1, pg18-19). Dr. LeeBurton testified he did not know the specific physical demand requirements of Petitioner's job other than what Petitioner told him (PX1, pg.19). He did not know when Petitioner was hired by Respondent or how long Petitioner had been working for Respondent before his alleged date of injury (PX1, pg.20). He did not know Petitioner's work schedule, how many hours per week Petitioner was working, or whether Petitioner was employed with Respondent part- or full-time (PX1, pg.20).

The Arbitration Hearing

This case proceeded to arbitration on October 25, 2018 in Collinsville. At the time of hearing the disputed issues included: accident; causal connection; medical benefits; temporary total disability benefits; and nature and extent. Four witnesses testified, including Petitioner and Christina Hatfield, Oscar Escovedo, and Anthony Cunningham. At the commencement of the hearing Petitioner moved to amend his Application for Adjustment of Claim, without objection, to allege a repetitive trauma injury to his bilateral hands.

Petitioner testified that he was hired by Respondent on December 27, 2017. Petitioner alleges bilateral carpal tunnel syndrome resulting from repetitive trauma which manifested on

January 12, 2018, just 17 days after he was hired. From his date of hire through January 13, 2018, Petitioner worked a total of 104.00 regular hours and no overtime hours for Respondent (RX4). He worked Monday through Friday and had the weekends off.

Petitioner testified that he was employed as a materials supervisor for Respondent. He testified that during his first couple of days on the job he was learning the production side which involved moving meat logs weighing 26 – 28 pounds apiece. He would place the meat logs in a metal bucket with wheels. Each bucket would carry about 15 – 20 meat logs. The meat logs would be taken to the production line, removed from the bucket, and placed into another bucket. Petitioner testified that while learning the production side during his first few days of his employment with Respondent, he did not experience any problems with his hands.

After the first couple of days working on the production side, Petitioner began learning the packaging side. He worked on the packaging side for approximately a week and a half before his date of injury, excluding weekends. He learned how to look up different types of packaging in the computer. Petitioner would find the product and move it between semi-trucks to stage it for the week. He was required to move pallets which came pre-stacked with boxes. Petitioner testified he was not required to stack boxes on the pallets. The pallets would be moved with pallet jacks and sometimes weighed upwards of 1,700 pounds. To operate the pallet jack, Petitioner would align the wheels, pump the jack off the ground five to six inches, and push or pull the pallet to its destination. Petitioner would move approximately 10 to 30 pallets per shift and the pallets would be moved approximately 50 to 75 feet on flat ground. Petitioner had the aid of two other individuals while moving pallets. Initially Petitioner worked that particular job only two or three hours a day and after training was completed, he would spend five hours a day moving pallets. When Petitioner was not moving pallets, he was learning either how to run reports or helping on the production side.

Petitioner testified that sometime around January 12, 2018, it became harder to ball up his hands and make a fist. He first reported his injury to his supervisor, Christina Hatfield, on Tuesday, January 16, 2018, as the plant was closed on Monday January 15th for the Martin Luther King, Jr. holiday. Petitioner was also off work that preceding Saturday and Sunday in accordance with his regular work schedule. Petitioner testified he never told Ms. Hatfield that he had a previous injury involving his hands.

Petitioner testified that after surgery his hands improved and his grip strength was much better. He has not followed up with any doctor since he last saw Dr. Sensintaffer in May of 2018. Petitioner is not currently taking any prescription medications for his hands.

Respondent called Christina Hatfield as a witness. Ms. Hatfield has been employed by Respondent as the general manager of inventory for almost three years. She oversees and manages the warehouse operations as well as two off site warehouses. Petitioner was Ms. Hatfield's second shift materials supervisor. The plant supervisors would oversee the employees and report directly to Ms. Hatfield. She testified the plant was closed on Monday January 15th for the Martin Luther King, Jr. holiday and reopened on Tuesday, January 16, 2018. That Tuesday, Petitioner reported to Ms. Hatfield that he would not be able to perform any physical work but would just supervise the employees. When asked what happened, Petitioner said his hands were just sore and hurting him. Ms. Hatfield immediately asked whether Petitioner was injured at work, which Petitioner denied; he said he had an old injury. From what Ms. Hatfield could recall, Petitioner mentioned his old injury involved pulling cables; however, on cross-examination and redirect examination she indicated that what she firmly recalled was that Petitioner told her he had an "old injury" and she wasn't even sure he had said anything about pulling cables. . Ms. Hatfield testified at no time during her conversation with Petitioner on January 16, 2018 did Petitioner mention that he hurt his hands at work or that he was injured on the job. She thereafter escorted Petitioner to the nurse. Ms. Hatfield testified both Oscar Escovedo and Anthony Cunningham were present during her conversation with Petitioner on January 16, 2018.

Ms. Hatfield testified Petitioner returned to the plant on January 30, 2018 to turn in his work restrictions. She testified at that time the assumption in the plant was that Petitioner had been out dealing with a personal medical issue. Ms. Hatfield held a meeting in the conference room with Oscar Escovedo and Petitioner to determine how to accommodate Petitioner's restrictions. During their conversation, Petitioner made a comment about how he was injured at work while pulling a pallet of flour. Ms. Hatfield immediately stopped the meeting and got the nurse and human resources involved, as an alleged work-related injury was outside the scope of her responsibility.

Ms. Hatfiled also testified that Petitioner's employment file, including any notes prepared by her, had been given to Respondent's counsel.

Respondent also called Oscar Escovedo as a witness. Mr. Escovedo has been employed as a warehouse supervisor with Respondent for four years. He directly supervised Petitioner during his employment with Respondent. Mr. Escovedo testified he was called into Ms. Hatfield's office on January 16, 2018 to discuss Petitioner's hands. According to Mr. Escovedo, Petitioner was not sure what happened, but stated that his hands hurt and he had a hard time gripping his steering wheel. He further testified that there was a discussion about whether he could work because work was aggravating his hands and Petitioner stated he could still supervise the employees that day but was ultimately sent home because Ms. Hatfield wouldn't allow him to work as his job involved more than just supervision. Mr. Escovedo testified that Petitioner did not provide any indication or suggestion about having injured his hands at work during the conversation. Mr. Escovedo first learned that Petitioner was alleging his injury was work-related approximately two weeks later when Petitioner returned with a doctor's note and thereafter mentioned he was injured at work while pushing a pallet. Mr. Escovedo testified that Tony Cunningham was not present during the meeting on January 16th.

Lastly, Respondent called Anthony Cunningham as a witness. Mr. Cunningham has been employed as a shipping supervisor with Respondent for 17 years. Mr. Cunningham recalled a conversation between Petitioner and Ms. Hatfield that took place in Ms. Hatfield's office in January. Petitioner stated his hand was hurting and Ms. Hatfield immediately asked what happened. Petitioner denied that he was injured at work and was told to see the nurse. Mr. Cunningham testified that at no time during the conversation did Petitioner mention he injured his hands at work. Moreover, when specifically asked whether he was injured at work, Petitioner responded no but rather, stated it was an old injury from years before. Mr. Cunningham was unable to explain why Mr. Escovedo and Petitioner stated that he wasn't present during the January 16th conversation. He further testified that he created a report about the conversation and it was put in Petitioner's employment file but he didn't know why the report wasn't placed in evidence by Respondent.

Proofs were closed.

The Arbitrator Concludes:

1. **As to Issue C, whether an accident occurred that arose out of and in the course of Petitioner's employment?**

2. As to Issue F, whether Petitioner's current condition of ill-being is causally related to the injury?

Petitioner failed to prove that he sustained an accident on January 12, 2018 that arose out of and in the course of his employment or that his current condition of ill-being in his hands/wrists is causally related to his accident or his employment duties for Respondent.

The law is clear that in a repetitive trauma case, the unique facts of each case must be closely and independently analyzed. Having done so, the Arbitrator concludes that Petitioner did not sustain an accident which arose out of and in the course of his employment with Respondent.

A claimant seeking benefits under a repetitive trauma theory must meet the same burden of proof as a claimant alleging a single, accidental injury. *Peoria County Belwood Nursing Home v. Indus. Comm'n*, 115 Ill. 2d 524 (1987). Moreover, even though a repetitive trauma is not traceable to a specific time, place or cause, it is still essential that a claimant establish a specific date on which the injury is deemed to have occurred. *Three "D" Discount Store v. Indus. Comm'n*, 198 Ill. App. 3d 43, 47 (1989). In order to prevail under a repetitive trauma theory, a claimant must establish that his work duties were sufficiently repetitive in nature, occurrence and force so as to cause a gradual breakdown of the claimant's physical condition. *Williams v. Indus. Comm'n*, 244 Ill. App. 3d 204, 211 (1993).

The existence of health problems prior to a work-related injury neither deprives the claimant of a right to benefits nor relieves the claimant of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Indus. Comm'n*, 141 Ill. App. 3d 289 (1986). The courts have established that when a pre-existing condition is aggravated by employment, it may constitute a work-related accident. *Peoria Motors v. Indus. Comm'n*, 92 Ill. 2d 260 (1982); *Cook Co. v. Indus. Comm'n*, 68 Ill. 2d 24 (1977). However, the claimant bears the burden of proving that the pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Lawless v. Indus. Comm'n*, 96 Ill. 2d 260 (1983); *Lyons v. Indus. Comm'n*, 96 Ill. 2d 198 (1983). Additionally, compensation will be denied where an injured employee's health has deteriorated so that any normal daily activity is an aggravation. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193 (2003).

The crux of the dispute between the parties herein is whether Petitioner worked for Respondent long enough to, in fact, cause or aggravate his pre-existing carpal tunnel syndrome.

There is no dispute that Petitioner had been previously diagnosed with the condition in 2010. It further appears that Petitioner underwent no treatment between October of 2010 and January of 2018.

The Arbitrator notes that when Petitioner first sought medical treatment with Dr. Sensintaffar on January 24, 2018, he complained of bilateral hand pain worse on the left "over the past several months" (PX3). That contemporaneous medical record fails to corroborate Petitioner's testimony that he first experienced symptoms at work while moving pallets just two weeks earlier on January 12, 2018. The Arbitrator places more weight on Petitioner's initial statement to Dr. Sensintaffar as documented in the records. It was not until January 30, 2018, six days after Petitioner sought treatment with Dr. Sensintaffar and they discussed possible treatment options, that Petitioner thereafter informed his employer of his allegations that his hand condition was causally related to his employment with Respondent. Petitioner testified that on January 30, 2018 both hands were bothering him and he could not even clench them at all. However, when he completed the Team Member Statement of Injury or Illness Form on January 30, 2018, he only listed an injury to his left hand (RX2), despite having been to the doctor just six days earlier with complaints of bilateral hand pain.

It is well established that in repetitive trauma claims, the claimant generally relies on medical testimony establishing a causal connection between the work performed and the claimant's disability. *Nunn v. Indus. Comm'n*, 157 Ill. App. 3d 470, 477 (4th Dist. 1987). Although medical testimony as to causation is not necessarily always required, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that a claimant's work activities caused the condition complained of. *Id.* at 478. In such cases there must be a showing that the injury is work-related and not the result of a normal degenerative aging process. *Id.* In addition, even where a doctor provides an opinion as to causation, it is well established that a doctor's findings and opinions can be undermined or even discarded through his reliance on inaccurate or incomplete information. *Comer v. Nabisco*, 1999 Ill. Wrk. Comp. LEXIS 532; See also *Horath v. Indus. Comm'n*, 96 Ill. 2d 349 (1980).

In this case, the development of Petitioner's bilateral carpal tunnel syndrome dates back to 2010 (RX5). That condition undisputedly developed well before his employment with Respondent. Although Petitioner experienced symptoms of his pre-existing carpal tunnel

syndrome while allegedly moving pallets at work, as Dr. Kutnik explained, there is a distinction between merely a temporary manifestation of symptoms and a demonstrable progression of the underlying disease.

The Arbitrator concludes Dr. Kutnik's testimony and opinions are more credible than those of Dr. LeeBurton's, as Dr. Kutnik's opinions were better informed. Dr. Kutnik performed a Section 12 examination of Petitioner on August 27, 2018. In conjunction with his physical examination, Dr. Kutnik reviewed Petitioner's medical records which pre-dated his alleged date of injury, as well as Dr. Sensintaffar's and Dr. LeeBurton's records (RX1, pg.9-10). Dr. Kutnik also reviewed a written job description for Petitioner's position as a materials supervisor while employed with Respondent (RX1, pg.10). Dr. Kutnik testified that Petitioner reported pain and numbness in his hands which began in January of 2018 after pulling pallets and using a manual pallet jack at work (RX1, pg.7). The Arbitrator notes Petitioner's reported onset of symptoms to Dr. Kutnik is contradicted by Dr. Sensintaffar's initial medical record in which Petitioner reported bilateral hand pain over the past several months (PX3).

Dr. Kutnik opined that Petitioner's employment with Respondent was not the cause of his bilateral carpal tunnel syndrome given Petitioner's limited exposure time (RX1, pg.11). Petitioner was employed with Respondent for a total of 17 days and worked a total of 104.00 hours prior to his alleged date of injury (RX4). Dr. Kutnik testified Petitioner's exposure time was not enough to cause any chronic structural changes which would result in the development of carpal tunnel syndrome (RX1, pg.11). Dr. Kutnik testified that the development of carpal tunnel syndrome occurs as time progresses and the ligament thickens with repetitive microtrauma (RX1, pg.11). Similarly, Dr. LeeBurton agreed that carpal tunnel syndrome develops over a period of time and in Petitioner's case, was not caused by just one specific incident (PX1, pg.18).

Dr. Kutnik testified Petitioner merely suffered a temporary aggravation of symptoms and the need for the bilateral carpal tunnel releases was not caused by Petitioner's brief employment with Respondent (RX1, pg.25). Dr. Kutnik explained the distinction between "symptoms" and "disease" (RX1, pg.17). "Disease" refers to the underlying structural or chemical abnormalities, whereas "symptoms" are simply a manifestation of the underlying disease (RX1, pg.23-24). Both Dr. Kutnik and Dr. LeeBurton agree Petitioner had the underlying, pre-existing disease of carpal tunnel syndrome before he began working for Respondent (PX1 pg.15; RX1, pg.14). Dr. Kutnik testified that a temporary increase in symptoms as in Petitioner's case is not the same as a

progression or aggravation of the underlying disease or diagnosis (RX1, pg.17). Dr. Kutnik testified that Petitioner's employment with Respondent did not cause any thickening or structural changes (RX1, pg.21-22, 25). He explained "just because somebody's symptoms increase with certain activities or over time does not necessarily mean whatever they were doing at that point is what causes the disease to progress" (RX1, pg.24). As Dr. Kutnik provided in an example, an individual's symptoms may be worse at night when they sleep, "[b]ut I don't know anyone who says that sleeping is going to cause carpal tunnel syndrome" (RX1, pg.25). While Dr. Kutnik acknowledged it was possible that lifting a moving a pallet jack can cause an increase in symptoms of carpal tunnel syndrome, he testified that a normal daily activity of living such as sleeping may just as well also aggravate symptoms (RX1, pg.25). The Arbitrator concludes that while Petitioner may have suffered a temporary increase in symptoms of his pre-existing bilateral carpal tunnel syndrome on January 12, 2018, that the need for surgery was not causally related to Petitioner's 17-day employment with Respondent.

The Arbitrator is not persuaded by the opinions and testimony of Dr. LeeBurton. In his initial office note, while Dr. LeeBurton provided his opinion that Petitioner's carpal tunnel syndrome "could be related to his repetitive motions while working" (PX2); however, that record is devoid of any documentation or information whatsoever concerning Petitioner's employment and/or job duties. In fact, apart from that statement, there is no mention in Dr. LeeBurton's records that Petitioner's symptoms were aggravated by his employment with Respondent. According to the records, Petitioner did not indicate, by history, that he associated his problems with work. Furthermore, Dr. LeeBurton admitted he did not know where Petitioner was working or Petitioner's job title at the time of his initial evaluation (PX1, pg.18-19). Dr. LeeBurton further admitted he did not know the specific physical demand requirements of Petitioner's job other than what Petitioner told him (PX1, pg.19), which is not documented anywhere in his records. He admitted he did not know when Petitioner was hired by Respondent or how long he had been working there before his alleged date of injury (PX1, pg.20). Dr. LeeBurton also admitted he did not know Petitioner's work schedule, how many hours per week Petitioner was working leading up to his alleged date of injury, or whether Petitioner was employed part- or full-time with Respondent (PX1, pg.20).

Dr. LeeBurton's causation opinion was based on a hypothetical scenario posed by Petitioner's attorney at his deposition over Respondent's objection. That hypothetical scenario

assumed an inaccurate length of employment of "approximately 30 days" during which time Petitioner did "inventory control that includes staging trucks" and stacking pallets "all day long with 27-to-30-pound bags, 15 to 20 at a time" (PX1, pg.13-14). It further assumed Petitioner performed those tasks "five days a week, ten hours a day" and his hands became symptomatic "after a month of doing this activity" (PX1, pg.14). Assuming those facts to be true, Dr. LeeBurton testified that he believed the work-related items "could have exacerbated [Petitioner's] carpal tunnel syndrome" (PX1, pg.15).

The Arbitrator concludes that, based upon Petitioner's own testimony concerning his job duties, the hypothetical scenario which Dr. LeeBurton relied upon in establishing his causation opinion is wholly inconsistent with the evidence. It is undisputed that Petitioner was hired 17 days, not 30 days, before his alleged date of injury. Of those 17 total days, Petitioner testified he did not work weekends and was also off work on Monday, January 15, 2018 for the Martin Luther King, Jr. holiday. Petitioner testified at arbitration that he was not required to stack boxes on the pallets but rather, the pallets came pre-stacked with boxes. Petitioner also did not load pallets for "ten hours a day" for "a month" as the hypothetical posed; Petitioner testified he initially worked in the packaging side only two or three hours a day and after training was completed, he would spend up to five hours a day moving pallets. The Arbitrator concludes Dr. LeeBurton's causation opinion is based on incomplete and inaccurate information concerning Petitioner's length of employment and the frequency and nature of his job duties with Respondent. The Arbitrator finds Dr. LeeBurton's opinion lacks persuasiveness in comparison to Dr. Kutnik's. Moreover, the Arbitrator finds Dr. Kutnik more qualified that Dr. LeeBurton in providing a medical causation opinion. Dr. LeeBurton is a board eligible general orthopedist (PX1) whereas Dr. Kutnik is a board certified orthopedic surgeon (RX1). Moreover, Dr. LeeBurton's only publications include children's books (PX1) whereas Dr. Kutnik has written numerous textbook chapters and research articles concerning upper extremity conditions (RX1).

Moreover, Dr. LeeBurton did not review any medical records pre-dating his treatment of Petitioner nor did he review Dr. Sensintaffar's records (PX1, pg.17). Dr. LeeBurton did not even know the name of Petitioner's employer, let alone Petitioner's job title, job duties, frequency of which Petitioner performed his job duties, or the correct length of Petitioner's employment with Respondent prior to the alleged date of injury (PX1, pg.18-20). Conversely, Dr. Kutnik reviewed all of Petitioner's medical records, including records documenting Petitioner's prior diagnoses of

bilateral carpal tunnel syndrome dating back to 2010 (RX1, pg.9-10). Dr. Kutnik also reviewed a written job description in addition to taking a job description from Petitioner, and he had knowledge of Petitioner's employer and job title (RX1, pg.8-10). Dr. Kutnik had knowledge of the correct date of hire and length of Petitioner's employment with Respondent (RX1, pg.11). Dr. Kutnik's opinion was well reasoned and based on a complete and accurate understanding of Petitioner's medical history, length of employment, description and frequency of Petitioner's job duties; it is thus more credible than Dr. LeeBurton's.

The Arbitrator has also considered the testimony of the other witnesses testifying at the hearing. According to the general manager of inventory, Christina Hatfield, on Tuesday, January 16, 2018 Petitioner reported that he would not be able to perform any physical work but would just supervise the employees. When asked what happened, Petitioner said his hands were sore and hurting him. Ms. Hatfield immediately specifically asked whether Petitioner was injured at work, which Petitioner denied and he instead admitted he had an old injury. Ms. Hatfield testified credibly that at no time during her conversation with Petitioner on January 16, 2018 did Petitioner mention that he hurt his hands at work or that he was injured on the job.

Warehouse supervisor Oscar Escovedo also testified that on January 16, 2018 Petitioner advised Ms. Hatfield that his hands hurt and he had a hard time gripping his steering wheel, but Petitioner was not sure what happened. Mr. Escovedo testified credibly that Petitioner did not provide any indication that he injured his hands at work during the conversation. He first learned that Petitioner was alleging his injury was work-related approximately two weeks later on January 30, 2018 when Petitioner returned with Dr. Sinsentaffar's work slip and mentioned he was injured at work on January 12, 2018 while pushing a pallet. Further, shipping supervisor Anthony Cunningham testified credibly about overhearing a conversation between Petitioner and Ms. Hatfield that took place in Ms. Hatfield's office in January. Petitioner stated his hand was hurting and Ms. Hatfield immediately asked what happened. Petitioner denied that he was injured at work and was told to see the nurse. Mr. Cunningham testified that at no time during the conversation did Petitioner mention he injured his hands at work. Moreover, when Petitioner was specifically asked whether he was injured at work, Petitioner denied a work accident and stated it was an old injury.

The Arbitrator is fully aware that there were some inconsistencies in the witnesses' testimony regarding who was in the presence of whom when certain conversations took place and

she is also aware that there was testimony about investigation notes and reports which could be found in Petitioner's employment file and which weren't made a part of the records. However, these records were fully obtainable by both parties and, given the live testimony of the witnesses, not necessarily needed. Most importantly, the issues discussed in these conversations aren't that germane to the liability determination as the crux of the dispute, as noted above, is a medical issue for the experts.

Given the foregoing, and in reliance on the testimony of Petitioner and the persuasive opinions of Dr. Kutnik, the Arbitrator concludes that Petitioner failed to prove that his current condition of ill-being in his hands is causally related to his employment with Respondent or that he sustained an accident on January 12, 2018 that arose out of his employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded. All other issues are rendered moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GLEN GODDARD,

Petitioner,

vs. NO: 11 WC 43294

EMERALD PERFORMANCE MATERIALS,

Respondent.

19IWCC0430

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, causal connection, medical expenses, including prospective medical, occupational disease and exposure, temporary total disability, nature and extent of disability, and the admissibility of Dr. Desai's deposition, 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.

Causal Connection

The Commission affirms and adopts the Decision of the Arbitrator with the exception of the finding of causal connection between the Petitioner's diabetes condition to the occupational exposure as set forth under section (J), Medical. The Commission finds the Petitioner's diabetes condition is not causally related to the Petitioner's occupational disease based upon Dr. Fletcher's concession that he could not state with medical certainty that the diabetes is related to the Petitioner's renal disease. T. 200. The Commission finds no other opinion or medical support in the record corroborating the theory that there is a causal relationship. As such, the Respondent is not liable for the medical treatment and related bills incurred, or to be incurred, for the diabetes condition.

19IWCC0430

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 11, 2018 is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $981.29 per week for a period of 17 weeks, representing temporary total benefits from October 27, 2011 through February 23, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive a credit pursuant to section 8(j), excepting amounts paid by Petitioner to reimburse Cigna, for short-term and long-term disability benefits received against the award of temporary total disability benefits.

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 §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 reasonable and necessary medical services, as set forth in Petitioner's Exhibit 37, directly to the providers, according to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act except those medical or pharmaceutical bills related to the Petitioner's diabetes condition. Respondent shall resolve any subrogation claims asserted by Humana for payments made for related medical treatment, and hold Petitioner harmless against said subrogation claims. Respondent shall reimburse Petitioner for out-of-pocket payments for related medical expenses.

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 12 2019
DLS/bsd
0072419
46

Stephen Mathis

Thomas J. Tyrrell

19IWCC0430

Dissent

I agree with the majority that the Petitioner's diabetes condition is not related to the occupational exposure, however, I would take it a step further and would have also reversed the decision of the Arbitrator regarding causation to his renal and hypertension conditions. Dr. Sparrow, Petitioner's treating nephrologist, opined that Petitioner's medical condition was idiopathic. Further, his medical records state this opinion numerous times.

The "perceived conflicts' with the experts has the effect of either cancelling each other out or we accept they are professionals doing their jobs and looking at the situation with unbiased eyes. Nevertheless, the physician who noted that Petitioner had nephrotic range proteinuria, ordered the renal biopsy, diagnosed the condition of membranous nephropathy after receiving the results of the biopsy, and who treated the Petitioner since he began having symptoms up to and through his remission, is in the best position to judge this rare medical condition and causation issues of his patient.

We have no way of determining what effect, if any, Petitioner's job had on his illness. There was no evidence offered by the Petitioner regarding which chemical Petitioner was exposed to; in what amount of concentration he was exposed; or the length of time he was exposed. Additionally, no information was provided regarding the amounts of exposure required to cause the medical condition that Petitioner is claiming was work-related. Therefore, I respectfully disagree with the majority on the issue causal connection with respect to the renal issues and would deny benefits.

Deborah L. Simpson

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GODDARD, GLEN
Employee/Petitioner

Case# **11WC043294**

EMERALD PERFORMANCE MATERIALS
Employer/Respondent

19IWCC0430

On 10/11/2018, 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 2.38% shall accrue from the date listed above to the day before the 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:

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

19IWCC0430

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Glen Goddard
Employee/Petitioner

v.

Emerald Performance Materials
Employer/Respondent

Case # 11 WC 043294

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **07/19/18**. 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. [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 **October 28, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,550.88 over 16 weeks**; the average weekly wage was $**1,471.93**.

On the date of accident, Petitioner was **44** 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** for TTD, $**0** for TPD, $**0** for maintenance, and $ for other benefits, for a total credit of $. The parties stipulated to the credit due the Respondent.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, as set forth in Petitioner's Exhibit 37, directly to the providers, according to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall resolve any subrogation claims asserted by Humana for payments made for related medical treatment, and hold Petitioner harmless against said subrogation claims.

Respondent shall reimburse Petitioner for out-of-pocket payments for related medical expenses in the amount of $1,410.00.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $981.29 /week for 17 weeks, representing total temporary disability benefits from October 27, 2011 through February 23, 2012, pursuant to Section 8(b) of the Act.

Respondent shall receive a credit pursuant to section 8(j), excepting amounts paid by Petitioner to reimburse Cigna, for short-term and long-term disability benefits received against the award of temporary total disability benefits.

Nature and Extent

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 200 weeks, because the injuries sustained caused the 40 % loss of the person as a whole, as provided in Section 8 (d) 2 of the Act.

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

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

D. Dglas McCarty

Signature of Arbitrator

10-02-2018
Date

OCT 11 2018

ADDENDUM

STATEMENT OF FACTS

Petitioner has brought this matter against Respondent alleging he developed secondary membranous nephropathy from repetitive exposure to toxic chemicals, including Cure-Rite, Hydrogen Sulfide, Methylene Chloride, Morpholine, Toluene, and Carbon Disulfide, which manifested on October 28, 2011.

1. PETITIONER'S TESTIMONY

Petitioner testified he is not currently employed, and the last time he was employed was 2011 with Respondent. TR, p. 36. His actual last date working in the Respondent's facility was March 16, 2011. He left at that time due to a labor dispute. TR, p. 109. He testified he is currently on social-security disability for kidney issues and due to his medications. TR, P. 37.

Petitioner testified he graduated from high school in 1985, and that he entered the Air Force in 1986. TR, p. 38. He was in the Air Force until April 1, 1993. TR, p. 38-39. He testified he began working for BF Goodrich Chemicals in June of 1993 at the same plant which eventually Emerald Performance Materials. TR, p. 39-40. He testified there were a succession of owners, but the products, management, and buildings were the same. TR, p. 40. It was a polymer chemical plant that made rubber accelerators. TR, p. 40.

Petitioner testified he made a diagram of the plant, PX 43, and that the plant sat on approximately 40 acres. TR, p. 41. He testified he worked in Building 725 from 2002 or 2003 to 2011, and that he worked in Building 722, where a product called 3114 was made. TR, p. 41-42. He testified product 3114 is used to maintain the color in plastics. TR. P. 42. He testified he worked in Building 712, which was no on the diagram. TR, p. 42. He testified that, in his 20 years at the plant, he had been required to work in other buildings at times, and that Building 711, the crude building, was the only place he never worked. TR, p. 42-43. He testified he delivered raw materials and helped with maintenance there, but he did not make the product in that building. TR, p. 43. He testified maintenance involved leaks. TR., p. 43. He would help the operator. TR, p. 43-44. If they had leaks or pump problems, and there were not enough other employees around, he helped work through the issues, so he would be exposed to those chemicals. TR, p. 43-44.

Petitioner reviewed PX 44-50, which he identified as buildings from the plant. TR, p. 45-48. He testified chemicals from Building 725 would be discharged through vents on the roof, but that the vents were not depicted in the photograph marked PX 50. TR., p. 48. He testified he working through all four seasons, and that during the winter, the only ventilation was a couple of emergency ventilation fans on the outside of the building, that or opening the door. TR, p. 49. He testified most of these vents were not operational throughout the year. TR, p. 49. Either the fans were out, or something was wrong with the electrical supply, or the motors were burned up, but they were never replaced. TR, p. 49-50. There were 21 emergency fans in the building, and eight of them worked. TR. P. 50. From 2003 to 2011 when he worked in the building, there were no more than 8 functional fans on all three floors. TR, p. 50. He testified he wrote work orders for the fans to be repaired or replaced several times to the maintenance department, but that they were not repaired due to the cost. TR, p. 50-51.

Petitioner testified, regarding the ability to properly vent the building, that it was really bad inside. TR, p. 51-52. There was dust and fumes he could not get away from. TR, p. 52. He testified there was bleach reactor vent that went to the roof. TR, p. 52. When making a bleach charge you put chlorine in at the end, and when you were pushing chlorine too fast it would vent out the roof and trip an alarm which shut off the bleach until the reactor cooled. TR, p. 52. He testified Respondent made modifications to the top of the building to stop the chlorine from shutting down. TR, p. 52-53. They could not make bleach fast enough to keep up with production schedules, so they moved the alarm away from the vent to keep it from going off. TR, p. 53. The alarm would

still go off, so they took a heavy trash bag and duck taped it around the alarm to it could not sense the chlorine. TR, p. 53-54

Petitioner testified he also wore a rattler to pick up on the hydrogen sulfide, H2S, gas from the NaSH crude building. TR, p. 54. He testified the H2S gas would blow from the NaSH unit into the fresh air intake on the roof of Building 725 depending on the wind direction. TR, p. 54-55. He testified this would still trigger the rattlers, and that the highest he had in his building was 65 parts per million, five times the trigger point of the unit. TR, p. 55. It would go off constantly. TR, p. 55.

Petitioner testified the building was ventilated the same way in the summer time. TR, p. 55. He testified Building 725 had a vent header, which was where all the reactors, wash tanks and other vessels vent through one 12-inch line that goes out to the interceptor pit between buildings. TR, p. 55-56. He testified it had holes in it that looked like swiss cheese, and that due to the holes, the chemicals would vent right back into the building, TR, p. 56. He testified this occurred the whole time he working in that building. TR, p. 56. He testified he wrote work orders to have this corrected, but that it never was, presumable due to costs. TR, p. 57.

Petitioner testified Building 725 had breathing air filters, and that as they deteriorated they turned from blue to gray. TR, p. 57-58. He testified there were 5 stations per floor, but that due to the cost of the filters, they were told they could only have one per floor. TR, p. 58. He testified he relied on air from these stations to maintain fresh air in the mask he wore. TR, p. 58-59. He testified if he was working on a floor that did not have fresh air he still used the filter, it was just bad. TR, p. 59.

Petitioner testified there was a lot of dust in the building, caused by a rubber accelerator called BBTS, and another called Cure-Rite 18. TR, p. 59-60. He testified both products produced powder which was airborne in Building 725. TR, p. 61. He would breath the dust, even in the pressurized panel room; it was everywhere. TR, p. 61. The dust was like snow and the floor was completely covered. TR, p. 61-62. He would wear dust masks or fresh-air supply, a Nomex fireproof uniform, glasses and a hard hat to try to prevent inhalation of and contact with the powder. TR, p. 62. Even with this equipment, the dusting was terrible; no matter where he was he could not get away from it. TR, p. 62. He testified that to remove the dust they should have replaced the fans, but they never did. TR, p. 62-63.

Petitioner testified methylene chlorine was a raw material that went into the reaction of Cure-Rite 18, and that he would have been exposed from the holes in the vent header. TR, p. 65. He testified he could smell the methylene chlorine through his respirator. TR, p. 65-66. He testified methylene chlorine went upstairs to the third floor through a condenser where is was dropped into a decanner. TR, p. 67. The decanner would get plugged frequently, and they would have to open it up and rod it out, at which time they were exposed to gallons and gallons of methylene chloride. TR, p. 67-68.

Petitioner testified morpholine was also a raw material in Cure-Rite 18, and that he was exposed through leaks, maintenance issues, whether the pump seal is going out, and through the vent header. TR, p. 69. He testified morpholine went in as a liquid and came out as a vapor, and that as a liquid, it would get onto his skin even though he was wearing his equipment. TR, p. 69-70. He was able to distinguish morpholine because it burned the skin. TR, p 70.

Petitioner testified toluene is a solvent form Building 711. TR, p. 71. It would enter the interceptor pit as a vapor, and then anything in the pit would blow back into the building. TR, p. 71. The interceptor pit was his responsibility, so he was exposed to the vapor. TR, p. 71. There were also issues with toluene leaking in Building 711, and he was involved in the repairs or attempts to segregate the product. TR, p. 72. He was sent to buy kiddy

pools to collect toluene from the leaks. TR, p. 72-73. When the pools filled, they were dumped into the sewer, which then led to the interceptor pit behind his building. TR, p. 73.

Petitioner testified carbon disulfide was a raw material that goes into the manufacture of Cure-Rite 18, and that he would have been exposed through the vent header system and through leaks. TR, p. 74-75.

Petitioner testified he wore a special type of respirator because he has a hole in his skull, and that a normal respirator pushed directly on the hole causing severe pain. TR, p 75-76. The special respirator did not completely prevent exposure to airborne chemicals; he could taste Cure-Rite 18, which burned, dried him out and caused flu-like symptoms. TR, p. 76. He would also wear a dust mask while moving through the building because his hood was connected to a fresh-air station. TR, p, 76-77. He wore a Nomex fire-retardant uniform, but it was not successful in keeping dust off of him. TR, p. 77. He testified the filter from his respirator would last about two months, but that he would continue to use old filters because Respondent did not replace them because of money. TR, p. 88-89.

Petitioner testified he ran a fluid bed dryer for both Cure-Rite 18 and BBTS. TR, p. 78. The fluid bed dryer added a binder to the powder and ultimately it became dried pellets. TR, p. 78. He testified the pellets would break up and create dust on the second floor and then down to the first floor because the air pressure would blow downstairs. TR, p. 79. There was a dust-collector for the fluid bed dryer that would plug frequently, and when plugged, dust would push into the building. TR, p. 79.

Petitioner testified there were no H2S alarms in the NaSH press, and that they were going to use the chlorine alarm from Building 725, but they never moved it. TR, p. 80.

Petitioner testified Respondent purchased ventless bags which were filled with the pellets using air pressure. TR, 9. 80. He testified the plant manager poked holes in the front of the bag to release the air pressure, which caused powder to spray all over. TR, p. 81. He testified the pellets were transported from the screener to the bagging hopper using a hapman conveyor, but it fell apart and then they had to bulk bag. TR, p. 81. This consisted of putting the pellets into nylon bags manually and take them to the bagging hopper on the third floor. TR, p. 81-82. This process exposed him to dust. TR, p. 82. The Cure-Rite 18 bulk bags included instructions that powder should not be on the exterior of the bags because people purchasing the product did not want the dust on their other products and would not accept it. TR, p. 84. They were told to blow or sweep it off, which sent the dust airborne. TR, p. 85.

Petitioner testified sweco is a round screener which screen large chunks for recycle, and the super fine stuff would go into a bag to be packaged. TR, p. 82-83. It leaked constantly BBTS and Cure-Rite 18 powder constantly. TR, p. 83. He testified they had to evacuate the building in 2008 or 2009 for 3 to 4 hours due to a buildup of TBA fumes, a raw material used in the manufacture of BBTS. TR, p. 83-84.

Petitioner testified he would shower when he left the plant, and that his clothes stayed at the facility and were laundered by the company. TR, p. 85. He changed into street clothes before going home. TR, p. 85-86. He would go to sleep and still smell the chemicals on him when he awoke the next day. TR, p. 86. He could smell it on himself even though he showered, and it left a residue on his clothing and sheets which turned them yellow to brown. TR, p. 86-87. That occurred a lot when he worked in the 3114 building in 1994 and 1995. TR, p. 87.

Petitioner testified that during the last year of his employment he worked from 600 to 800 hours of overtime, and that his shifts were 12 hours. TR, p. 87-88. He testified that when he worked in Building 725 he was employed as a chemical operator and his job was to manufacture BBTS and Cure-Rite products. TR, p. 90. His duties included making charges, a 2000-gallon reaction, and packaging the products out. TR, p. 90-91.

Petitioner testified he was exposed through his skin and through breathing, and that he was constantly sick when working for Respondent. TR, p. 91.

2. TESTIMONY OF DAVID SMID

Petitioner testified he worked at the plant with David Smid, who testified via his evidence deposition entered into evidence as PX 36. Mr. Smid testified he worked for Respondent between 2005 and 2010 as a first-class chemical operator. PX 36, p. 12. He testified that he was voted to be part of the safety committee with Respondent, which met once a month to look at concerns of employees in the work area. PX 36, p. 15. He testified most of the recommendations they made to management were denied for budgetary reasons. PX 36, p. 15-16. Things like fixing pipes, valves, failing pumps and leaks never moved forward. PX 36, p. 16. He testified a lot of the exhaust fans in Building 712 did not work, and that nothing was done. PX 36, p. 33. He testified he would walk in and could smell the morpholine and toluene, and that was a given for any building. PX 36, p. 34.

Mr. Smid testified anything exhausted out of the NaSH building would hit Building 725. PX 36, p. 53-54. He testified that, depending on the wind, they were the first in line, and anything expelled would get picked up by their intake fans for fresh air. PX 36, p. 54.

Mr. Smid further testified that he worked overtime in Building 725. Id at 54, 55. His job was bagging the Cure Rite 18. He wore a respirator, but the Cure Rite would become airborne, and cover the workers. He said that the whole floor looked like it had snowed. He said that he looked like a "donut." Id at 57. He said that the dust would get on your skin, particularly if you were sweating. He said that he had occasion to see the Petitioner covered in powder when performing the bagging job in Building 725. Id at 107.

Petitioner testified the exposures described in Mr. Smid's deposition related to the same products he was exposed to, and that the types of exposures detailed in Mr. Smid's deposition remained constant throughout Petitioner's employment. TR, p. 95.

3. GOVERNMENT MATERIALS, REPORTS, AND INVESTIGATIONS

Petitioner's Exhibits 15 through 22 are Material Safety Data Sheets and U.S. Department of Health and Human Services information regarding the various chemicals present at Respondent's facility which Petitioner claims he was exposed to on a regular basis during his employment. The MSDS for BBTS states, under chronic health effects, that kidney effects have been observed in laboratory animals, and Cure-Rite exposure can cause irritation of the mucous membranes by respiratory or dermal contact. PX 15, 16. Hydrogen Sulfide exposure can cause sensitivity to light, nausea, headache, drowsiness, dizziness, hallucinations, tremors, visual disturbance, nerve damage, brain damage, convulsions, sleep disturbances, and long-term effects on the brain. PX 17. Methylene Chloride exposure can cause confusion, lightheadedness, nausea, vomiting, headache fatigue, unconsciousness, and central nervous system depression, as well as aggravation of kidney disorders. PX 18. Morpholine exposure can cause irritation to the respiratory system, and damage to major organs including the kidneys, liver, and bladder. PX 19. Toluene exposure can cause irritation and depression of the central nervous system, nausea, headache, dizziness, fatigue, drowsiness, unconsciousness, and blurred vision, and that it may cause damage to the kidneys. PX 20.

Carbon Disulfide exposure can cause organic brain damage, peripheral nervous system decrements, neurobehavioral dysfunction, ocular and auditory effects, severe irritation of the eyes, skin, and mucous membranes, headache, dizziness, nausea, vomiting, euphoria, convulsions, muscle weakness, possible death by respiratory failure, gastrointestinal disturbances, kidney and liver damage, sleeplessness, nervousness, anorexia,

dilated pupils, death, polyneuritis, emotional disturbances, psychosis, atherosclerosis, hypertension, weight loss, anemia, and Parkinson-like syndrome. PX 21, 22.

Petitioner's Exhibits 23-26 are Environmental Protection Agency (EPA) Non-Compliant Reports and Findings of Violations regarding the Respondent from 2007-2010, the Petitioner's employment period. The Reports document in detail, leaking valves, connectors, and pumps from which chemicals were allowed to escape. PX 23-26.

On September 29, 2010, Respondent was fined $158,000.00 for violations, including but not limited to, the release of Carbon Disulfide on five separate occasions in 2009. PX 28. During a twelve-hour period on July 25, 2009, 597.8 pounds of Carbon Disulfide were spilled, emitted, discharged, or escaped into the air. Carbon Disulfide is labeled an "extremely hazardous material" by the EPA. PX 28.

Further, on January 25, 2009, 261 pounds of Hydrogen Sulfide, also an "extremely hazardous material" as classified by the EPA, were spilled, emitted, discharged, or escaped into the air. PX 28. The release of Carbon Disulfide and Hydrogen Sulfide did not only affect the plant, but the surrounding Marshall County, Illinois area. PX 2). Respondent did not immediately notify the Nuclear Regulation Commission of the release of 859 pounds of "extremely hazardous material". The Respondent was also fined for leaks of Carbon Disulfide and Hydrogen Sulfide on July 27, 2009, July 28, 2009, October 8, 2009, October 19, 2009 for which it failed to immediately notify various responding government agencies. PX 28.

On March 19, 2013, the National Institute for Occupational Safety and Health (NIOSH), a division of the Centers for Disease Control (CDC), issued a report regarding Respondent. Of note, only two former employees were interviewed for the report and while air samples tested for chemicals were either low or undetectable, there were multiple reports from employees with complaints of dermal exposure to chemicals throughout their workday.

Petitioner worked in Building 725 as an operator/bagger, where he was exposed to OTOS at 8 times higher levels known compared to the manufacturer's occupational exposure limit (OEL) according to the NIOSH data. PX34. The NIOSH air sampling did not account for possible skin absorption of chemicals meaning no one has even measured the dermal exposure from the excessive OTOS (CURE-RITE 18 POWER) dust. Morpholine and Carbon Disulfide are used in the manufacture of OTOS (CURE-RITE* 18 Powder) and both chemicals are known nephrotoxic.

In the report, NIOSH ordered Respondent to conduct further training regarding personal protective clothing, use of additional protective personal clothing, including nitrile gloves, and revise its respiratory protection program to conform to Occupational Safety and Health Administration (OSHA) guidelines. PX 32.

In October 2012 and July 2013, the CDC and NIOSH conducted evaluations of the Respondent's facilities. PX 34. Respondent had prior notice of said inspection, only current employees were interviewed, and only records from some past employees were reviewed. Based upon this review of unspecified records, it was opined that two former employees' chronic kidney diseases were unrelated to the work. Which records the CDC and NIOSH had access to and actually reviewed are not disclosed in the Report. PX 34.

Throughout the evaluation, leaking pipes and substantial steam leaks were noted. Pipes were noted to have molten sulfur buildup. Several deficiencies, including pinched and excessive ventilation ductwork were documented. PX 34.

The CDC and NIOSH concluded that there was an overexposure of some chemicals, and that employees complained of eye, nose, throat, and skin irritation at work consistent with exposure to workplace chemical irritants. It was also noted that Respondent's employees worked with chemicals known or suspected to cause

cancer. Respondent was ordered to improve local exhaust ventilations, follow OSHA respiratory protection standard, and have employees use personal protective equipment including gloves. PX 34.

A section of the CDC/ NIOSH Report titled "Limitations" stated "[t]he exposure concentration we measured in July 2013 may not reflect the same exposure concentrations on other days and in previous years. Our air sampling did not account for possible skin absorption of chemicals". PX 34, p. 13.

In summary, the NIOSH report confirmed that Emerald was a dangerous workplace and that the employees were exposed to high levels of toxic chemicals and there was inadequate protection provided to the employees.

4. MEDICAL TREATMENT

Petitioner testified he started noticing changes in his body in 2010. TR, p. 96. He testified his primary care physician was Dr. Arnold Faber. TR, p. 96. On May 13, 2011, Petitioner presented to Dr. Faber at Princeton Family Physicians to review the results of recent lab work, and based on the results Dr. Faber referred Petitioner for an ultrasound of his kidneys. PX 1. Petitioner presented to Perry Memorial Hospital on May 16, 2011, which was negative. PX 3. He returned to Dr. Faber on May 17, 2011 to review the results, at which time Dr. Faber referred him to a nephrology specialist. PX 1.

On May 26, 2011, Petitioner presented to the Illinois Kidney Disease & Hypertension Center for a consultation with nephrologist Dr. Robert Sparrow. PX 3. Dr. Sparrow noted that Petitioner began noticing swelling in his lower extremities the prior September, and then in the past month he noticed marked lower extremity edema and that he gained approximately 40 pounds over a 14-day period of time. PX 4. Dr. Sparrow noted he had nephrotic range proteinuria, which he characterized as massive. PX 4. Dr. Sparrow also discussed possible indications for a kidney biopsy. PX 4. Dr. Sparrow ordered a renal biopsy on June 9, 2011. PX 4.

On June 17, 2011, Petitioner presented to OSF St. Francis Medical Center for a left renal biopsy. PX 38. The specimen was sent to NephroPath, where it was reviewed by pathologist Dr. Alexis A. Harris. PX 39. Dr. Harris diagnosed Petitioner with membranous glomerulopathy, and commented that the "presence of mesangial deposits raise suspicion of secondary membranous glomerulopathy of which etiologic agents include autoimmune disease, infection, certain drug exposure and malignancy." PX 39.

Petitioner followed up with Dr. Sparrow regarding the results of the biopsy on June 23, 2011. PX 4. Dr. Sparrow diagnosed him with membranous nephropathy, which he opined was most likely idiopathic. PX 4. He also noted, however, that Petitioner did have some mesangial deposits. PX 4. Dr. Sparrow prescribed Lisinopril as an initial therapy and noted that if Petitioner did not respond in 2-3 months he would proceed with Cytoxan and prednisone. PX 4. He also diagnosed Petitioner with hypertension and high blood pressure, which he opined were likely related to glomerulonephritis. PX 4.

On September 22, 2011, Dr. Sparrow noted Petitioner had received no benefit from his initial therapy in terms of loss of edema or his weight, and that his creatinine had also increased. PX 4. Due to Petitioner's worsening renal function, Dr. Sparrow elected to proceed with Cytoxan and prednisone, and noted Petitioner was to follow up with him monthly for at least 6 months and then reevaluate for further treatment. PX 4.

On October 27, 2011 Dr. Sparrow placed Petitioner on work restrictions through his next office visit. PX 4, 5, 8. Petitioner requested an extended, paid leave of absence November 2, 2011. PX 7. He testified that he received 6 months of short-term disability from Respondent, and then received long-term disability benefits through Cigna,

which he paid for. TR, p. 114-115. He testified he received long-term benefits through April 26, 2014, after which he went on social security. TR, p. 118-119. He testified he had to reimburse Cigna. TR, p. 119-120.

Petitioner testified he initially met with attorney Timothy Shay on October 28, 2011.TR, p. 111. He testified that he met with Dr. David Fletcher at the request of Mr. Shay on November 16, 2011. and that at that time Dr. Fletcher alerted him that there may be a causal relationship. TR, p. 97. Petitioner continued to follow up with Dr. Fletcher, who acted as the occupational health consultant gatekeeper and was assessed with chronic kidney disease (CKD) as a result of workplace exposures. PX 6.

Petitioner returned to Dr. Sparrow on February 23, 2012. PX 4. Dr. Sparrow opined that Petitioner appeared to be in partial remission, based on his urine protein-creatinine ratios over the preceding two to four weeks. PX 4. Dr. Sparrow decreased Petitioner's Prednisone dosage, and continued his Cytoxan treatment. PX 4. Petitioner was switched from Cytoxan to CellCept on August 9, 2012. PX 4.

On December 20, 2013, Petitioner followed up with Dr. Sparrow and reported that he continued to not feel well. PX 5. Specifically, he complained of severe back pain, edema, inability to walk, and that he felt terrible overall PX 5. Dr. Sparrow noted that Petitioner had been on CellCept for a year, and that he was in complete remission. PX 5. Dr. Sparrow discontinued his CellCept treatment, warned him of the possibility of relapse, and recommended that he continue to follow up. PX 5. Dr. Sparrow continued to diagnose Petitioner with hypertension as well PX 5.

On May 17, 2018, Petitioner returned to Dr. Sparrow for a follow up regarding his membranous nephropathy, hypertension, and related problems. PX 4. Dr. Sparrow noted Petitioner's membranous nephropathy remained in remission and recommended he follow up in one year. PX 4. He also noted nephrotic syndrome, secondary to the membranous nephropathy. PX 4. Dr. Sparrow also diagnosed him with noninsulin-dependent diabetes mellitus and hypertension. PX 4.

Petitioner returned to D. Fletcher on July 16, 2018 complaining of constant burning, stabbing, and aching pain, which he characterized as moderate to severe. PX 41. This pain was accompanied by numbness. PX 41. He also reported that his pain was not improving. PX 41. Dr. Fletcher assessed Petitioner with secondary membranous nephropathy, which he noted was in remission. PX 41. Dr. Fletcher also assessed Petitioner with diabetes and hypertension, and noted that Petitioner had never developed these conditions until his work-related kidney disease. PX 41. Dr. Fletcher further noted that Petitioner was deconditioned from his health conditions, and that he was currently disabled. PX 41.

Dr. Fletcher opined that Petitioner had been disabled from gainful employment due to his workplace exposure since 2011, and that he would need life-long medical monitoring and require medications to help him urinate and to control his edema. PX 41. Dr. Fletcher recommended a work status of no work capacity, and opined that Petitioner was permanently, totally disabled. PX 41.

5. TESTIMONY OF DR. DAVID FLETCHER

Dr. David Fletcher is a board-certified occupational medicine physician, who since 2016 has served on the Illinois Workers Compensation Commission Medical Fee Advisory Board. Dr. Fletcher testified he has been retained in the past by companies dealing with the production and manufacturing of chemicals. PX 14, TR, p. 146. He testified he served as the medical director with chemical manufacturers in Illiopolis (Borden Chemical) for over a decade, where he handled OSHA medical surveillance, supervised a plant nurse that was employed by him and workers' compensation services. TR, p. 146-147. He testified he has experience with the industry and with the requirements for hazardous materials medical surveillance. TR, p. 146-147.

Dr. Fletcher testified he first saw Petitioner on November 16, 2011, at which time he had been diagnosed with membranous nephropathy. TR, p. 150. He testified he then began to collect material which would assist him in deciding whether Petitioner's condition was work related, which included Petitioner's last medical surveillance exam with Dr. Faber, which occurred in September 2009. TR, p. 151, PX 42. Dr. Fletcher testified that, based on his review of Dr. Faber's record, Petitioner had no manifestations of renal disease at the time of the 2009 exam as there was no protein in the petitioner's urine. TR, p. 153. Dr. Fletcher also testified the report demonstrated no evidence of diabetes. TR p. 154.

Dr. Fletcher testified he reviewed Material Safety Data Sheets for various chemicals which Petitioner was exposed to as part of his employment with Respondent. TR, p. 155-157, PX 15-21. Dr. Fletcher testified two chemicals from the Material Safety Data Sheets, morpholine and carbon disulfide, are nephrotic and cause immune reactions which cause membranous nephropathy. TR, p. 158. He testified these agents are used in the production of Cure-Rite 18 powder, and are the causative agents in Petitioner's occupational disease. TR, p. 158. He testified there is some research that hydrocarbon solvents such as methylene chloride and hydrogen sulfide are also potentially nephrotic. TR, p. 158.

Dr. Fletcher testified there are two different types of membranous nephropathy: primary and secondary. TR, p. 163-164. Primary is idiopathic, or without cause, and secondary means there is some kind of infection, toxic exposure, cancer, or autoimmune disease which causes the membranous nephropathy. TR, p. 164. He testified that with secondary membranous nephropathy, immune complexes are deposited on the membrane called the mesangi. TR, p. 164. He testified these deposits are what you look for when trying to diagnose between primary and secondary. TR, p. 164.

Dr. Fletcher testified Petitioner's June 17, 2011 renal biopsy revealed the presence of mesangial deposits. TR, p. 164-165. He testified this is the key document regarding the causation of Petitioner's condition. TR, p. 165. Dr. Fletcher testified the renal biopsy confirms that Petitioner has an occupational-related renal disease because he had mesangial deposits, which indicates secondary membranous nephropathy. TR, p. 165. He testified he reviewed the color photographs of the biopsy. TR, p. 166. Dr. Fletcher testified that, for a diagnosis of primary membranous nephropathy, he would expect there to be no mesangial deposits. TR, p. 167.

Dr. Fletcher testified he conducted medical research regarding the causal relationship between chemical exposures and membranous nephropathy. TR, p. 168-169. He testified that he reviewed a wide body of literature supporting a causative link to chemical exposure and secondary membranous nephropathy. TR, p. 169-179, PX 51-56. Dr. Fletcher reviewed case study, submitted into evidence as Petitioner's Exhibit 58, which studied a series of kidney biopsies of subjects exposed to carbon disulfide. Fletcher Dep. p. 29-30. He testified the study the study showed a link with exposure and proteinuria, which was Petitioner's manifestation. Fletcher Dep., p. 30-31.

He testified that Dr. Conibear and Dr. Desai opined that there was no literature supporting a link, contrary to the body of literature he reviewed. TR, p. 179. Dr. Fletcher testified that his research supports his opinion that, within a reasonable degree of medical certainty, morpholine and carbon disulfide exposure have been causative of Petitioner's secondary membranous nephropathy. TR, p. 179-180.

Dr. Fletcher testified that if Petitioner had primary, or idiopathic, membranous nephropathy and was removed from the exposure, he would expect the condition to continue to progress. TR, p. 171-172. He testified the fact that Petitioner had not gotten worse and has remained in remission is evidence of the causal relationship. TR, p. 172.

Dr. Fletcher testified his practice differs from that of Dr. Shirley Conibear in that she is more of a consultant, whereas ninety percent of his practice is clinical, where he acts as a treating physician. TR, p. 148. He testified that he read her deposition, and that she did not review the Material Safety Data Sheets or the pathology report from Petitioner's June 17, 2011 renal biopsy, nor was she aware of fines which had been levied against Respondent. TR, p. 180-181. He testified he agreed with Dr. Conibear's opinion that the ability to smell chemicals while wearing a respirator is a sign of some chemical exposure. TR, p. 181.

Dr. Fletcher testified he reviewed Dr. Desai's deposition, and disagrees with her diagnosis of primary membranous nephropathy. TR, p. 181-182. Dr. Fletcher testified he personally examined Petitioner on several occasions. TR, p. 180. He agreed with Dr. Desai that carbon disulfide and Cure-Rite (OTOS) can have an effect on the kidneys. TR, p. 182.

Dr. Fletcher testified he typically enters a plant to make recommendations and to collect data as an occupational medicine physician, but that he was not granted permission to enter the plant. TR, p. 189. He testified he instead visited the outside of the plant, approximately fifty yards outside of Building 725. TR, p. 189-190. He testified he noticed an odor. TR. P. 190. He testified he was involved in the NIOSH inspection of the plant. TR, p. 190. Once NIOSH decides to make an assessment, they notify the employer to give them time to prep. TR, p. 191. He testified NIOSH conducted two assessments, and that that first was incomplete because the Cure-Rite 18 (OTOS) was not being manufactured at the time, and the second was delayed so that Respondent could perform maintenance. TR, p. 192-195.

Dr. Fletcher reviewed the medical records from Petitioner's July 16, 2018 consultation. TR, p. 198-199, PX 41. He testified Petitioner had gone into remission, which supported his opinion that he improved after being away from the exposure. TR, p. 199. He testified Petitioner still had edema, problems with fluid retention, and that he had diabetes and hypertension. TR, p. 199-200. Dr. Fletcher testified he believed there was a relationship between Petitioner's renal disease and his hypertension and diabetes. TR., p. 200.

Dr. Fletcher testified Petitioner's ability to be gainfully employed is extremely low because one of the results of chronic renal disease, even in remission, is fatigue. TR, p. 203. He testified Petitioner has gained weight due to his condition, which has worsened his sleep apnea and the osteoarthritis of his left knee. TR, p. 203-204.

Dr. Fletcher testified that in assessing an occupational disease case, it is very important to look at the frequency, duration, and intensity of exposure. TR, p. 204. He testified that there is no doubt in his mind Petitioner meets the criteria for an occupational exposure. TR, p. 205.

6. TESTIMONY OF DR. SHIRLEY CONIBEAR

The Evidence Deposition of Dr. Shirley Conibear, Respondent's Section 12 physician, was entered into evidence as Respondent's Exhibit 1. Dr. Conibear is a board-certified occupational medicine physician, and rendered opinions regarding Petitioner in an August 28, 2015 Report, RX 1, Ex 2.

In her Report, Dr. Conibear agrees with Petitioner's diagnosis of nephrotic syndrome secondary to membranous nephropathy, however, she disagreed that Petitioner's condition was causally related to his occupation exposure. RX 1, Ex 2. Specifically, she testified there are no epidemiological studies which identify occupational exposure as being a cause of membranous nephropathy, neither is it supported by toxicologic literature of kidney damage. RX 1, p. 18.

Dr. Conibear testified Petitioner informed her he could frequently smell chemicals while wearing a respirator, and that this indicates exposure. RX 1, p. 8-9. She testified that, during her evaluation of Petitioner, they did not discuss the specific chemicals Petitioner was exposed to in the plant. RX 1, p. 16. She testified she was not able to correlate the chemicals listed by Dr. Fletcher with those in the health hazard report she reviewed and the NIOSH report. RX 1, p. 16-17. Dr. Conibear testified that she did not review any citations leveled by the EPA against Respondent. RX 1, p. 24. She testified she did not review any Material Data Safety Sheets in the preparation of her Report and formulation of her opinions. RX 1, p. 29-30. She testified she did no independent research regarding Cure-Rite or carbon disulfide. RX 1, p. 33-35. Dr. Conibear testified she did not review any pathology reports related to Petitioner's renal biopsy, and that she does not know the significance of mesangial deposits as they relate to causation. RX 1, p. 44.

Dr. Conibear testified the level of Cure-Rite 18 in the air at the plant was not assessed as part of the NIOSH report. RX 1, p. 36. However, OTOS is the acronym for N'-Oxydiethylenethiocarbamyl-N'-oxydiethylensulfenamide, which Emerald manufactures with the brand name CURE-RITE* 18 Powder by combining methylene chloride, morpholine, bleach, and carbon disulfide in a reactor and the levels found by NIOSH were higher than recommended. Dr. Conibear agreed the NIOSH report found deficiencies in ductwork and ventilation, and that this would have an effect on employee exposure. RX 1, p. 39-40. She also agreed that, as Petitioner no longer worked at the plant at the time the sampling was done, its findings were not representative of his exposures. RX 1, p. 41.

While Dr. Conibear disagreed that Petitioner's condition was causally related to his occupational exposure, she opined that he would need ongoing medical treatment. RX 1, p. 18. She agreed that Petitioner's high blood pressure was a result of a combination of his kidney disease and his medications. RX 1, p. 45. She further opined that Petitioner could perform sedentary work with limited walking. RX 1, p. 18-19.

Dr. Conibear testified approximately ten to fifteen percent of her practice is dedicated to medical legal work. RX 1, p. 6. She testified this amounted to about $100,000.00 annually. RX 1, p. 51. She testified that a further ten percent of her employment consists of consulting for chemical plants. RX 1, p. 50.

7. TESIMONY OF DR. AMISHI DESAI

The Evidence Deposition of Dr. Amishi Desai, Respondent's Section 12 physician, was entered into evidence as Respondent's Exhibit 2. Dr. Desai is a board-certified nephrologist, and rendered opinions regarding Petitioner in a June 12, 2017 Report, RX 2, Ex 2.

In her Report, Dr. Desai diagnoses Petitioner with primary membranous nephropathy. RX 2, Ex 2. Dr. Desai testified primary membranous nephropathy occurs when there is no other medical condition or disease which cases the pathology. RX 2, p. 12. She testified he was tested for hepatitis and Lupus, which could be causes of secondary membranous nephropathy, and was negative. RX 2, 13. She opined Petitioner was classified as primary because he did not have another condition which would cause membranous nephropathy. RX 2, p. 12-13. Dr. Desai testified she did not find any literature linking the chemicals Petitioner was exposed to Petitioner's kidney disease. RX 2, p. 25-26.

Dr. Desai testified secondary causes are not necessarily comorbid medical conditions, and that exposure to toxins can be a secondary cause. RX 2, p. 34-35. She testified that approximately one percent of her clinic's

practice it related to membranous glomerulonephropathy, and that none of her research or publications address membranous nephropathy. RX 2, p. 33, 35.

Dr. Desai agreed that the Material Safety Data Sheet for carbon disulfide indicates that is affects the kidneys. RX 2, p. 50-51. She testified that it did not specifically list membranous nephropathy, but also testified that she was not asked to review this chemical and did not look into the chemical. RX 2, p. 51-52. She also agreed the Material Safety Data Sheet for BBTS listed kidney effects, but that she did not include this in her report. RX 2, p. 53. She also testified that her supplemental report did not include all the chemicals for which she was provided Material Safety Data Sheets. RX 2, p. 56. She testified she was not provided with information regarding consent orders against Respondent. RX 2, p. 65.

Dr. Desai agreed that mesangial deposits can be evidence of a secondary cause. RX 2, p. 60. She agreed that she could not rule out a secondary cause based on the biopsy report. RX 2, p. 61. She testified the mesangial deposits are suggestive that there's a possible secondary component. RX 2, p. 62 She opined that the secondary component was unrelated, but agreed there is evidence which could suggest an exposure of a secondary cause, given the deposits. RX 2, p. 63. She testified she is not an occupational disease specialist, did not examine Petitioner, and did not visit the plant. RX 2, p. 63. She testified she did not believe there was a relationship between the mesangial deposits and Petitioner's condition, but at admitted she did not know the extent of the deposits. RX 2, p. 79.

Dr. Desai testified Petitioner is in remission and that no further treatment is necessary, other than monitoring. RX 2, p. 15-16. She testified he would not have any activity restrictions. RX 2, p. 16. Dr. Desai also agreed, however, that some patients develop irreversible kidney damage within two to twenty years, and that those patients would go on to have kidney failure. RX 2, p. 58. She agreed hypertension can be caused by glomerulonephritis. RX 2, p. 74.

Dr. Desai was asked how Respondent's counsel came to contact her to perform a review of the case, and Respondent's counsel objected to the question. RX, p. 36. Dr. Desai then initially testified she was contact by an acquaintance, before admitting she was in fact contacted by her brother, who is an attorney with Respondent's counsel's firm. RX 2, p. 36-37. She testified her brother is a partner in the firm, and that she did not think about whether performed the examination would be a conflict of interest. RX 2, p. 37-38. Dr. Desai reviewed the letter of introduction she received from Respondent's counsel, and agreed that it contained information of a non-medical nature, including opinions and Respondent's position regarding the claim. RX 2, p. 45-47. Dr. Desai testified she charged $12,000.00 for her review, not including $1,000.00 per hour for her deposition. RX 2, p. 63.

CONCLUSIONS OF LAW

With regard to issue (C), Accident, the Arbitrator finds as follows:

After a review of the totality of the evidence, the Arbitrator finds that the Petitioner has clearly established an exposure, as defined by the Workers' Occupational Diseases Act, in the course of his employment with Respondent. "To recover compensation under the Act, a claimant must prove both that he or she suffers from an occupational disease and that a causal connection exists between the disease and his or her employment." *Bernardoni v. Industrial Comm'n*, 362 Ill.App.3d 582, 594, 298 Ill.Dec. 530, 840 N.E.2d 300, 310 (2005). While a disease may be compensable under the Illinois Workers' Compensation Act if it is either aggravated or caused by accidental injury or trauma, the Workers' Occupations Diseases Act applies to diseases caused or aggravated

by a "gradual insidious process." *Permanent Const. Co. v. Industrial Commission*, 380 Ill. 47, 43 N.E.2d 557, 141 A.L.R. 1484 (1942).

An occupational disease is defined as "a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d) (West 2004).

Under the Workers' Occupational Diseases Act, an employee experiences exposure "when, for any length of time, however short, he or she is employed in an occupational process in which the hazard of the disease exists." 820 Ill. Comp. Stat Ann. 310/1(d). An employee is not required to provide any proof of the amount, time, or duration of exposure. An employee does not have to identify the particular exposure from employment that caused the disease. Proof of a hazardous exposure is "conclusively established" when the employee proves employment in an occupation in which the hazard exists. *See Freeman United Coal Min. Co. v. Industrial Com'n,* 188 Ill. 2d 243, 242 Ill. Dec. 108, 720 N.E.2d 1063 (1999).

"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." *Caterpillar Tractor,* 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d at 667. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor,* 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d at 667. *See Knox County YMCA v. Industrial Comm'n,* 311 Ill.App.3d 880, 244 Ill.Dec. 286, 725 N.E.2d 759 (2000).

Dr. Fletcher testified that two of the chemicals to which the Petitioner was exposed were causally related to the development of his kidney disease. They were morpholine and carbon disulfide. He further said that they were used in the production of Cure-Rite 18 powder.

The Petitioner said that between 2003 and 2011 when he worked in Building 725, he was exposed to Cure-Rite 18 powder. He said that he inhaled dust from the product and also had skin contact with it, particularly when he was performing an operation to bag the product.

A co-worker, David Smid, provided corroborative testimony to that of the Petitioner. He said that he also worked in Building 725 during the same period of time. While it was not his regular building, he worked overtime there, performing the bagging operation. He said that the Cure-Rite dust would become airborne and cover the workers like snow. He said that he observed the Petitioner covered with dust while bagging.

Finally, the NIOSH study based upon air samples taken in July 2013 showed that workers were exposed to excessive amounts of the two chemicals when performing the bagging operation described above.

Based upon the above evidence, which was basically unrebutted, the Petitioner has proven that he was exposed to hazardous chemicals. The next issue is whether the exposure and the chemicals are causally related his conditions of ill being.

With regard to issue (F), Causal Connection, the Arbitrator finds:

After a review of the totality of the evidence, the Arbitrator finds that Petitioner's membranous nephropathy, and associated resulting symptomatology, including but not limited to, hypertension and diabetes, arose out of and in the course of his repetitive chemical exposure, which manifested on October 28, 2011.

An occupational disease is compensable if it is a causative factor in the resulting disability or condition of ill-being, even if other non-occupational factors contribute to the condition. *Old Ben Coal Co. v. Industrial Com'n*, 217 Ill. App. 3d 70, 159 Ill. Dec. 967, 576 N.E.2d 890 (5th Dist. 1991) (the appellate court affirmed disability benefits for the claimant as a result of occupational pneumoconiosis—from his work as a coal miner—even though he had smoked a pack of cigarettes a day for thirty-five years).

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

Medical testimony was provided by Dr. David Fletcher, Dr. Shirley Conibear, and Dr. Amishi Desai. Dr. Fletcher testified he first saw Petitioner on November 16, 2011, at which time he had been diagnosed with membranous nephropathy. TR, p. 150. Both Dr. Conibear and Dr. Desai agree with Petitioner's diagnosis of membranous nephropathy, however, a dispute exists as to whether Petitioner suffers from primary idiopathic membranous nephropathy, or secondary membranous nephropathy.

Dr. Fletcher testified the pathology report from Petitioner's June 17, 2011 renal biopsy is the key document regarding the causation of Petitioner's condition. TR, p. 165, PX 39. Dr. Fletcher testified that, with secondary membranous nephropathy, immune complexes are deposited on the membrane called the mesangi. TR, p. 164. He testified that these deposits distinguish between primary or secondary membranous nephropathy. TR, p. 164.

Dr. Fletcher testified Petitioner's June 17, 2011 renal biopsy revealed the presence of mesangial deposits. TR, p. 164-165. He testified the renal biopsy confirms that Petitioner has an occupational-related renal disease because he had mesangial deposits, which indicates secondary membranous nephropathy. TR, p. 165. Dr. Fletcher testified that, for a diagnosis of primary membranous nephropathy, he would expect there to be no mesangial deposits. TR, p. 167. Dr. Fletcher testified two chemicals, morpholine and carbon disulfide, are nephrotic and cause immune system reactions which cause membranous nephropathy, and that there is some research that hydrocarbon solvents such as methylene chloride and hydrogen sulfide are also potentially nephrotic. TR, p. 158.

While Dr. Desai disagreed that the mesangial deposits indicated secondary membranous nephropathy, she agreed that mesangial deposits can be evidence of a secondary cause, and that she could not rule out a secondary cause based on the biopsy report. RX 2, p. 61. She also testified that she was not aware of the extent of the mesangial deposits in Petitioner's case. RX 2, p. 79. Finally, she agreed that while she felt the Petitioner had idiopathic membranous nephropathy, she could not rule out exposure to a secondary cause given the mesangial deposits. RX 2, p. 63. Dr. Fletcher, however, testified that he had reviewed the color photographs of the biopsy. TR, p. 166. Dr. Conibear testified she did not review any pathology reports related to Petitioner's renal biopsy, and that she does not know the significance of mesangial deposits as they relate to causation. RX 1, p. 44.

Further, both Dr. Conibear and Dr. Desai deny the presence of medical literature which identify occupational exposure as being a cause of membranous nephropathy. As such, they deny that Petitioner's exposure could be a secondary cause of membranous nephropathy. Contrary to this position, however, Dr.

Fletcher testified extensively regarding his review of a wide body of literature supporting a causative link to chemical exposure and secondary membranous nephropathy. TR, p. 169-179, PX 51-56. Dr. Fletcher also testified regarding a case study linking carbon disulfide exposure and proteinuria, which was Petitioner's manifestation. Fletcher Dep., p. 30-31, PX 58. The assertions made by both Dr. Conibear and Dr. Desai that there are no studies linking occupational exposure with secondary membranous nephropathy are therefore contradicted by the evidence.

Moreover, Dr. Fletcher testified that if Petitioner had primary, or idiopathic, membranous nephropathy and was removed from the exposure, he would expect the condition to continue to progress. TR, p. 171-172. He testified the fact that Petitioner had not gotten worse and has remained in remission is evidence of the causal relationship. TR, p. 172. Dr. Fletcher also testified that in assessing an occupational disease case, it is very important to look at the frequency, duration, and intensity of exposure. TR, p. 204. He testified that there is no doubt in his mind Petitioner meets the criteria for an occupational exposure. TR, p. 205.

Finally, having reviewed the totality of the evidence, the Arbitrator gives more weight to the opinions of Dr. Fletcher than to those of Dr. Conibear or Dr. Desai. First, as Petitioner has been examined by Dr. Fletcher on numerous occasions since 2011, Dr. Fletcher had significantly more time to examine, evaluate and treat Petitioner. Further, while Dr. Conibear performed an examination of Petitioner on August 28, 2015, Dr. Desai did not examine Petitioner.

Second, as is noted above, both Dr. Conibear and Dr. Desai state that there is no literature supporting a causal link, contrary to the body of literature he reviewed. TR, p. 179. Dr. Fletcher, on the other hand, testified extensively regarding the medical research he conducted regarding the causal relationship between chemical exposures and membranous nephropathy. TR, p. 168-169. Copies of medical literature relied upon by Dr. Fletcher have been entered into evidence.

Third, Dr. Fletcher has demonstrated a greater understanding of the conditions of the plant and chemicals Petitioner was exposed to. He testified he visited the outside of the plant, and that he was involved in the NIOSH inspection of the plant and communicated frequently with the NIOSH investigators. TR, p. 190. Neither Dr. Conibear nor Dr. Desai visited the plant. Further, Dr. Conibear testified that during her evaluation of Petitioner they did not discuss the specific chemicals Petitioner was exposed to in the plant, and that she did not review any Material Safety Data Sheets. RX 1, p. 16-17. With respect to Dr. Desai, she testified that the Material Safety Data Sheet for BBTS listed kidney effects, but that she did not include this in her report, and that her supplemental report did not include all the chemicals for which she was provided Material Safety Data Sheets. RX 2, p. 53, 56.

Dr. Sparrow has been the Petitioner's treating specialist since diagnosing the condition back on May 26, 2011. The Arbitrator has reviewed his office records through May 17, 2018 and concludes that the doctor did not ever render an explained opinion on causation. At the initial office visit, it does not appear that any discussion was had concerning the Petitioner's job duties or exposures. Dr. Sparrow diagnosed primary glomerulopathy, meaning idiopathic, as he could identify no obvious secondary cause. On June 17, 2011, the Petitioner underwent the biopsy which revealed the mesangial deposits. At the next office visit of June 23, Dr. Sparrow concluded the Petitioner's condition was most likely idiopathic, although he did have some mesangial deposits. Dr. Sparrow continued to characterize the disease in that fashion until February 23, 2012, when he determined the Petitioner to be in partial remission.

Dr. Harris from Neuropath interpreted the biopsy and issued a report dated June 18, 2011. He said that the presence of mesangial immune deposits raised suspicion for secondary membranous glomerulopathy of which etiologic agents could include certain drug exposures. PX 39 His comments came after he viewed the biopsy results after staining. This interpretation differs from that of Dr. Desai.

The parties both question the credibility of their experts. The Respondent argues that Dr. Fletcher is biased because he was hired by the Petitioner's attorney to get involved in the case and because he acknowledged during his testimony that he considered himself to be an advocate for the Petitioner's position on compensability. The Petitioner challenges the impartiality of Dr. Desai because her brother is a partner in the law firm representing the Respondent in this case. The Arbitrator recognizes the arguments and finds them to have some merit. However, he believes that both Dr. Fletcher and Dr. Desai based their opinions on their experience and extensive documentation pertaining to this case. In general, both witnesses are credible.

Caselaw supports the Petitioner's claim. In *Beeler v. Indus. Comm'n*, 179 Ill. App. 3d 463, 534 N.E.2d 408 (5th Dist. 1989), the Appellate Court found that the determination of Industrial Commission that the decedent's exposure to zinc oxide dust in the course of his employment was causally related to his death was not against manifest weight of the evidence where the evidence established that the decedent complained of dust in the workplace to his medical providers, as set forth in his medical records, and his treating physician opined that exposure to zinc oxide dust aggravated his pre-existing respiratory condition. The Court upheld this decision despite Respondent's arguably more qualified independent medical evaluator testifying that zinc oxide dust was harmless in any quantity.

In *Jarrett v. Indus. Comm'n of Illinois*, 156 Ill. App. 3d 898, 511 N.E.2d 144 (4th Dist. 1987), the Appellate Court held that for purposes of determining the claimant's entitlement to benefits under Workers' Occupational Diseases Act, the Industrial Commission's finding for the claimant who occasionally worked in conditions in which he breathed and swallowed phenothiazine and had dust on his sweaty skin was not against manifest weight of evidence. Phenothiazine was used on the jobsite at least several days during almost every month of year, the claimant was responsible for dumping phenothiazine into a hopper over extended period, and protective masks may not have been available to the claimant over a period of years. Furthermore, the Court held the commission as entitled to rely on the opinions of the claimant's treating physicians, who held the claimant's seizure disorder was caused by the exposure, despite contradictory testimony from the employer's experts.

Considering the above, the Arbitrator finds that the Petitioner's neurotoxic encephalopathy and hypertension arose out of and in the course of his repetitive chemical exposure while working for the Respondent.

The amended accident date of November 16, 2011 is the date of the Petitioner's initial examination with Dr. Fletcher. A review of the office note from that visit shows that the condition and the possibility that it might be related to work exposures were considered. PX 6A Accordingly, the Arbitrator finds that this is an appropriate manifestation date.

In regard to (J), Medical, the Arbitrator finds:

An employer is required to provide or pay for "all the necessary first ad, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a). An employer's liability continues as long as the medical services are required to relieve the injured employee from the effects of the injury. *Efengee Electrical Supply Co. v. Industrial Comm'n,* 36 Ill.2d 450, 453, 223 N.E.2d 135 (1967); Elmhurst Memorial Hospital, 323 Ill.App.3d at 764. *Morrison Senior Dining v. Illinois Workers' Comp. Comm'n*, 2013 IL App (1st) 120979WC-U. The claimant bears the burden of proving, by a preponderance of the evidence, his entitlement to an award of medical expenses under Section 8(a). *Max Shepard, Inc. v. Industrial Comm'n,* 348 Ill.App.3d 893, 903, 284 Ill.Dec. 401, 810 N.E.2d 54 (2004); *Westin Hotel v. Indus. Comm'n of Illinois*, 372 Ill. App. 3d 527, 546, 865 N.E.2d 342, 359 (2007).

The standard of reasonableness is that which is usual and customary for similar services in the community where the services were rendered. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill.App.3d 641, 650,

164 Ill.Dec. 181, 187, 582 N.E.2d 744, 750 (1991); *Ingalls Mem'l Hosp. v. Indus. Comm'n*, 241 Ill. App. 3d 710, 717, 609 N.E.2d 775, 781 (1993).

While Dr. Conibear and Dr. Desai dispute a causal relationship between Petitioner's occupational exposure and his current condition of ill-being, neither offered any testimony that Petitioner's treatment had been unreasonable or unnecessary.

Further, Dr. Fletcher testified he believed there was a relationship between Petitioner's renal disease and his hypertension and diabetes. TR., p. 200. Dr. Sparrow also opined that Petitioner's hypertension and high blood pressure were likely related to glomerulonephritis. PX 4. Dr. Conibear agreed that Petitioner's high blood pressure was a result of a combination of his kidney disease and his medications. RX 1, p. 45. The Arbitrator therefore finds Petitioner's treatment for hypertension and diabetes to be reasonable, necessary, and related to his occupational exposure.

As such, the Arbitrator finds that the Respondent shall pay Petitioner's medical bills, as outlined in Petitioner's Exhibit 37, directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8.2 of the Act. Respondent shall resolve any subrogation claims asserted by Humana for payments made for related medical treatment, and hold Petitioner harmless against said subrogation claims. Respondent shall reimburse Petitioner for out-of-pocket payments for related medical expenses in the amount of $1,410.00.

In regard to (K), Temporary Total Disability, the Arbitrator finds:

A claimant is temporarily and totally disabled from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of her injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n,* 138 Ill.2d 107, 149 Ill.Dec. 253, 561 N.E.2d 623 (1990). To be entitled to TTD benefits, it is a claimant's burden to prove not only that he did not work, but also that he was unable to work. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n,* 236 Ill.2d 132, 148, 337 Ill.Dec. 707, 923 N.E.2d 266 (2010); *Westin Hotel v. Industrial Comm'n,* 372 Ill.App.3d 527, 542–43, 310 Ill.Dec. 18, 865 N.E.2d 342 (2007); *Shafer v. Illinois Workers' Comp. Comm'n,* 2011 IL App (4th) 100505WC, 976 N.E.2d 1, 13.

On October 27, 2011 Dr. Sparrow examined the Petitioner and gave him a note to be off work. PX 8. The Petitioner, it should be noted, testified that he had not worked for the Respondent since March 16, 2011, when he was part of a company lock-out due to a labor dispute.

The Arbitrator finds that Petitioner reached maximum medical improvement on February 23, 2012, at which time Dr. Sparrow opined that he was in partial remission. The evidence supports that as a result of his injuries and treatment, Petitioner missed work from October 27, 2011 through February 23, 2012, totaling 17 weeks. As such, the Arbitrator orders Respondent to pay $981.29 per week for a period of 17 weeks, representing the temporary total disability owed to Petitioner, as provided in Section 8(b) of the Act.

Petitioner received sort-term disability and long-term disability benefits for a period of time for which Respondent is due a credit pursuant to section 8(j) of the Act. Petitioner also testified that he had to reimburse Cigna for long-term disability benefits paid. At the time of Arbitration, the parties were unable to ascertain the amount of said credit. Upon agreement of the parties, the Respondent shall receive a credit pursuant to section 8(j), excepting amounts paid by Petitioner to reimburse Cigna, for short-term and long-term disability benefits received against the award of temporary total disability benefits.

With regard to issue (L), Nature and Extent, the Arbitrator finds as follows:

Petitioner testified that he has not worked since March 2011 when he was part of a labor dispute with the Respondent. He testified that he is receiving social security disability benefits at the present time. His current symptoms include swelling of the legs, fatigue, excessive urination and back pain.

Dr. Sparrow's treatment notes were admitted into evidence. They show that on February 23, 2012, the Petitioner was deemed to be in partial remission as a result of his blood tests. He was found to have significant muscle fatigue and weakness which the doctor said were most likely steroid induced. Over the next year the Petitioner's symptoms waxed and waned, as the doctor tried to adjust his medicine. On January 30, 2013, Dr. Sparrow filled out a Physical Ability Assessment form, placing the Petitioner at the Medium Work level. He opined that the Petitioner could lift 10 pounds regularly and up to 50 pounds a third of the day. On December 12, 2013, Dr. Sparrow opined that the Petitioner was limited to Sedentary work on a form for Cigna Insurance. He completed another Physical Ability Assessment form on January 15, 2014 stating the same thing. The next actual treatment note offered into evidence was an examination done on May 17, 2018. Dr. Sparrow noted that the Petitioner continues in remission, felt reasonably well and had well controlled hypertension. He was found to have pitting edema of the lower legs.

The only other treating doctor was the PCP, Dr. Faber. His notes are sparse with respect to the Petitioner's work- related conditions. He did note during an examination on May 23, 2014 that the Petitioner had mild pedal edema. PX 1

Petitioner is claiming entitlement to an odd lot permanent and total award. However, the request is based upon the assertion that Dr. Sparrow has kept the Petitioner off work since his treatment began. As noted above, that is not the case. The Petitioner is now 51 years old. He presented no evidence that he looked for work within his restrictions. His restrictions are significant however. A Sedentary work restriction decreases his occupational base.

Based upon the above, the Arbitrator awards the Petitioner 40 % Person As A Whole under Section 8 (d) (2) 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VSEVOLOD SMOVSKIY,
Petitioner,

vs.

NO: 18WC 2058

19IWCC0431

STATE OF ILLINOIS,
IYC - ST. CHARLES,
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 temporary total disability and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 11, 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.

AUG 12 2019

DATED:

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

DDM/tdm
d: 7/17/19
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMOVSKIY, VSEVOLOD (STEVE)
Employee/Petitioner

Case# **18WC002058**

19IWCC0431

STATE OF ILLINOIS-IYC-ST CHARLES
Employer/Respondent

On 9/11/2018, 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 2.26% 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:

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

6153 ASSISTANT ATTORNEY GENERAL
ALYSSA SILVESTRI
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 62794-8255

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

SEP 11 2018

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

19IWCC0431

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Vsevolod (Steve) Samovskiy
Employee/Petitioner

v.

State of Illinois-IYC-St. Charles
Employer/Respondent

Case # **18** WC **2058**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **August 7, 2018**. By stipulation, the parties agree:

On the date of accident, **June 1, 2017**, 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 **$52,668.00**, and the average weekly wage was **$1,012.85**.

At the time of injury, Petitioner was **29** 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 **$2,508.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$2,508.00**.

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

Per the stipulation of the parties, the medical bills submitted as PX 1 either have been paid by Respondent or shall be paid directly to the providers by Respondent, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $675.23/week for 3 5/7 weeks, commencing June 11, 2017 through July 6, 2017, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $2,508.00 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner the sum of $607.71/week for a further period of **2.2** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of use of the left little finger**.

Respondent shall pay Petitioner compensation that has accrued from **June 1, 2017** through **August 7, 2018**, 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

September 7, 2018
Date

ICArbDecN&E p.2

SEP 11 2018

19IWCC0431

Statement of Facts

Petitioner Steve Samovskiy testified that on June 10, 2017, he was employed by Respondent IYC-St. Charles as a Juvenile Justice Specialist. He had been employed by Respondent for 2 years and 3 months. He testified that on June 10, 2017, he observed a youth swing on another correction officer. He went to help and assist restraining him and as they were restraining him, Petitioner was kicked in the left pinky finger. The medical history documents that while attempting to secure a youth in restraints, he was kicked and then caught his left small finger in the chains of the handcuffs.

Petitioner was seen at Physicians Immediate Care on June 11, 2017 (PX 3). Petitioner reported the work injury and complained of constant pain in the left fingers. Petitioner reported a prior fracture of the finger in the past. The physical examination noted a deformity of the left little finger PIP joint. There was tenderness, loss of motion and swelling noted. X-rays noted an old fracture of the proximal phalanx with degenerative changes with ossific density. Petitioner was diagnosed with a sprain of the interphalangeal joint of the left little finger (PX 3).

Petitioner was seen by Dr. Biafora on referral from Physicians Immediate Care on June 15, 2017 (PX 4). He provided a consistent history of accident. He reported a fracture to the left small finger about 10 years ago. He has a small deformity at the PIP joint thereafter. He described swelling and mild deformity. He denied any functional loss. The physical examination noted mild to moderate swelling with an abrasion. Dr. Biafora noted that there was a clear bony deformity of the left small finger revealed on x-ray that pre-existed the recent work injury. He assessed a ligament strain. He recommended buddy strapping the finger (PX 4). Dr. Biafora saw Petitioner on July 6, 2017. He noted improvement. Petitioner still had a 10 to15 degree flexion contracture of the PIP. The remainder of his examination was normal. He noted possible trace swelling. He released Petitioner to return to unrestricted work (PX 4)

Petitioner was also seen by Dr. Carl Hill (PX 5). Dr. Hill first saw Petitioner on July 6, 2017. His notes reflect an incident occurred 12 to 24 hours ago. Petitioner reported pain in the left hand of 8/10. Physical exam records decreased range of motion, tenderness and bony tenderness of the left hand. Dr. Hill diagnosed a dislocated finger on the left hand. He saw Petitioner again on August 4, 2017. He released Petitioner to unrestricted work (PX 5).

Petitioner testified he returned to full duty work. He testified he notices pain especially in the wintertime, in the course of his job duties, when the temperature changes, and with the physical and strenuous conditions of his job. He constantly uses his hands, whether restraining individuals, retrieving items or putting on gloves. It becomes an issue because the finger constantly swells up. It is easy to reinjure. He carries some ibuprofen occasionally in case there is a flare-up.

Conclusions of Law

In support of the Arbitrator's decision with respect to 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 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 Juvenile Justice Specialist at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that his duties require him to restrain inmates and other unexpected uses of his hands. 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 29 years old at the time of the accident. He would be considered a younger worker and, even though he had a pre-existing finger deformity as well as the injury, he would be expected to in the work force using his hands for an extended period of time. 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 has returned to his regular job and has been place on no physical limitations. 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 had a prior fracture to the left little finger. Dr. Biafora noted the angulation and swelling were related to this pre-existing condition. Petitioner suffered a sprain of the little finger. His treatment consisted of buddy strapping. He was returned to full unrestricted duty by Dr. Biafora on July 6, 2017. Dr. Hill's physical exam records decreased range of motion, tenderness and bony tenderness of the left hand. He diagnosed a dislocated finger on the left hand. Because of these facts, 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 left little finger pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emily Purcell,

Petitioner,

vs. No. 16 WC 30424

University of Illinois,

Respondent.

19IWCC0432

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 disability and permanent disability, and being advised of the facts and law, affirms with changes the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms the Arbitrator's finding that Petitioner was not a traveling employee at the time of the accident. See *Allenbaugh v. Workers' Compensation Comm'n*, 2016 IL App (3d) 150284WC. However, the Commission disagrees with the Arbitrator that Petitioner was not acting in the course of her employment at the time of the accident. Petitioner was on Respondent's campus, on her way to drop off her time card before starting work. Thus, she was injured on Respondent's premises within a reasonable time period before commencing her job duties, which is sufficient to satisfy the "in the course of" test. See *Chicago Transit Authority v. Industrial Comm'n*, 61 Ill. 2d 78 (1975); *Deal v. Industrial Comm'n*, 65 Ill. 2d 234, 238-39 (1976).

The Commission affirms the denial of the claim for failure to prove the accident arose out of Petitioner's employment with Respondent. Petitioner failed to establish a causal nexus between the risk of injury and the employment. See *Caterpillar Tractor Co. v. Industrial*

19IWCC0432

Comm'n, 129 Ill. 2d 52 (1989); *McAllister v. Workers' Compensation Comm'n*, 2019 IL App (1st) 162747WC.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 21, 2018, is hereby affirmed with changes.

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

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

DATED: AUG 13 2019
o-07/17/2019
SM/sk
44

Stephen Mathis

Douglas McCarthy

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PURCELL, EMILY
Employee/Petitioner

Case# **16WC030424**

UNIVERSITY OF ILLINOIS
Employer/Respondent

19IWCC0432

On 9/21/2018, 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 2.29% shall accrue from the date listed above to the day before the 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

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

0734 HEYL ROYSTER VOELKER & ALLEN
JOSEPH K GUYETTE
301 N NEIL ST SUITE 505
CHAMPAIGN, IL 61824-1190

1073 UNIVERSITY OF ILLINOIS
100 TRADE CENTER DR
SUITE 103
CHAMPAIGN, IL 61820

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

SEP 21 2018

Brendan A. Purcell, Acting Secretary
Illinois Workers' Compensation Commission

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

EMILY PURCELL
Employee/Petitioner

v.

UNIVERSITY OF ILLINOIS
Employer/Respondent

Case # **16** WC **30424**

Consolidated cases: _____

19IWCC0432

An *Application for Adjustment 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 **Urbana**, on **July 11, 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 **September 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 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**6,882.06**; the average weekly wage was $**553.13**.

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

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that she sustained an accident which arose out of and in the course of her employment on September 9, 2016. All benefits are denied.

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

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

Signature of Arbitrator

September 18, 2018
Date

SEP 21 2018

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

19IWCC0432

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

EMILY PURCELL
Employee/Petitioner

v. Case #: **16 WC 30424**

UNIVERSITY OF ILLINOIS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties agreed that Petitioner sustained an accident on September 9, 2016, which resulted in injuries to her right elbow, and that her injuries were causally related to the accident. Respondent disputed that the accident arose out of and in the course of her employment. Respondent further disputed liability for medical bills, temporary total disability, and permanent partial disability, but stipulated that the dispute as to those issues stemmed from accident only.

On September 9, 2016, Petitioner was 30 years old, single, and had no dependent children. She was employed as an administrative assistant on a temporary or "extra help" basis. She testified that her regular work hours were 8:30 a.m. to 5:00 p.m., Monday through Friday, and that she was paid for 7.5 hours per day. Her primary job duty was to facilitate the day-to-day operations of the Mortenson Center, a group that focuses on international libraries. She testified that her job required her to leave her office located in the Undergraduate Library on a daily basis to perform various duties around campus and that she worked with departments on and off campus for purposes of event planning and coordination. She testified that when she had to go to other campus buildings she would generally walk but would also take the bus. She occasionally gave tours of the campus, which involved walking around with international visitors. She managed her own daily schedule, decided when to complete various tasks, and decided what route to take when moving about on and off campus. She testified that she never drove her own vehicle to work, as parking was expensive and was not available near her office.

Petitioner testified that she was required to turn in her time card at the Personnel Services Building every other Friday. She described this as a "job duty". She testified that she would typically walk from her office to the Personnel Services Building or take the bus through campus and that she was not directed by Respondent as to the route she had to take to complete this task. She was not required to drop off the time card at any particular time of day and testified that she

"always" did so during her work hours, but sometimes did so before she went to her office in the morning, and never did so during her lunch hour.

Petitioner testified that on September 9, 2016, she took the (Brown line) bus to campus for work and was dropped off at approximately 8:20 a.m. on the east side of Sixth Street, near its intersection with Gregory Drive. She reviewed Petitioner's Exhibit 1B and marked with an "X" where the bus dropped her off. She testified that after she exited the bus she intended to walk to the Personnel Services Building to drop off her time card. She noted that the Personnel Services Building was in the opposite direction from her office in the Undergraduate Library. She testified that she walked to the back of the bus and walked west across Sixth Street with the intention of turning north on Sixth Street and then turning west on Gregory in order to walk to the Personnel Services Building. She marked with an "O" where she crossed Sixth Street (PX1B) and noted this was the most direct route across the street.

Petitioner testified that after she crossed Sixth Street she attempted to "hop" over the chain barrier/fence located in front of the Business Instructional Facility Building. She reviewed Petitioner's Exhibit 1C and marked with an "X" where she went over the chain. As she attempted to go over the chain, the heel of her shoe got caught and she fell onto her right elbow. She testified that after she fell she realized that she had dislocated her elbow. She was able to get up with the assistance of a woman later identified as Deanna.

Following her fall, Petitioner was taken by ambulance to Presence Covenant Medical Center. She followed up with Carle Trauma Services and Carle Department of Hand Surgery and ultimately underwent surgery on September 19, 2016. She did not work between September 14, 2016, and the date of her surgery. Following surgery, she underwent a course of physical therapy at Carle but moved to Roswell, New Mexico for a new job before therapy was completed. She testified that she was not financially able to resume her physical therapy until after her employer-sponsored health insurance began. She was seen by a nurse practitioner in Roswell shortly thereafter, who referred her to Sun Country Physical Therapy. After undergoing an initial evaluation there, she began receiving physical therapy services at Sprint Sports Rehabilitation Clinic. Her initial therapy visit was on February 22, 2017, and her records from that visit document that she presented with decreased range of motion and required skilled therapy to address increased pain, decreased strength, decreased range of motion, and decreased function. Objective measurements were taken on that date showing that her right elbow extension was significantly decreased. Petitioner testified that after attending six additional therapy visits, she discontinued therapy pre-maturely because she could not afford the co-payment and she did not feel that continuing formal therapy was of benefit.

Petitioner testified that currently she continues to have reduced range of motion with her right arm, which she demonstrated to the Arbitrator. She noted that the lack of full extension hinders her work, as it makes it difficult to reach up for books and other materials. She explained that she continues to have pain in her elbow and takes Ibuprofen on a daily basis. In addition, she is no longer able to perform certain poses in yoga.

On cross-examination, Petitioner acknowledged that she was an extra help employee, meaning that she was a temporary employee without benefits, sick leave, vacation leave, or

insurance. She acknowledged she was paid on an hourly basis, that she was not paid for lunch, was not paid for the time that it took her to travel from home to get to work, and was not paid for the time it took her to travel from work to home at the end of the day.

Petitioner admitted that, on the occasions when she would go out and do something on campus in conjunction with her employment, it was done at the direction of her supervisor Clara Chu or another supervisor. She acknowledged that she has her own office and desk at the Undergraduate Library.

Petitioner initially testified that she was told by her supervisor, Clara Chu, that she was allowed to turn in her time card during her work hours. She further testified that an HR representative for the University, Skye Arseneau, also told her that she could turn in her time cards during work hours. She subsequently testified, however, "It was just understood that, as this was a function of my job and I was required to physically turn it in, that I would be able to do it during my work day." Finally, she testified that she did not know if somebody actually told her that she was able to turn her time cards in during work hours.

Petitioner acknowledged that she got off the bus before her work day began and admitted that the time she fell was before her work day began. She admitted that there was no defect with regard to the chain fence or the ground around the fence where she fell.

Petitioner explained that the route she took to cross the street was the most direct route. She acknowledged that approximately 10-15 feet to the left of where she fell, there was no chain that would have been blocking her route. She admitted that there were no obstructions or anything else that would have prevented her from taking a route that would have allowed her to avoid the chain fence. She admitted that she could have walked further south to use the actual cross walk, where there was no chain blocking her route. She acknowledged that it would have been safer to use a route that did not require her to cross the chain, and that taking the safe route would have taken no more than a couple of extra seconds.

On re-direct, Petitioner confirmed there were no other errands that she completed for her employer before arriving to her office. She testified that her supervisor never advised her to turn in her time card outside of work hours.

Petitioner called her direct supervisor, Clara Chu, as a witness. She is a Librarian Faculty at the University. She testified that Petitioner's job duties required her to leave the office "at times", and that she would walk between the buildings on campus when completing those duties. She was aware that Petitioner took the bus to work. She testified that Petitioner's work day began at 8:30 a.m., but noted there was flexibility to start later if, for example, her bus was late. Ms. Chu testified that temporary employees, including Petitioner, were required to turn in time cards at the Personnel Services Building in order to get paid. She noted that Petitioner typically turned in her time card every other Friday, but that it could be done at any time prior. She testified that she did not instruct Petitioner to turn in the time card at a certain time of day nor to turn it in outside of work hours. She noted, however, "My assumption would be that she would turn it in during her breaks, like lunch or so forth, or after."

Respondent called Ms. Skye Arseneau as a witness. She is the Human Resources Associate with the Main Library at the University of Illinois campus and has been in that position since November 2011. Prior to that she worked in the Extra Help Division at Staff Human Resources. She explained that "extra help" employees are hourly, at-will employees and she stated, "They are only paid for the time that they are actually working."

Ms. Arseneau testified that time reporting must be done very accurately and that extra help employees can be marked off for as little as one minute. She testified that these employees were supposed to complete their timesheets during non-work hours and that they were not paid for the time it took to physically drop off their time cards. She noted that the time cards were to be turned in before work, at lunch, or after work. She explained that there is an exterior drop box at the Personnel Services Building so that employees can turn in time cards even when the department is closed. She testified that extra help employees are told during their information session that time cards are not to be turned in during work hours. She acknowledged, however, that she had no personal knowledge that Petitioner was so informed.

Petitioner testified on rebuttal that she never attended any training prior to becoming employed as an extra help Administrative Assistant and that she was never asked to attend such a training session. She further testified that she was not advised by anyone that her time cards were to be turned in during non-work hours. On cross-examination, she admitted that her time card reflected that she worked three hours on the first day that she was employed as an extra help employee. She explained that she spent those three hours working with Skye Arseneau, filling out paperwork.

Petitioner's Exhibit 3 is an email exchange of September 9, 2016, between Deanna Dale of the University's College of Business and Clara Chu, Petitioner's supervisor. The emails indicate that Petitioner called out to her as she was preparing to enter the building and advised she had fallen and could not use her arm. She helped Petitioner up, gathered her personal effects, took her to the office, and arranged for the EMTs to be called.

Petitioner's Exhibit 1 is three photographs showing the location of her fall. The first photograph depicts the chain that caused the Petitioner to trip (PX1A). The second photograph shows the location of the incident, as Petitioner testified to and marked accordingly. The Arbitrator notes that the picture also shows the crosswalk referenced in Petitioner's testimony, which is not far from the location where she indicated that she actually crossed (PX1B). The third photograph shows the area where Petitioner fell, from the view across the street at approximately the location where she crossed. The Arbitrator notes that the chain ends slightly to the left of where Petitioner fell, beyond which the street is not separated from the sidewalk by any type of chain or fence or barrier (PX1C). Respondent's Exhibit 5 is seven photographs showing the same area.

Petitioner's Exhibit 2 is a map of the University. It shows that Petitioner's office in the Undergraduate Library (#99 at D4) is to the south of the main quad, slightly on the east side of the map. The Personnel Services Building (#154 at D2), where Petitioner was going in order to turn in her time card, is at the far west side of campus.

Respondent's Exhibit 1 is the First Report of Injury, completed by Ms. Arseneau, which indicates that Petitioner's work hours were 8:30 a.m. to 5:00 p.m. Respondent's Exhibit 2 is the Public Injury Report, which indicates that Petitioner's fall occurred at approximately 8:25 a.m.

Following the accident, Petitioner was taken by ambulance to Presence Covenant Medical Center. It was noted she had no range of motion and obvious deformity in her right elbow secondary to a fall that morning. X-rays revealed dislocation of the elbow joint and a fracture of the radial head. PX4, PX5. Petitioner was transferred to Carle Hospital Orthopedics and she was evaluated by Dr. Mark Palermo. As to history, Dr. Palermo stated, "She was walking into work this morning, she stepped over a chain which was intended to block cars from driving whether or not supposed to on University property. She got her foot snagged on the chain and fell landing on her right upper extremity." Petitioner underwent a closed reduction under conscious sedation, was put in a long arm splint, and was discharged home with a prescription for Norco. She was advised to follow up with Carle pending the results of a CT scan taken that day. PX6.

On September 11, 2016, Petitioner presented to Carle Hospital emergency room and requested a refill of her Norco prescription. It was noted that her follow up appointment with Orthopedics had not yet been scheduled by the department and that Petitioner appeared to be taking her medication as prescribed. For that reason, the prescription was refilled. PX7.

On September 12, 2016, Petitioner presented to the Hand Surgery Clinic at Carle and reported her current level of pain was 5/10. On examination, there was a significant amount of swelling of the upper arm and elbow and down the hand. The CT scan was reviewed, which showed a comminuted radial head fracture, coronoid fracture, and "felt to be" avulsion fractures, consistent with medial and lateral collateral ligament injuries. Surgery was recommended, to include open reduction and internal fixation of the right radial head/right radial head replacement, possible repair of the coronoid, and possible repair of the collateral ligaments. Surgery was scheduled for September 19, 2016, after preoperative screening. Petitioner's long arm splint was replaced, and x-rays were taken that showed satisfactory reduction of the elbow. Petitioner indicated that she would like to return to work for Respondent preoperatively and she was allowed to do so "as long as she is not on narcotic pain medication and is comfortable in her splint and sling." It was also discussed that she would likely need be off work postoperatively for 10-14 days, based upon her findings in the operating room. PX8.

On September 19, 2016, Petitioner underwent surgery by Dr. Clifford Johnson at Carle Hospital. The surgery consisted of (1) open treatment of right elbow fracture dislocation; (2) open reduction and internal fixation of right radial head; and (3) repair of right elbow lateral ulnar collateral ligament. Intraoperatively, the ulnar collateral ligament was found to be completely avulsed from the humerus. A fracture to the radial head was also observed that encompassed about one-third of it, with two sizeable fragments that were extracted. Postoperative diagnosis was right elbow fracture dislocation. PX11.

Petitioner followed up with Dr. Johnson on November 1, 2016, and reported she was doing very well with no pain. She was doing daily home exercises and working with physical therapy. X-rays showed that the radial head fixation remained in place without complication and that there was satisfactory progression of healing. Physical therapy was upgraded to include active assisted

motion and strengthening. Petitioner was allowed to do most of her normal activities with work, but doing mostly left-handed work. PX12.

Petitioner returned to Dr. Johnson on December 13, 2016, and reported that her pain was only a one or two. X-rays showed appropriate healing of the radial head and neck fractures. It was noted that she was moving to New Mexico, and Dr. Johnson wrote an order for continued therapy and follow up as needed in New Mexico. PX12.

Additional medical records show that Petitioner was seen by Roswell MediCo Clinic on February 9, 2017, and Sun County Physical Therapy on February 16, 2017. PX14, PX15. She was also seen by Sprint Sports Rehabilitation Clinic on February 22, March 3, 10, 24, April 7, 12, and May 3, 2017. PX16.

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 ILS 305/2; *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 201 (2003); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Il.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). 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 (1989).

Generally, an employee injured while going to or returning from her place of employment has not sustained an injury that arose out of or in the course of the employment. *Commonwealth Edison Co. v. Industrial Comm'n*, 86 Ill.2d 534, 537 (1981). In explaining the purpose of this rule, the Supreme Court stated, "The employee's trip to and from work is the product of his own decision as to where he wants to live, a matter in which his employer ordinarily has no interest." *Sjostrom v. Sproule*, 33 Ill.2d 40, 43 (1965). An exception to this rule applies when an employee qualifies as a "traveling employee". A traveling employee is one whose work duties require her to travel away from her employer's premises. A traveling employee is considered to be "in the course of" her employment from the time she leaves her home until she returns. An injury sustained by a traveling employee "arises out of" her employment if she is injured while engaging in conduct that was reasonably foreseeable. In order to qualify as a traveling employee, the work-related travel "must be more than a regular commute from the employee's home to the employer's premises". *Pryor v. Illinois Workers' Compensation Comm'n*, 2015 Ill.App.(2d) 130874 WC.

In this case, Petitioner failed to establish that she was a traveling employee. Her supervisor, Ms. Chu, testified that Petitioner's tasks outside of the building that housed her office were uncommon. Further, when Petitioner had work outside of the library, those tasks were at the specific direction of her supervisor. Ms. Chu did not direct her to undertake any tasks outside of the library on the morning she was injured.

At the time that Petitioner fell, she was walking in the opposite direction of her office in the library. She explained that this was because she was intending to turn in her time card. She testified that it was "understood" that this task could be completed during work hours. That testimony is contradicted by both her supervisor, Ms. Chu, and the University's Human Resources representative, Ms. Arseneau. Petitioner explained that she was never told she could not turn in her time card during work hours. However, her misunderstanding on this issue does not make the activity of turning in her time card a work-related task. Further, Petitioner testified that she had a three-hour session with Human Resources on her first day as an extra help employee. If this topic was not addressed during that session, the Petitioner certainly had an opportunity to resolve any misunderstanding.

The facts of this case establish that Petitioner was not a traveling employee at the time of her accident. She had not yet begun her work day and she was not asked by her supervisor to undertake any tasks outside of her office at the time. To the contrary, at the time that Petitioner was injured, she was engaged in a task that was specifically prohibited during work hours.

Even if, *arguendo,* Petitioner was a traveling employee at the time of her accident, her decision to hop over the fence constitutes a personal risk unrelated to her employment. As a result, the injuries she sustained in this accident would not be compensable.

Only those injuries which "arise out of" and "in the course of" the employment relationship are compensable. Whether an employee's injuries "arise out of" the employment may be determined under two different approaches. First, an injury arises out of the employment where its origin stems from a risk connected with, or incidental to, the employment. 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. Second, an injury arises out of the employment where it is caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment. Under either approach, an injury does not arise out of the employment where an employee voluntarily exposes himself to an unnecessary personal danger solely for her own convenience. *Dodson v. Industrial Comm'n*, 308 Ill.App.3d 572, 575-576 (5th Dist. 1999).

In the *Dodson* case, the claimant was exiting her employer's premises through the employee exit. She then proceeded down several steps of concrete sidewalk leading to the employee parking area. Because it was raining hard, she left the sidewalk and walked across a grassy slope to reach the driver's side of a car. She testified that she walked across the grass because it was the most direct route to her car. While walking on the grassy slope, claimant fell and was injured. In analyzing these facts, the Appellate Court found that claimant's voluntary decision to traverse the grassy slope, instead of the walkway, exposed her to an unnecessary danger entirely separate from her employment responsibilities. In addition, the Court found that claimant's decision not to use

the walkway was for her own benefit and not that of her employer. Consequently, the Court held that claimant's injuries did not arise out of her employment.

In this case, Petitioner's decision to hop over the chain fence had nothing to do with her employment responsibilities. She was simply taking a short cut of her own choosing. Petitioner acknowledged that she could have walked an additional 10 to 15 feet to avoid the chain fence altogether, that the route around the fence would have taken no more than a couple of extra seconds, and that it would have been safer to take a route that avoided the fence. Further, she acknowledged that she did not cross the street in the crosswalk and that by doing so she would have avoided the chain fence as well.

Based on the foregoing and record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident on September 9, 2016, that arose out of and in the course of her employment with Respondent. In fact, the preponderance of the evidence establishes the opposite. All other issues are rendered moot and the Arbitrator makes no findings regarding same. All benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD BLANKUS,

Petitioner,

vs. NO: 12 WC 39388

CITY OF CHICAGO,

Respondent.

19IWCC0433

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, medical expenses, temporary total disability, nature and extent, and "5(b) credit/recovery," 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.

Under the Order section, on page 2 of 7, we strike everything in the first paragraph after the first sentence. We clarify that Respondent is required to pay $3,921.90 for medical expenses under §8(a) of the Act pursuant to the fee schedule in §8.2 of the Act.

We also strike the last two paragraphs on page 2 relating to §5(b) of the Act. Pursuant to *Freer v. Hysan Corp.*, "The plain meaning of section 5(b) imposes the duty of protecting the employer's lien upon the court. ... The statute does not envisage any role for the Industrial Commission in the protection of the employer's right of reimbursement." 108 Ill. 2d 421, 426 (1985). For the same reason, we strike the paragraphs on page 7 relating to Petitioner's Third Party Settlement.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,007.68 per week for a period of 124-4/7 weeks, that being the period of

19IWCC0433

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 $1,007.68 per week for a period of 52 weeks, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,921.90 for medical expenses under §8(a) of the Act pursuant to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,007.68 per week for life, commencing December 12, 2015, as provided in Section 8(f) of the Act, because the injury caused the permanent and total disability of the petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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

Pursuant to §19(f)(2) of the Act, Respondent is not required to file an appeal bond 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 15 2019

Maria E. Portela

D. Douglas McCarthy

L. Elizabeth Coppoletti

SE/
O: 6/18/19
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BLANKUS, RONALD
Employee/Petitioner

Case# **12WC039388**

CITY OF CHICAGO
Employer/Respondent

19IWCC0433

On 8/9/2017, 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:

0728 LAW OFFICES OF THOMAS W DUDA
330 W COLFAX ST
PALATINE, IL 60067

0766 HENNESSY & ROACH PC
ERICA A LEVIN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ronald Blankus
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **12 WC 39388**

19IWCC0433

An *Application for Adjustment 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 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 **Section 5(b) credit/attorneys fees**

FINDINGS

On **July 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 $**78,594.88**; the average weekly wage was $**1,511.44**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**125,672.09** for TTD, $**0** for TPD, $**52,399.36** for maintenance, and $**0** for other benefits, for a total credit of $**178,071.45**.

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

ORDER

Respondent shall pay $3,921.90 for medical services, as provided in Section 8(a) of the Act. Respondent shall provide payment information to Petitioner relative to any credit issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

Respondent shall pay Petitioner temporary total disability benefits of $1,007.68/week for 124 4/7^{ths} weeks, commencing July 21, 2012 through December 12, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,007.68/week for 52 weeks, commencing December 13, 2014 through December 11, 2015, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $$1,007.68/week for life, commencing December 12, 2015, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

Respondent shall receive a credit for any benefits owed until the third party recovery is exhausted, as provided in Section 5(b) of the Act.

Respondent shall pay Petitioner's third party attorney $251.92/week until the third party recovery is exhausted, as provided in Section 5(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.

Milton Black

Signature of Arbitrator

August 9, 2017
Date

AUG 9 - 2017

FACTS

On July 20, 2012, Petitioner was a 60 year old employee of Respondent, working in the water department. Petitioner was a water meter reader, which involved driving his personal vehicle to various residential and commercial locations to record the water usage of city residents. At times, he would have to gain access to a vault or underground site, which would be require the lifting of heavy mid street covers before climbing down a below ground ladder. Petitioner was a high school graduate with no post-high school formal education or vocational training. Before his employment with Respondent, which began in 1987, he had worked as a laborer, delivering pizzas, and as a security guard (PX 27).

On July 20, 2012, Petitioner was driving his personal vehicle at work when it was struck by a truck operated by FedEx Freight Inc. Petitioner testified that he suffered injuries to his head, back and right shoulder. Petitioner was taken by ambulance to the Mercy Hospital emergency room. He was examined, a head CT scan was performed, and he was sent home with instructions to follow up with Mercy Works (PX 3).

On the July 23, 2012 visit to Mercy Works, Petitioner complained of a headache and at times he felt nauseated and off balance. He complained of right arm pain and neck pain (7-8/10), particularly when rotating to the left. He complained of low back pain radiating to the right leg and down the right lower leg with numbness rated at 8/10. Petitioner was taken off work and prescribed medication. On July 30, 2012, an MRI of the lumbar spine was prescribed, and it was performed at the University of Illinois on August 8, 2012. That MRI disclosed multilevel degenerative disc disease with varying degrees of both spinal canal stenosis and foraminal stenosis as well as abdominal aortic aneurysm and left common iliac artery aneurysm. Physical therapy was initiated at the August 15, 2012 examination. Petitioner continued treating at Mercy Works through December 27, 2012 (PX 3).

Petitioner was admitted to University of Illinois Hospital from October 1, 2012 to October 8, 2012 for several surgical procedures performed by Dr. Borhani, including resection of the abdominal aortic aneurysm and left common iliac artery, endarterectomy, thromboendarterectomy, and bilateral common femoral artery revascularization. Those surgeries had to be performed before Petitioner could initiate orthopedic treatment, as suggested by Dr. Diadula at Mercy Works. The orthopedic surgeon was Dr. Siemionow, and the first visit was on November 20, 2012 (PX 11).

Petitioner was seen at the University of Illinois Hospital on November 20, 2012 for his low back complaints. He was seen by Dr. Lester, an assistant to the attending orthopedic surgeon, Dr. Siemionow. Drs. Lester and Siemionow noted in their "Assessment/Plan" that although they were unable to tell whether the herniations were present before the injury, they were certain that the trauma exacerbated any preexisting

condition (PX 5). The records confirmed that Petitioner had scheduled an earlier appointment, but due to the abdominal aortic aneurysm discovered on the lumbar MRI, it had to be postponed to accomplish the required urgent surgery. Petitioner had low back pain worse with sitting and walking. He had numbness in his lower extremities. Petitioner continued to complain of neck pain. His right shoulder had improved.

The examination disclosed tenderness over the lumbar spine worse to the left with slightly decreased sensation bilaterally. The MRI showed severe lateral disc herniation at L3-L4 on the left and some moderate bilateral foraminal stenosis at L5-S1. (PX 5). A prescription of physical therapy, Norco, and Valium were made. Surgery, including an L3-S1 fusion, was discussed (PX 5).

Physical therapy to the cervical and lumbar spine was conducted three times a week for four weeks. Petitioner followed up with Dr. Siemionow. Petitioner complained that physical therapy was not working. He complained of throbbing on the left side of his back which was overall unchanged since starting physical therapy. He complained that he was unable to lay on his left side, he had pain with walking, he was only able to drive 30 to 45 minutes, had difficulty standing, and reportedly lost his balance when standing up. An epidural injection was prescribed (PX 6). On April 26, 2013, Dr. Siemionow determined that conservative measures had failed and recommended a multilevel lumbar fusion. The surgical recommendation was contested initially under the utilization review procedure.

On May 15, 2013, Dr. Butler, Respondent's retained orthopedic surgeon, examined Petitioner. There was a report and addendum (PX 15, PX16). Dr. Butler opined that the diagnosis was properly stated and supported by the records and objective findings (PX 15). Dr. Butler further opined that the accident seemed to be the major contributing factor to the aggravation that necessitated surgery (PX 16).

Lumbar surgery was performed at the University of Illinois Hospital. Petitioner was admitted and operated upon on October 21, 2013. Dr. Siemionow performed a transforaminal lumbar interbody fusion with the application of biomechanical device at L3-S1 (PX 11). Dr. Siemionow also performed decompression of the thecal sac with bilateral facetectomies at L5-S1. A pars resection bilaterally was performed at the L5 level. An L4 laminectomy with bilateral facetectomy and pars resection bilaterally was done with reference to the L4 nerve roots (PX 11). Petitioner was released from the hospital on October 26, 2013, wearing a hard lumbar back brace. The hospital records contain Dr. Siemionow's opinion that the injury at work resulted in exacerbation of a pre-existing condition. Dr. Siemionow's operative report and discharge summary state that the exacerbation of the pre-existing condition turned into a permanent aggravation (PX 11).

Petitioner had his first follow up visit was November 5, 2013 and was seen initially weekly and eventually monthly to track his progress. He continued wearing his brace at least intermittently through December 10, 2014. A CT scan was performed in November, 2013, due to radiating right calf pain. The CT scan showed that the right S1 pedicle screw was very close to the right S1 nerve root (PX 11). Physical therapy was initiated. A TENS unit, Vicodin and a Fentanyl patch were prescribed.

On March 11, 2014, Dr. Siemionow interrupted physical therapy for four weeks, because it was causing low back pain. On April 8, 2014, Dr. Siemionow noted continued muscle pain in the right iliac crest due to overworking that area during therapy. Dr. Siemionow initially prescribed a return to work with restrictions for sedentary work. Petitioner was not to work more than 3 days a week for 3 hours a day, 30 minutes at a time with 15 minute breaks. Respondent had no work within those restrictions (PX 11). In a December 2, 2014 progress note, Dr. Siemionow recorded work restrictions of 3 days of work, 3 hours a day, with 15 minute break every 30 minutes and no lifting, only sedentary work. In that note Dr. Siemionow indicated that the Petitioner had

reached maximum medical improvement. Petitioner was seen on March 3, 2015, complaining of right leg weakness which particularly affected him when he tried to cross his legs. Respondent remained unable to find a job that would fit the job restrictions.

On April 30, 2015, Petitioner underwent a functional capacity evaluation at NovaCare on referral from Dr. Siemionow. Petitioner demonstrated the ability to work at a light physical demand level, with modifications and limitations on lifting and balance. Primary limiting factors were listed as strength and balance deficits. The evaluation was reported to be valid (PX 24).

Petitioner testified that following his release from Dr. Siemionow, he began participating in a job search through a City of Chicago vocational program. Job logs submitted for this program show that Petitioner applied to the minimum requirement of 10 jobs per week between January 19, 2015 and August 16, 2015 (PX 23).

On August 4, 2015, Petitioner was seen by Dr. Leila Hagshenas for back pain complaints. Dr. Hagshenas advised of the risk of restarting medications at the same high does after having been off pain meds for many months and she recommended a short-acting Norco as needed for acute flare (PX 25).

In November, 2016, Petitioner met with rehabilitation counselor Steven Blumenthal for a vocational rehabilitation interview. Based upon that interview and a review of medical records, Mr. Blumenthal concluded that Petitioner is not employable in any job in a stable labor market and would not be a candidate for vocational rehabilitation services. (PX 27).

Respondent retained the Vocomotive, Inc. to perform vocational assessment and services. Lisa Helma. the Vocamotive representative, did not prepare a formal report, but her records include an email that documents her opinion that Petitioner was totally disabled. That email is as follows:

> From: Lisa Helma
> Sent: Friday, January 27, 2017 10:58 AM
> To: 'andrea.miceli@committeeonfinance.org'; Sharon Zajac
> Subject: Ronald Blankus
>
> Ms. Miceli:
>
> On December 15, 2016, I sent you an email letting you know my opinions on Mr. Blankus.
>
> Given the situational factors, I did not feel that he was employable, especially with his restrictions from November 15, 2016. At that time, Dr. Simionow reported that Mr. Blankus was released with a 10 pound lifting restriction, no bending, no ladder or stair climbing, no driving, and limited to a 3 day work week for maximum 3 hours per day with 15 minute breaks every 30 minutes.
>
> Those restrictions will not make him a candidate for any type of stable labor market.
>
> I am aware that he had the FCE, however; the FCE is not a release to return to work and at this time his treating physician has overrode the FCE. No doctor has

released Mr. Blankus within the parameters of the FCE or with any other restrictions.

Please advise as to whether you would like a report at this time or whether we should put the file on hold.

I am going to be out of the office starting this afternoon and will not be returning until Tuesday

Thank you,
Lisa"

(PX 28)

Thereafter, in a February 28, 2017 report, Dr. Butler concluded with the opinion that "The patient has returned to the pre-accident status in regards to the cervical spine." (PX 17).

Petitioner testified that he has continuing ongoing symptoms.

On November 3, 2015, Petitioner entered into a settlement agreement to resolve his third party lawsuit against FedEx Freight, Inc. for the lump sum of $1,250,000.00 (RX2).

CAUSATION

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident of July 20, 2012.

The Arbitrator bases this conclusion on Petitioner's credible testimony, the corroborative and consistent medical records, the persuasive and compelling opinions of Dr. Siemionow, and the consistent sequence of events.

MEDICAL

The Arbitrator finds that the Petitioner's claimed claim medical expenses are reasonable, necessary, and related.

The Arbitrator bases this conclusion on the review of all testimonial and documentary evidence.

MAINTENANCE

The parties stipulated that Respondent paid temporary total disability benefits from July 21, 2012 through December 12, 2014 at the weekly rate of $1,007.68. Dr. Siemionow found that Petitioner had reached maximum medical improvement on December 2, 2014.

Beginning on December 13, 2014 Petitioner, under the supervision of Coventry Workers' Comp Services, engaged in a self-directed but unsuccessful job search. Petitioner's job search ended when there was a settlement of a third-party personal injury case arising out of the July 20, 2012 accident. Respondent's last maintenance payment was on December 11, 2015.

Based upon the foregoing, the Arbitrator finds that Petitioner is entitled to maintenance for the period of December 13, 2014 through December 11, 2015

NATURE AND EXTENT

Petitioner was 60 years old with a high school diploma at the time of the accident. Petitioner worked for the City of Chicago in the water department as a meter reader for 25 years. His job required physical medium type work. The reliable medical records, particularly Dr. Siemionow's persuasive records, evidence that Petitioner cannot return to his previous job as a water meter reader. Petitioner's job search was unsuccessful. The report of Steven Blumenthal and the email of Lisa Helma evidence that there is no stable labor market for Petitioner.

Petitioner has carried his burden, which Respondent has not rebutted, that Petitioner falls into the category of odd lot permanent total disability.

Based upon the foregoing, the Arbitrator finds that Petitioner is entitled to permanent total disability benefits.

PETITIONER'S THIRD PARTY SETTLEMENT

On November 3, 2015, Petitioner entered settled his third party case against FedEx Freight, Inc. for $1,250,000.00. Respondent is entitled to recovery pursuant to Section 5(b). Respondent is entitled to reimbursement from and worker's compensation lien against that settlement. The settlement amount is to be applied toward Respondent's future obligation to pay compensation benefits by deducting court costs and attorney fees of 25% from the sum of the total amount of workers' compensation benefits already paid by Respondent and treating the resulting net amount as advance payment of compensation. Respondent shall receive credit for the full amount of any benefits owed until the third party recovery is exhausted.

Respondent is responsible for payment of attorney fees to the Petitioner's attorney who obtained the third party recovery, in the amount of 25% of any benefit owed to Petitioner. 25% of the weekly maintenance and permanent total disability rate of $1007.68 computes to $251.92.

Based upon the foregoing, the Arbitrator so concludes and so orders.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eva Sacharczuk,

Petitioner,

vs. No. 16 WC 08958

Cook County Stroger Hospital,

Respondent.

19IWCC0434

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 jurisdiction, causal connection, medical expenses, prospective medical care, temporary disability, penalties, attorney fees, procedural issues and evidentiary rulings, 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).

The Commission does not believe an award of penalties and attorney fees is appropriate. Based on the early follow-up records from Dr. Romano, Respondent could reasonably believe the right knee injury was only a contusion needing minimal follow-up. Further, the Commission does not consider Respondent's reliance on the opinions of Dr. Weber to be unreasonable. Having closely read the deposition of Dr. Weber, the Commission disagrees with the Arbitrator that Dr. Weber "left out portions of Dr. Romano's medical notes that would have essentially contradicted her conclusions of Petitioner being asymptomatic, admitting that she kept portions in and out that would help the case." Dr. Weber did admit that in summarizing Dr. Romano's medical records she did not include *all* of Petitioner's complaints. Dr. Weber did not testify

Petitioner was asymptomatic. Rather, Dr. Weber opined that on April 11, 2016, Petitioner's right knee patellar chondromalacia was asymptomatic—indicating the aggravation had resolved. Dr. Weber acknowledged Petitioner's other subjective right knee complaints, but saw no supporting objective findings.

The Commission clarifies that the award of prospective medical care contemplates surgery and incidental care, as recommended by Dr. Romano and Dr. Tu.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 21, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay medical expenses of $4,615.00 pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given §8(j) credit for the amounts paid by its group health insurance for treatment of the right knee injury, provided that Respondent holds Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving this credit.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for further treatment for the right knee condition recommended by Dr. Romano and Dr. Tu, including surgery and incidental care, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of penalties and attorney fees 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.

DATED: AUG 15 2019
o-06/19/2019
SM/sk
44

Stephen Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." Id. at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in Hollywood Casino, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

SACHARCZUK, EVA
Employee/Petitioner

Case# **16WC008958**

COOK COUNTY STROGER HOSPITAL
Employer/Respondent

19IWCC0434

On 8/21/2018, 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 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2337 INMAN & FITZGIBBONS LTD
JUDY NASH
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

EVA SACHARCZUK
Employee/Petitioner

v.

COOK COUNTY STROGER HOSPITAL
Employer/Respondent

Case # **16** WC **08958**

Consolidated cases: **n/a**

19IWCC0434

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **June 14, 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

19IWCC0434

FINDINGS

On the date of accident, **August 5, 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 for the right knee ***is*** causally related to the accident. All other alleged condition(s) are reserved.

In the year preceding the injury, Petitioner earned **$79,552.20**; the average weekly wage was **$1,529.85**.

On the date of accident, Petitioner was **52** 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 **$10,344.86** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,344.86**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay for and authorize the treatment recommendations of Drs. Romano and Tu, including any and all incidental care thereto.

Respondent shall pay reasonable and necessary medical services totaling the gross amount of **$4,615.00**, as provided in Sections 8(a) and 8.2 of the Act. To the extent Respondent has paid some or all of these bills for the right knee, 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.

Pursuant to Section 19(k), the Respondent shall pay **$1,657.50** in penalties.
Pursuant to Section 16, Respondent shall pay **$331.50** in attorney fees.
Pursuant to Section 19(l), Petitioner's request for penalties is ***denied***.

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

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

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

Signature of Arbitrator

8-21-18
Date

AUG 21 2018

FINDINGS OF FACT

Eva Sacharczuk ("Petitioner") alleged injuries arising out of and in the course of her employment with Cook County John Stroger hospital to her right knee occurring on August 5, 2015. Ax1. On June 14, 2018, the parties proceeded to arbitration on the disputed issues of causal connection, liability for unpaid medical bills and prospective medical treatment. The parties clarified that trial would be held as to the right knee only and that Petitioner's other alleged injuries to the cervical spine/neck and right thumb would be reserved. Respondent objected to trial based upon its assertion that Petitioner's other alleged injuries, namely to the cervical spine/neck and right thumb, should also be arbitrated. The Arbitrator found that Petitioner was free to elect her remedy and which portions of her claim she wished to arbitrate, that no good cause existed to further continue Petitioner's 19(b) request for immediate hearing, that the parties had made agreements to try this matter as to the right knee only prior to the date of trial and that no party would otherwise be prejudiced. Accordingly, Respondent's request to continue was denied. The following is a recitation of the facts adduced at trial.

Petitioner testified that on August 5, 2015 she was working for Respondent as a dialysis nurse and has done so since June 2015. She was required to take a physical exam to be medically cleared prior to being hired and was in fact cleared by Respondent. Her job duties as a dialysis nurse consist of setting up the dialysis machines, putting the patients on /taking them off of the machines, moving and cleaning the machines, draining the machines and lifting an acid jug and bicarb jug weighing approximately 25-35 pounds and 40 pounds, respectively. Petitioner testified that she is also required to push inpatients on stretchers.

Petitioner testified that she began work at 7:00 AM on August 5, 2015. She was performing her regular job duties when she slipped and fell on water that was leaking from a dialysis machine onto the floor. Petitioner testified that she had seen the machines leak on prior occasions. She explained that the older machines leaked, and she had personal knowledge of this because she could see it. Petitioner testified that in her experience, even while working elsewhere as a dialysis nurse, that dialysis machines will leak. Petitioner testified that she had immediate pain subsequent to the fall in her knees, hands and back. Petitioner testified that her right thumb was "dangling" and "cracked off to the left." She had acute right knee pain that was throbbing in nature and she testified she knew she needed immediate medical attention. A witness statement was taken indicating the witness saw Petitioner fall and hit her knee. Rx2. Petitioner also gave a written statement. Rx2.

Petitioner reported the accident to her supervisor who instructed her to go to Employee Health Services Petitioner testified Employee Health directed her to her primary because they "do not treat." She then went to West Suburban Hospital and was treated in the emergency room where she underwent x-rays and was provided pain medication.

Petitioner testified that she saw Dr. John Fernandez of Midwest Orthopedics at Rush for her right thumb injury. The right thumb injury is not in dispute and Petitioner has been released from care by Dr. Fernandez

Petitioner testified that she saw Dr. Romano of Romano Orthopedics for her right knee injury and that she underwent physical therapy per Dr. Romano's treatment plan from the September 9, 2015 office visit. Px2. She followed up with Dr. Romano on October 12, 2015. Px2. Dr. Romano noted that she had trouble walking down the stairs due to right knee pain. She was unable to kneel and had limited range of motion in the right knee. She complained of numbness and tingling in the toes at times, as well as popping and locking in the right knee. On physical exam, there was mild patellar tenderness and she was unable to exert full pressure on the right knee. Her pain was 10/10 while trying to kneel on the right knee. She had difficulty with sleeping and was unable to sleep through the night. Dr. Romano recommended that Petitioner undergo an MRI of the right

lower extremity. This was performed at West Suburban Medical Center on November 9, 2015. Px1. The radiologist's impression was that Petitioner had an undersurface tear of the medial meniscus body and posterior horn, increased signal within the posterior cruciate ligament suggestive of a partial thickness tear, as well as fluid anterior to the tibial tuberosity suggestive of superficial infrapatellar bursitis. Px1, 2.

Petitioner followed up with Dr. Romano on November 19, 2015. Px2. Dr. Romano noted that she had difficulty walking after sitting for a prolonged period of time as well as difficulty getting in and out of the car. She did not kneel anymore due to right knee pain and held the banisters for support when going down stairs. Upon physical examination, Dr. Romano noted medial joint line tenderness in the right knee. He recommended that Petitioner continue physical therapy at that time but allowed her to return to work without restrictions.

On December 21, 2015, Petitioner followed-up with Dr. Romano who noted that she continued to experience intermittent pain in her right knee. Px2. She struggled with pain after physical therapy. She was taking Aleve and Motrin that did not provide much relief. On exam, Dr. Romano noted tenderness over the medial joint line. On January 28, 2016, Dr. Romano administered a Kenalog injection to Petitioner's right knee and recommended continuing with physical therapy.

On February 29, 2016, Petitioner returned to Dr. Romano. Px2. He noted that she cannot perform home exercises due to right knee pain. According to the medical notes, physical therapy was very helpful and reduced her pain but once therapy ended, her knee pain worsened. Petitioner reported that her pain oscillated from behind the right knee to the front of her knee cap and was exacerbated by going downstairs, extending her leg fully and taking her socks off. Dr. Romano noted upon physical examination that she exhibited an antalgic gait, tenderness to the medial joint line of the right knee, positive McMurray's test in supine but a negative McMurray's with standing. At that point, Dr. Romano opined that conservative care had been unsuccessful and was a good candidate for surgical intervention.

Dr. Romano reiterated his recommendation for right knee surgery on March 24, 2016 and May 23, 2016 He noted that Petitioner was not improving with a home exercise program and her pain was aggravated by working and daily walking. Conservative care including physical therapy and a Kenalog injection had not been successful and Dr. Romano opined that surgical correction was warranted. Px2.

Petitioner testified that she wanted a second opinion regarding the necessity of right knee surgery and sought a second opinion from Dr. Kevin Tu of G&T Orthopedics. Px3. In his August 25, 2016 office note, Dr. Tu noted that since Petitioner's date of accident, she experienced pain localized to the anterior aspect of the right knee. She had undergone significant conservative treatment including physical therapy. Dr. Tu stated that Petitioner had a right knee injection that provided approximately one week of relief. At that time, she had been working with restrictions but was unable to push heavy equipment and had pain with kneeling. Dr. Tu stated that since Petitioner had temporary relief of her symptoms after a cortisone injection, this would indicate an intra-articular process with the right knee and that the only treatment option remaining was a diagnostic arthroscopy with possible partial meniscectomy, possible synovectomy and possible chondroplasty. Dr. Tu has continued to recommend the right knee arthroscopy to date.

Petitioner testified that she has continued to work with restrictions imposed by Dr. Tu, which consist of no kneeling, no lifting more than 75 pounds and no pushing more than 75 pounds. Petitioner testified that she would like to have the surgery, recommended by both Dr. Romano and Dr. Tu. Petitioner continues to have right knee pain and testified that she is "never free of pain" and has increased pain in winter and with humidity and rain. She takes pain medication regularly and ices her knee to help diminish the right knee pain but that the medications do not get rid of her pain. Her right knee pain is made worse by constant sitting and getting up as well as constant walking. Petitioner testified that it is very hard to walk in the mornings and that she has to

"warm up" her right knee and everything takes her longer due to her pain. The pain varies, depending on the activity, from a sharp pain to an aching pain.

Petitioner testified she drives to and from work and testified that if she sits too long, getting out of her car is very difficult and she limps for a while. Petitioner testified that she has never had this kind of right knee pain prior to the work-related injury on August 5, 2015. She had never sought any medical attention for her right knee prior to the work injury. Petitioner explained that her life has been affected in many ways since her injury: she cannot garden, she cannot walk long distances and utilizes a cane, she has missed out on vacations, has difficulty sleeping and everything takes her longer due to her right knee pain.

Deposition testimony of Dr. Kevin Tu

Dr. Kevin Tu, a board certified orthopedic surgeon, testified that he treats mostly knees and shoulders, with about 40% his practice dedicated to treatment of knee conditions, 40% dedicated to shoulder conditions and 20% dedicated to hands, elbows, ankles and feet. Px4. Dr. Verma testified that he treats approximately 300 cases surgically per year.

Dr. Tu testified that he saw Petitioner on August 25, 2016 in connection with an accidental work injury where she slipped on water that was on the floor. He testified that she landed on the front of her knee when she fell and that her pain was primarily in the front of the knee. Dr. Tu explained that she had complaints with kneeling and was unable to push heavy equipment. On physical exam, Dr. Tu noted patellofemoral instability and tenderness around the kneecap and front of the knee. Dr. Tu reviewed the MRI images and opined that she had early chondromalacia of the patellofemoral compartment. He testified that Petitioner did not have any right knee treatment prior to the date of accident per her reporting. Dr. Tu explained that because Petitioner had already undergone physical therapy and a cortisone injection with only temporary relief, the only treatment option left was to perform a diagnostic arthroscopy.

Dr. Tu opined that because Petitioner had temporary improvement of her symptoms for one week after the injection, that it was consistent with her having some sort of knee pathology. He further explained that because Petitioner only had minor relief from the first injection, another injection is unlikely to provide any additional benefit. Dr. Tu testified that MRIs are known to miss 10% of pathology and that it is not uncommon for patients to have meniscus tears or other pathology missed on MRI. Dr. Tu testified that Petitioner's subjective complaints were supported by his objective findings. Dr. Tu testified that he continued to recommend a right knee arthroscopy as her knee condition was not improving, however, workers' compensation denied the procedure, so he was unable to proceed.

Dr. Tu reviewed Dr. Kathleen Weber's report and testified that he was not agreement with her opinions. Dr. Tu testified that Dr. Weber opined Petitioner needed one physical therapy visit and that subsequent to that visit, she would be able to work full duty without restrictions. He testified that Dr. Weber noted Petitioner's right knee was asymptomatic but that each time he saw her, she was symptomatic Dr. Weber opined that Petitioner had reached maximum medical improvement and Dr. Tu disagreed on this issue due to the nature of Petitioner's complaints and the correlation between the subjective and objective findings. He also disagreed with Dr. Weber's diagnosis of a right knee contusion, testifying that this may be a part of the diagnosis since Petitioner's landed on the front of her knee.

Dr. Tu testified to a reasonable degree of medical and surgical certainty that there is a causal connection between the mechanism of injury to Petitioner's current condition of ill-being as well as the need for surgery. He explained that a direct fall to the front of the knee is consistent with the mechanism for aggravating

patellofemoral chondromalacia. Dr. Tu felt that the treatment rendered to Petitioner had been reasonable and necessary based upon a reasonable degree of medical certainty.

On cross examination, Dr. Tu continued to explain why he felt that surgery was the last remaining option for Petitioner. He testified that he is recommending the arthroscopy based upon several factors: the failure of conservative treatment, the temporary relief of the right knee injection, her subjective complaints along with the objective findings and her MRI findings. He reiterated the presence of right knee pathology and that there could be a meniscus tear and/or synovitis in the right knee and that surgery is to address all of these things as well as the aggravation of her preexisting condition.

Dr. Kathleen Weber's deposition

Dr. Kathleen Weber saw Petitioner on two occasions for the purpose of Section 12 exam at the request of Respondent, one on January 11, 2016 and one on April 11, 2016. Rx2. Dr. Weber testified that she does not have any orthopedic surgery training as she is a non-surgeon. Dr. Weber testified that for the first exam, she reviewed the MRI of the right knee in November 2015. She opined that there were preexisting chondral changes at the patella and some fluid in the front of the tibial tuberosity, suggestive of a contusion. The right knee diagnosis, according to Dr. Weber, was a right knee contusion and possible aggravation of the subtle patellofemoral chondromalacia. Dr. Weber believed that because Petitioner was not improving as quickly as she would have expected, that "it makes [her] wonder … if there's maybe secondary gains." Dr. Weber opined that Petitioner should continue in a patellofemoral based program and that if she continued to have knee pain, an injection could be considered. Rx2. Dr. Weber testified that she anticipated Petitioner would reach maximum medical improvement after undergoing an intraarticular injection to the right knee. At that time, Dr. Weber opined that her right knee injury was causally related to the work injury based upon the mechanism of injury.

Dr. Weber reexamined Petitioner on April 11, 2016 at Respondent's request. Dr. Weber admitted that she did not indicate in her report that Petitioner had problems sleeping due to her right knee pain nor did she indicate that Petitioner could not do her home exercises due to pain. In her report, Dr. Weber concluded that Petitioner's right knee patellar chondromalacia was "asymptomatic at this time." When questioned regarding Dr. Romano's medical note dated March 24, 2016 which was significant for right knee complaints, Dr. Weber testified that she did not have that medical note. The last medical note that Dr. Weber reviewed was from February 29, 2016.

Dr. Weber opined that Petitioner was asymptomatic at the time of the April 11, 2016 examination. Rx2. She also testified that Petitioner "continued to claim of discomfort." Dr. Weber testified that at the time of the second exam, Petitioner's aggravation of her preexisting condition in the right knee ended and again suggested secondary gain. Dr. Weber's treatment recommendation for Petitioner was one singular physical therapy session for the right knee. Dr. Weber further testified that there was no other treatment she would recommended for the right knee injury and that Petitioner could work full duty without restriction.

On cross-examination, Dr. Weber was asked why she did not include certain portions of the reviewed medical records into her report. Rx2. She testified she was "taking the important points that I think are important for the case." Dr. Weber admitted that she did not include anything in her second report from Dr. Romano's notes regarding Petitioner's complaints of right knee pain when walking down stairs, difficulty with walking and standing for long periods of time, that she was taking over-the-counter Aleve without relief and that she had tenderness to the medial joint line. Dr. Weber did acknowledge that Petitioner reported no prior work-related injuries and no prior knee issues. Further, she had not received any medical records regarding Petitioner's right knee that were prior to the date of accident to indicate a past medical history for the right knee

Dr. Weber reiterated her position on why Petitioner only needed one physical therapy session and that in her practice, she often times takes people out of physical therapy or does not send them at all.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator finds her testimony to be credible, forthright, candid and reliable.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being as it relates to the right knee is causally related to her undisputed work accident. Pursuant to Petitioner's request and the stipulation sheet entered into evidence, the Arbitrator makes no findings with respect to any other body part(s) and reserves ruling on same as to this issue.

It is undisputed that Petitioner was performing the regular duties of her employment on August 5, 2015, and that she was working in a full duty capacity without restriction. She had immediate pain in both hands, both knees and her back after the slip and fall on water. She reported the accident timely to her supervisor, presented to Employee Health Services, then went to the emergency room at West Suburban Hospital immediately following the accident.

Respondent argues that Petitioner's current right knee symptoms are not causally related to the August 5, 2015 accident. The Arbitrator disagrees. Respondent argues that Petitioner had a preexisting condition and therefore, a causal connection does not exist. In so arguing, Respondent relied on Dr. Weber's diagnosis that Petitioner suffered a right knee contusion and possible aggravation of the subtle patellofemoral chondromalacia. Even if Petitioner did have preexisting patellofemoral chondromalacia, Dr. Weber conceded Petitioner may have suffered an aggravation. Moreover, if there was such a preexisting condition, the Arbitrator finds the evidence shows that the work accident made Petitioner symptomatic in those areas and that therefore the work accident is a causative factor. Finally, aside from Dr. Weber finding a contusion and possible aggravation of preexisting patellofemoral chondromalacia, Dr. Weber failed to consider, weigh or otherwise opine on the other findings on MRI, which included possible tears it the medial meniscus and PCL.

Further, the Arbitrator notes that Dr. Weber opined that Petitioner was asymptomatic at the time of the April 11, 2016 examination. Rx2. However, in all the medical notes before and after that date, Petitioner was symptomatic and testified that she continued to be symptomatic at the time of trial on June 14, 2018. In addition, Dr. Weber admitted she left out portions of Dr. Romano's medical notes that would have essentially contradicted her conclusions of Petitioner being asymptomatic, admitting that she kept portions in and out that would help the case. The Arbitrator finds that Dr. Weber failed to properly and thoroughly consider all medical history in arriving at her conclusions and therefore her opinions are entitled to little, if any, weight, considering her admissions.

Dr. Tu's testimony supports a causal relationship between the traumatic work accident and Petitioner's right knee symptoms. Petitioner testified that she had no pain or problems with her right knee prior to her work injury. She had not treated with a medical professional regarding the right knee, was not taking any pain medications, and was working in a full duty capacity without restriction on the date of the accident. Further,

Dr. Tu's opinions are consistent with those of Dr. Romano, who also believed Petitioner remained symptomatic as a result of the work accident and was in need of further care.

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of August 5, 2015. The Arbitrator adopts the opinions of Dr. Kevin Tu, concluding that he is much more credible than Dr. Kathleen Weber.

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 incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her medical treatment for her right knee were both reasonable and necessary and that Respondent has not yet paid all appropriate charges for same. Pursuant to Petitioner's request and the stipulation sheet entered into evidence, the Arbitrator makes no findings with respect to any other body part(s) and reserves ruling on same as to this issue.

Because the Arbitrator finds that Petitioner's accident was causally connected to her current condition of ill-being, the Arbitrator concludes that Respondent is liable for all medical bills that are reasonably related to Petitioner's work injury as to the right knee, including bills from West Suburban Hospital, Dr. Victor Romano and Dr. Kevin Tu. Respondent shall pay reasonable and necessary medical services totaling the gross amount of **$4,615.00**, as provided in Sections 8(a) and 8.2 of the Act. To the extent Respondent has paid some or all of these bills for the right knee, Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her current condition of ill-being as it relates to the right knee has not yet stabilized or otherwise reached maximum medical improvement and that she is entitled to prospective medical care for same. Pursuant to Petitioner's request and the stipulation sheet entered into evidence, the Arbitrator makes no findings with respect to any other body part(s) on this issue and reserves ruling on same.

The evidence demonstrates that Petitioner's treating physicians have opined that Petitioner is in need of further care for the right knee. Petitioner expressed an interest and willingness to pursue same. Therefore, Respondent shall pay for and authorize the treatment recommendations of Drs. Romano and Tu, including any and all incidental care thereto.

ISSUE (M) Should penalties or fees be imposed upon Respondent?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. In issuing penalties, the standard to which the Respondent is held is one of objective reasonableness. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 442 N.E.2d 861 (1982). Merely obtaining an Section 12 exam does not relieve the Respondent of exposure to penalties. In this case, Respondent relied on Dr. Weber's opinions to deny compensation. In reviewing Dr. Weber's opinions the Arbitrator notes the following:

Dr. Weber is not an orthopaedic surgeon nor does she specialize in conditions of the knee; Dr. Weber diagnosed Petitioner with and causally related a right knee contusion; Dr. Weber admitted that there was a possible aggravation of patellofemoral chondromalacia yet failed to opine whether that aggravation was or could have been related to the undisputed work injury. The Arbitrator finds that it was objectively unreasonable to deny and continue compensation based upon these opinions without further clarification on the aggravation issue.

In addition, Dr. Weber recommended an injection for the right knee, yet it was unclear whether that recommendation was made to address the knee contusion she diagnosed and/or the aggravation she suspected. In this regard, Respondent unreasonably failed to clarify this and otherwise failed to authorize same. When Dr. Weber issued her second report, she now causally related the aggravation of patellar chondromalacia not resolved, yet Respondent did not pay benefits thru the date of that second report. Dr. Weber failed to state why the patellar chondromalacia was now resolved, stating only that McMurray's testing was negative for some time. Dr. Weber cited to negative McMurray's testing in the second report, a test used to evaluate meniscal pathology, but she failed to address this in the context of an aggravation of pre-existing patellofemoral chondromalacia. Further, Dr. Weber's physical exam of Petitioner on both occasions were largely the same yet Dr. Weber arrived at different conclusions and failed to reasonably reconcile same. For example, both times Petitioner's grind test was negative, yet Dr. Weber found the patellofemoral condition resolved only at the second exam without further explanation.

The Arbitrator concludes that the preponderance of the medical evidence indicated that Petitioner was entitled to compensation despite Dr. Weber's opinions, which were incomplete and insufficient. The Arbitrator notes that the test for issuing penalties upon Respondent is not whether there is any medical evidence to support non-payment of compensation, but whether the Respondent's conduct in relying on the medical opinion to contest liability is reasonable under the circumstances. *General Refractories v. The Industrial Comm'n*, 255 Ill. App. 3d 925, 627 N.E.2d 1270 (1994). In the instant case, Respondent's refusal to authorize surgery for 3 years was not made in good faith and it was objectively unreasonable to continue to rely on Dr. Weber's opinion. Of note, when surgery was denied to Dr. Tu's office, no explanation was given as to the basis for the denial. Rx8:T2. However, in its Response to the petition for fees and penalties, Respondent denied knowing of this recommendation and stated that the basis of its denial was Dr. Weber's opinions. Ax3.

Section 19(k) assesses discretionary penalties for the delay of payment of compensation for any unreasonable or vexatious delay, intentional underpayment or, if proceedings have been instituted or carried on by one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b), shall be considered unreasonable delay. The Arbitrator awards penalties equivalent to 50% of the net amount of $3,315.00 in outstanding medical bills. Therefore, pursuant to Section 19(k), the Respondent shall pay **$1,657.50** in penalties. The Arbitrator has considered that some insurance payments were made on these bills, but it is unclear whether those were carrier or group payments.

The Arbitrator concludes that Respondent is ***not liable*** for penalties pursuant to Section 19(l) as no evidence was submitted that demand for payment of benefits was made, as required by Section 19(l). Without such evidence of a demand, the Arbitrator need not consider whether Respondent produced evidence of any written reason for the delay in the payment of compensation.

The Arbitrator further assesses penalties for this period, pursuant to Section 16. The last paragraph of Section 16 states that when the Commission finds the employer, its agent, its service company or its insurance carrier has been guilty of delay or unfairness toward an employee and the adjustment, settlement or payment of benefits to such employee, within the purview of provisions of Paragraph C of Section 4, or has been guilty of

unreasonable or vexatious delay, intentional underpayment of compensation benefits or is engaged in frivolous defenses, which do not present a real controversy within the purview of the provisions of Paragraph K of Section 19 of this Act, the Commission may assess all or part of the attorney's fees and costs against such employer and/or his insurance carrier. The Arbitrator finds that Respondent, pursuant to Section 16, is liable for 20% of the amount the Arbitrator assesses in penalties pursuant to Sections 19(k) or 20% of $1,657.50, which equals **$331.50**.

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

DANIEL STEFFAN,

Petitioner,

vs. NO: 12 WC 4582

COOK COUNTY SHERIFF,

19IWCC0435

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 causation, temporary total disability, and maintenance, 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 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 views the evidence differently and finds that, when viewed in its entirety, Petitioner was not credible regarding his complaints and symptoms, his restrictions were based on these inaccuracies, and that he was able to return to an accommodated position on September 24, 2013, and return full duty to his preinjury employment as of November 6, 2014.

On April 24, 2012, Respondent's Section 12 physician, Dr. Simon Lee, diagnosed Petitioner as being status-post right foot contusion with metatarsalgia and opined that he had reached maximum medical improvement. Petitioner had a "limited physical exam indicating pain and generalized discomfort and discrete anatomic area and region" but it was not consistent with Reflex Sympathetic Dystrophy (RSD) or Chronic Regional Pain Syndrome (CRPS). Dr. Lee noted his agreement with the functional capacity evaluation which showed Petitioner was in the "modified heavy category" and his job description was only in the "medium" physical demand level. Dr. Lee noted, "The main limitation of allowing him to return back to work would be the fact that he is

essentially unable to have any type of significant prolonged standing, walking activity as well as would be unable to be in a position to protect himself in the event of any bodily harm."

From October 16, 2012 through September 17, 2013, Petitioner underwent a job search through GENEX, as evidenced by the letters and logs submitted in Px9. Respondent paid maintenance benefits during this period. Although the job search logs are lengthy, containing 359 pages, we find that it is not indicative of a diligent job search. Rather, the vast majority of Petitioner's entries appear to be cursory recitations of various jobs (some of which were provided by GENEX) and not evidence of a valid job search. For example, although the pages are dated "Week Of" at the top, the individual entries are not dated. Most of them indicate the "Person Contacted" was "Web" and the "Results" are "N/A." For nearly all of them, there is no indication of any follow up. Some of the entries, such as those during the week of June 24, 2013, indicate that Petitioner contacted a "Cashier" in person and was told to "Apply On Line" but there is insufficient evidence to show that Petitioner actually followed up and did apply online. We find this job search is evidence of Petitioner doing the absolute minimum to receive his maintenance benefits and not a diligent job search. We find it is more probable than not that Petitioner could have found employment, even with his purported restrictions, if he had actually desired to do so.

We are also mindful of the surveillance video taken of Petitioner on June 30, 2013. Petitioner is seen walking normally without a cane at a gas station; lifting and carrying what appears to be a full plastic, yellow gas container and putting it in the back of an SUV; driving; standing while filling another vehicle with gas from the yellow container; walking into a store carrying two empty 5-gallon plastic water bottles; pushing a grocery cart with groceries and the water bottles; and loading items (including the then-filled water bottles) onto a trailer behind a pickup truck. Petitioner walked normally with no evidence of any difficulty or pain while performing these tasks.

On July 15, 2013, Respondent sent Petitioner a letter to report for a transitional work assignment based on his work restrictions. Px10. Petitioner testified that he reported to the personnel office and met with Rosemarie Nolan on September 24, 2013. *T.27.* He performed a drug test and was ordered to return to work that day. A "Sheriff's Personnel Office Memorandum," dated that same day, from Rosemarie Nolan to John Murphy, Executive Director, indicates Petitioner had been released for duty but "needs cane in the workplace" and will be assigned to "the Visitation Center, Division 5." We find that, based on the restrictions of Dr. Lee, Petitioner's minimal job search, and the surveillance video that Petitioner had no reasonable basis to refuse that assignment at that time. Therefore, we modify the Arbitrator's award of temporary total disability to reflect a period of 145-6/7 weeks from December 8, 2010 through September 23, 2013. We also specifically affirm the Arbitrator's finding that the most likely reason Petitioner did not begin this accommodated job was because he was anticipating undergoing a gastric bypass surgery in January 2014.

Petitioner underwent another Functional Capacity Evaluation on October 4, 2013, which reflected that he was capable of performing at a medium physical demand level, which falls within his job classification. However, it was noted that Petitioner may have issues with kneeling, crawling, balancing, climbing, walking and standing. *Px7.*

Petitioner saw his treating physician, Dr. Roland, on November 7, 2013, complaining of 6-out-of-10 right foot pain that is aching and sharp and exacerbated by standing and walking. Dr.

Roland diagnosed Petitioner with RSD/CRPS and noted that he was still waiting for a trial spinal cord stimulator for his foot pain. *Px8.* We find that Dr. Roland's understanding of Petitioner's complaints is not consistent with Petitioner's activities as seen on the June 30, 2013 surveillance video, which is wholly inconsistent with someone suffering from 6/10 foot pain.

Petitioner testified that he eventually returned to work in September 2014 and was placed in the Visitor Center. *T.50.* On September 30, 2014, Dr. Mankowksi, the physician at the Cook County Bureau of Human Resources, wrote that Petitioner could return to work with restrictions of "Standing limited to 2 hours a day, walking 3-4 hours a day for moderate distance. Must allow employee to use cane for walking and standing the entire day. He can use right foot for 2 hours/day. May drive but limited to 2 hours per day. Can crouch and climb stairs and squat for one hour per day. No kneeling or crawling. Cleared to use service weapon." *Px14.*

Surveillance video taken on October 31, 2014, shows Petitioner walking normally without a cane and with no indication of pain. Yet, just a week later, he was examined again by Dr. Lee on November 6, 2014. Dr. Lee wrote, ""Currently, he uses a cane he states on a regular and consistent basis. He states he does not leave the house without a cane." This is contradicted by the video taken just a week prior. Dr. Lee noted that the only abnormal objective finding "or potentially considered subjective finding" was slight tenderness at the fourth metatarsophalangeal joint with palpation and slight diminished range of motion of that joint. Petitioner did not have any signs or symptoms consistent with CRPS and no further treatment was recommended, as he had reached maximum medical improvement. Dr. Lee saw no indication that Petitioner could not return to his previous baseline level of function and opined that he could return to full duty without restrictions.

A Sheriff's Personnel Office Memorandum from Sean Lynch, dated November 20, 2014, indicates that Petitioner was released to full duty work. *Rx3.* Petitioner testified that, on December 9, 2014, he was told by Lt. Pullman, the supervisor on the day shift, that Respondent could no longer accommodate his restrictions. *T.38.*

James Martin, the Workers' Compensation Claims Adjuster at Cook County Risk Management, testified that he ordered video surveillance in this case on a number of occasions (June 2013; July, August, and October 2014) and Respondent learned that Petitioner does not use the cane when he's away from work, which is contrary to what Petitioner told Respondent regarding his need to have a cane to walk around. *T.78-79.*

At the hearing, Petitioner testified that he uses his cane every day. *T.43.* On cross-examination, Petitioner testified that he needs a cane to walk around all the time but then clarified that he is able to walk short distances without it. *T.57, 62-63.* Petitioner admitted that he had seen the videos over lunchtime. *T.63.*

Based on the totality of the evidence, we find that Petitioner's credibility, since at least June 30, 2013, has been questionable regarding the severity of his right foot symptoms and complaints. Therefore, we find the opinions of Dr. Lee the most persuasive in this case. Although Petitioner may have some minimal, localized right foot complaints, he has failed to prove that these have prevented him from returning to his previous job duties as a Correctional Officer as of November 6, 2014. Therefore, the Arbitrator's award of maintenance after that date is vacated.

All else is affirmed and adopted. This matter is remanded for a determination of permanency, if any.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $721.00 per week for a period of 145-6/7 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 the Arbitrator's award for maintenance under §8(a) of the Act, from December 10, 2014 through February 17, 2016, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,745.67 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.

Pursuant to §19(f)(2) of the Act, Respondent is not required to file an appeal bond 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 15 2019

Maria E. Portela

D. Douglas McCarthy

L. Elizabeth Coppoletti

SE/
O: 6/18/19
49

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

STEFFAN, DANIEL
Employee/Petitioner

Case# **12WC004582**

COOK COUNTY SHERIFF
Employer/Respondent

19IWCC0435

On 7/21/2017, 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 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0132 STATE'S ATTY OF COOK COUNTY
STEVEN GARCIA
500 RICHARD J DALEY CENTER
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Daniel Steffan
Employee/Petitioner

v.

Cook County Sheriff
Employer/Respondent

Case # **12** WC **04582**

Consolidated cases: **D/N/A**

19IWCC0435

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, former Arbitrator of the Commission, in the city of **Chicago**, on **2/17/16**. Arbitrator Gale did not issue a decision prior to leaving the Commission. The parties agreed to have a different arbitrator review the existing record and issue a decision based on that record. In July 2017, the Commission assigned the matter to Arbitrator Mason for this purpose. After reviewing the transcript and 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 X TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

Based on the evidence, the Arbitrator finds the date of accident to be December 7 rather than December 9, 2010. On that date, 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.

For the reasons set forth in the decision, the Arbitrator finds that Petitioner established causation as to a right foot contusion and right fourth metatarsal pain condition that remained symptomatic as of the hearing but failed to prove causation as to complex regional pain syndrome [CRPS].

In the year preceding the injury, Petitioner earned $**56,238.52**; the average weekly wage was $**1,081.51**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**105,283.81** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**105,283.81**.

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

ORDER

PETITIONER IS AWARDED REASONABLE AND NECESSARY MEDICAL EXPENSES IN THE AMOUNT OF $10,745.67 (PHYSICAL THERAPY PERFORMED AT ATI, PX 1) IN ACCORDANCE WITH THE FEE SCHEDULE.

PETITIONER IS AWARDED TEMPORARY TOTAL DISABILITY BENEFITS FOR THE PERIOD OF DECEMBER 8, 2010, THROUGH OCTOBER 4, 2013 (THE DATE OF THE SECOND FUNCTIONAL CAPACITY EVALUATION), AND MAINTENANCE BENEFITS FROM DECEMBER 10, 2014 (THE DAY AFTER PETITIONER WAS TOLD HE WOULD NO LONGER BE ACCOMMODATED) THROUGH THE HEARING OF FEBRUARY 17, 2016. BASED ON THE STIPULATED AVERAGE WEEKLY WAGE, THE ARBITRATOR FINDS PETITIONER'S WEEKLY TEMPORARY TOTAL DISABILITY AND MAINTENANCE RATE TO BE $721.00. RESPONDENT IS ENTITLED TO CREDIT FOR THE $105,283.81 IN TEMPORARY TOTAL DISABILITY BENEFITS IT PAID PRIOR TO TRIAL, PER THE PARTIES' STIPULATION. ARB EXHIBIT 1.

THE ARBITRATOR DECLINES TO AWARD PROSPECTIVE CARE IN THE FORM OF A SPINAL CORD STIMULATOR.

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

7/21/17
Date

ICArbDec19(b)

JUL 21 2017

19IWCC0435

Procedural History

Former Arbitrator Gale conducted a 19(b)/8(a) hearing in this case on February 17, 2016. He subsequently left the Commission without having issued a decision. The parties later agreed in writing to have another arbitrator write a decision based on the existing record. In July 2017, the case was reassigned to Arbitrator Mason for this purpose. Arbitrator Mason reviewed the transcript and exhibits and, on July 14, 2017, viewed Respondent's surveillance video (RX 4) in its entirety.

Summary of Disputed Issues

The parties agree that Petitioner sustained an accident on December 9, 2010, while working as a correctional officer for Respondent. They also agree that Petitioner provided timely notice of this accident to Respondent. The disputed issues include causal connection, medical expenses, whether Petitioner is entitled to temporary total disability benefits after September 24, 2013 and prospective care, with Petitioner seeking a spinal cord stimulator. Arb Exh 1.

Arbitrator's Findings of Fact Based on Transcript of February 17, 2016 and Admitted Exhibits

Petitioner testified he is married and has three children under the age of 18. T. 9-10.

Petitioner testified he began working for Respondent on May 3, 2004. He started out as a correctional officer cadet and became a correctional officer three months later, after graduating from the academy. T. 10-11. He was assigned to Division 9, a maximum security unit, and was given a tier officer position, which involved monitoring inmate activity and safety. T. 11.

Petitioner testified he attended roll call at 10:45 PM on December 8, 2010 and started his shift at 11:00 PM. His supervisor directed him and a fellow officer, K. Polk, to go to the receiving area, via a transport cart, to pick up an inmate and bring him back to the unit. Petitioner testified the transport cart has three wheels and is battery-operated. It weighs about 1,000 pounds.

Petitioner testified his accident occurred at about 1:00 AM, after he and Polk arrived back at the unit. Petitioner got out of the cart to open two security doors. Polk was driving. The inmate, who was not able to walk, was riding in the back of the cart. As Petitioner was holding the second door open, Polk drove through the opening, rolling over Petitioner's right foot in the process. Petitioner testified he experienced a lot of pain in his foot when this happened. T. 13-14.

Petitioner testified he reported the injury to his supervisor, Lieutenant Pearson. He was able to finish his shift, which ended at 7:00 AM. He then sought treatment at Respondent's dispensary. [No dispensary records are in evidence.]

Petitioner testified he saw Dr. Martin, a podiatrist, on December 13, 2010, at the recommendation of his family physician, Dr. Kamboj. [Dr. Kamboj's records are not in evidence but Petitioner underwent right foot X-rays at his direction on December 7, 2010. The X-ray report is also not in evidence.]

Dr. Martin's initial handwritten note of December 13, 2010, reflects that Petitioner "got R foot run over by motorized cart at work" six days earlier. The note also reflects that Petitioner saw his "PCP" thereafter and underwent X-rays.

Dr. Martin noted that Petitioner was walking with a slight limp and had not been able to resume working. He noted tenderness and edema on right foot examination. He diagnosed a right foot contusion. He prescribed medication and directed Petitioner to stay off work. PX 2, p. 4.

A note in Dr. Martin's chart reflects that a member of the doctor's staff tried to contact Petitioner via telephone on December 20, 2010, to have him come in to undergo repeat X-rays to check for a stress fracture. PX 2, p. 5.

Petitioner returned to Dr. Martin on December 22, 2010 and complained of increased pain and swelling in his right foot. Petitioner rated his pain at 6/10. It appears the doctor obtained X-rays but no X-ray reports are in evidence. The doctor prescribed Tylenol #3. He directed Petitioner to stay off work and prescribed a right foot MRI.

Petitioner underwent the right foot MRI on January 5, 2011. The history section of the MRI report reads as follows: "right foot pain after foot was run over by a steel cart 12/7/10." The interpreting radiologist compared the images with a right foot X-ray taken on December 7, 2010. He was not able to identify any osseous pathology but noted non-specific mild subcutaneous edema along the dorsal surface of the fourth and fifth metatarsals. PX 2, pp. 8-9.

On January 6, 2011, Dr. Martin notified Petitioner of the MRI results, via telephone, and directed him to stay off work until the next visit, on January 19th. PX 2, p. 10.

Petitioner returned to Dr. Martin on January 19, 2011, with the doctor noting "no improvement." The doctor's handwritten examination findings are difficult to read but it appears he noted edema. He prescribed Daypro and Tylenol #3. He directed Petitioner to stay off work and continue wearing the boot. PX 2, p. 11.

On February 14, 2011, Dr. Martin noted that Petitioner denied improvement and had discontinued the boot and anti-inflammatory medication. The doctor prescribed therapy. PX 2, p. 12.

Petitioner underwent an initial physical therapy evaluation at ATI on March 4, 2011. The evaluating therapist noted an antalgic gait pattern and tenderness with palpation of the right peroneal tendon and lateral gastrocnemius, as well as tenderness of the fourth and fifth metatarsals. He indicated that Petitioner complained of constant pain along the side of his right foot that increased with changes of position. Petitioner continued attending therapy on a regular basis thereafter. PX 2, p. 18.

On March 26, 2011, Dr. Martin noted that Petitioner was attending therapy but denied improvement. He prescribed an EMG and referred Petitioner to Dr. Roland for pain management. PX 2, p. 13.

On April 8, 2011, Petitioner underwent right lower extremity EMG/NCV studies. Dr. Holmes, a neurologist, conducted these studies. He recorded a history of the work accident, indicating it occurred on December 7, 2010. He noted that Petitioner complained of burning pain in his right foot, particularly

in the lateral aspect, and denied any symptoms above the ankle. He also noted that Petitioner had tried several medications but was currently taking only Advil.

Dr. Holmes described the EMG/NCV studies as normal. He found no electrical evidence of any peripheral nerve injury in the right foot to explain Petitioner's symptoms. PX 4, pp. 5-9.

On April 14, 2011, Petitioner saw Dr. Roland, a pain physician, at Dr. Martin's referral. Dr. Roland recorded a history of the December 7, 2010 work accident, noting that a tire on a cart "rolled over and clipped [Petitioner's] right foot." He also noted that Petitioner had been experiencing right foot pain since this accident and had not yet returned to work.

Dr. Roland described Petitioner as 5 feet, 11 inches tall and weighing 337 pounds. He described Petitioner's gait as normal. He did not note any findings specific to the right foot. He diagnosed complex regional pain syndrome. He directed Petitioner to return in two weeks. PX 5, pp. 4-11.

On April 20, 2011, Dr. Martin noted the negative EMG results and described Petitioner as "doing about the same." He recommended a triple phase bone scan and continued pain management. PX 2, p. 14.

Petitioner underwent the triple phase bone scan on April 29, 2011. Dr. Azam interpreted this scan as showing "increased isotope localization involving the right 4th metatarsal bone, indicating ongoing bony reaction such as a fracture." He recommended clinical correlation. PX 2, p. 15,

Petitioner last attended therapy at ATI on May 16, 2011, with the therapist noting ongoing complaints and limited tolerance for standing and walking. Petitioner was discharged from therapy at this point per Dr. Martin, based on the results of the triple phase bone scan. PX 2, p. 18.

Petitioner also saw Dr. Roland on May 16, 2011, with the doctor noting a complaint of persistent right foot pain, rated 5/10, exacerbated by walking, standing and work. The doctor also noted the results of the recent bone scan. He recommended a lumbar paravertebral sympathetic block. PX 5, pp. 12-14.

On June 1, 2011, Dr. Martin noted that Petitioner had undergone a block but remained symptomatic. He again diagnosed a right foot contusion but indicated Petitioner might also have complex regional pain syndrome. PX 2, p. 19.

On June 15, 2011, Dr. Martin noted that Petitioner complained of cramping and tingling in the affected foot and had been wearing a cast for four weeks. On examination, the doctor noted edema and tenderness in the ankle and foot. He recommended that Petitioner follow up with Dr. Roland. PX 2, p. 20.

On July 20, 2011, Dr. Martin noted that Petitioner complained of worsening right foot symptoms and reported being unable to put weight on his foot. The doctor recommended that Petitioner continue wearing a boot and follow up with Dr. Roland. He released Petitioner to sedentary work with use of the boot. PX 2, p. 21.

On August 18, 2011, Dr. Roland administered a right lumbar paravertebral sympathetic block. PX 5.

Dr. Roland re-examined Petitioner on August 29, 2011. He noted that Petitioner reported one week of relief following the injection. He noted tenderness over the dorsum and lateral aspect of the right foot and "no allodynia, no nail or hair changes." He recommended a series of blocks. PX 5, pp. 22-27.

At Respondent's request, Petitioner saw Dr. Lee of Midwest Orthopaedics on September 27, 2011, for purposes of a Section 12 examination. The doctor's report of that date sets forth a history of the work accident. The doctor noted that Petitioner finished his shift after the accident but was experiencing significant pain by that time. He also noted that Petitioner wore a cast for about a month after the accident, per Dr. Martin, but was now wearing a CAM boot. He indicated that Petitioner reported deriving about 20 to 30% pain relief following a recent sympathetic block by Dr. Roland.

Dr. Lee noted complaints of constant burning pain, stiffness over the forefoot, difficulty moving the lateral toes, inability to bear weight on the forefoot and extreme hypersensitivity. He indicated Petitioner was taking Lyrica and Tramadol for these symptoms.

Dr. Lee described Petitioner as 5 feet, 11 inches tall and weighing 330 pounds. He removed the CAM boot before examining Petitioner. He noted that Petitioner bore weight on his right heel rather than forefoot when walking. He saw no skin changes. He noted some "mild coolness to touch on the right side compared to the left" and some "mild flexible clawing of the lesser toes bilaterally." With further palpation, he noted "pinpoint tenderness over the fourth MTP joint as well as along the distal aspect of the fourth metatarsal shaft" and some moderate tenderness under the second, third and fifth MTP joints. He noted "no significant hypersensitivity to light touch over the skin" and a full range of ankle motion.

Dr. Lee obtained right foot X-rays. He indicated the films showed no fractures or other abnormalities. He interpreted the MRI images from January 2011 as negative.

Dr. Lee diagnosed "status post right foot contusion with metatarsalgia and possible RSD/CRPS." He described Petitioner's degree of disability as mild to moderate. He found a causal relationship between the work accident and Petitioner's current condition. He indicated Petitioner should be restricted to sedentary duty. He addressed treatment needs as follows:

> "His presentation as well as his exam does not appear to be classic for RSD or CRPS although he does describe improvement with the sympathetic blocks. Ultimately, indications would be to continue with subsequent workup and treatment for CRPS especially in light of his response to his initial injection as well as subsequent consideration based on his symptoms and complaints of a specific fourth MTP digital block to determine whether or not this provides any pinpoint localization and improvement of pain or complaints."

PX 14, pp. 23-27. PX 16.

Dr. Lee issued an addendum on September 30, 2011, after reviewing an accident report, a job description, Dr. Martin's records, the EMG/NCV report, the bone scan report, Dr. Roland's notes and

physical therapy notes. [No accident report is in evidence. A Dictionary of Occupational Titles job description appears at page 12 of PX 6 but no Respondent job description is in evidence.]

Dr. Lee indicated that his review of the additional materials did not prompt him to change any of the opinions he voiced in his September 27, 2011 report. PX 14, pp. 28-29. PX 16.

On December 6, 2011, Dr. Martin noted that Petitioner had undergone multiple injections and was now complaining of episodes of "complete numbness" in his right leg from the hip down. He also noted that Petitioner was no longer wearing the boot as he did not find it helpful. He continued to keep Petitioner off work and recommended ongoing pain management. PX 2, pp. 25-26.

Dr. Martin's records reflect that Petitioner cancelled appointments on January 12 and 23, 2012.

At Dr. Roland's direction, Petitioner underwent a functional capacity evaluation at ATI on March 7, 2012. T. 19-20. The evaluator, Chad Koch, ATC, CSCS, rated the evaluation as valid. He noted that he had not received a specific job description from Respondent. He rated Petitioner's job as a medium physical demand level occupation, based on the Dictionary of Occupational Titles. He found Petitioner capable of "what is best described as a 'modified' heavy physical demand level" based on Petitioner's lifting tolerances. He recommended that Petitioner only occasionally (i.e., 1-33% of the time) engage in "activities such as stairs, climbing and right foot repetition." He recommended that Petitioner engage in balancing activities on a minimally occasional basis. He noted that Petitioner had a "low tolerance to standing and walking." PX 2, pp. 30-31.

At Respondent's request, Dr. Lee re-examined Petitioner on April 24, 2012. In his report of that date, Dr. Lee noted that Petitioner had undergone seven sympathetic blocks to date, with none as effective as the first one and none providing any substantial benefit. He also noted that Petitioner had undergone an injection in the lateral forefoot, over the region of the fourth or fifth metatarsophalangeal joint and that this "did nothing to alleviate his pain." He noted that Petitioner actually felt worse than he felt at the time of the prior examination in September 2011. He indicated that Petitioner remained off work and complained of constant 8/10 pain and difficulty walking more than one block. He also noted that Petitioner described his entire right leg as "going numb" once his pain progressed.

Dr. Lee noted that Petitioner now weighed 350 pounds. He described Petitioner as wearing gym shoes, using a cane and exhibiting "more flat-footed weight bearing." He noted no skin discoloration, venous flushing or hair pattern changes. He further noted a full range of ankle motion, intact sensation and "some mild decreased flexion and extension at the MTP joints of the right lateral three toes." He indicated that further palpation revealed tenderness directly over the fourth MTP joint "with lesser involvement in the third and fifth" joints. He detected no significant hypersensitivity.

Dr. Lee obtained additional right foot X-rays. He interpreted the films as showing no abnormalities.

Dr. Lee noted the results of the recent functional capacity evaluation.

Dr. Lee diagnosed "status post right foot contusion with metatarsalgia." He described the degree of disability as mild. He saw no need for additional treatment. He characterized the treatment to date as reasonable and necessary. He found a causal relationship between the accident and

Petitioner's current condition. He reiterated that Petitioner "does not appear to have classic symptoms [or] signs consistent with RSD/CRPS." He found Petitioner to be at maximum medical improvement.

Dr. Lee addressed Petitioner's work capacity as follows:

> "I would agree with his functional capacity evaluation. Ultimately, while he is considered modified heavy category and his job description as indicated by FCE may demand a medium physical demand level . . . the main limitation of allowing him to return back to work would be the fact that he is essentially unable to have any type of significant prolonged standing, walking activity as well as would be unable to be in a position to protect himself in the event of any bodily harm."

PX 14, pp. 1-21. PX 16.

The Arbitrator notes that, while Dr. Lee found Petitioner to be at maximum medical improvement in his narrative report, he stated in his "quick report" of April 24, 2012 that Petitioner required more treatment "per pain specialist." PX 14, p. 17.

Petitioner testified he received a letter from Respondent's personnel department, directing him to appear for a meeting. On September 5, 2012, he met with Rosemarie Nolan at the Daley Center. He testified that Nolan was then head of personnel for Respondent. T. 21. He subsequently met with Pat Conway at GENEX on several occasions. He testified that Conway "was handling the job relocation program." GENEX required him to submit a minimum of ten job applications per week. GENEX provided him with five leads each week and he was required to find another five on his own. T. 22.

Petitioner testified he looked for work, through GENEX, between September 2012 and October 2013. He identified PX 9 as the job applications he submitted during this time. [PX 9 consists of 359 pages of job search records covering the period October 2012 to September 2013.] Petitioner testified he received no job offers from any of the employers he contacted. T. 23-24.

Surveillance video obtained on the afternoon of Saturday, June 29, 2013 shows Petitioner lifting a toddler into an SUV/van and walking between a short distance between this vehicle and a residence on a couple of occasions. Petitioner is not using a cane and exhibits no limp. RX 4.

Surveillance video obtained on the morning of Sunday, June 30, 2013, shows Petitioner at a gas station, filling a container and getting into an SUV/van. Petitioner is wearing flip flops and is not using a cane. At approximately 9:15 AM, he gets into the vehicle but does not close the driver's side door. He pulls forward a short distance, with his left foot and leg outside the vehicle. He then walks outside the vehicle, gets back into it and drives away. He has no cane. At approximately 9:36 AM the same day, he can be seen standing near a red truck, adjacent to a road, with his back to the camera. He puts gas into the red truck and then drives away in that vehicle. At approximately 10:15 AM, he gets out of the red truck, lifts a toddler out of the truck and walks with the toddler into a store, while carrying two clear water jugs. He exits the store later, pushing a cart that contains various grocery items. He is wearing flip flops and exhibits no gait abnormality. He has no cane. He and the child walk maybe 100 yards. He lifts the child into a flatbed trailer and then transfers various items, including the two water jugs, a

multi-can pack of beverage cans, into the trailer. He then transfers the child and a watermelon into the vehicle and drives away. RX 4.

On July 1, 2013, Rosemarie Nolan, Respondent's personnel director, sent Petitioner a letter directing him to appear at the personnel office no later than July 15th to surrender his credentials (i.e., his star, hat shield, sheriff's identification card and County identification card). Nolan indicated that all Sheriff employees in a non-active duty status were required to surrender these credentials and that Petitioner had failed to respond to an earlier letter dated May 24, 2013. PX 11.

On July 15, 2013, Rosemarie Nolan sent Petitioner another letter referencing Dr. Lee's opinions as to work capacity and indicating Respondent, in conjunction with the union, had "agreed to transitional work assignment(s) for up to six months for correctional officers that have temporary qualifying restrictions." Nolan directed Petitioner to report to the personnel office "no later than Monday, July 22, 2013." PX 10.

Petitioner testified he had not yet turned in his credentials when he received Nolan's letter of July 15, 2013. T. 26-27. He continued looking for work via GENEX after July 15, 2013. T. 27. PX 9.

It is agreed that Petitioner did not report to Respondent's personnel office on July 22, 2013.

On September 23, 2013, Dr. Roland prescribed a repeat functional capacity evaluation. PX 6, p. 89. Petitioner underwent this repeat evaluation at ATI on October 4, 2013. Chad Koch was again the evaluator. He described the evaluation as valid. He relied on the Dictionary of Occupational Titles job description, noting he did not receive a specific job description from Respondent. He found that Petitioner was functioning at a medium physical demand level, meaning he could occasionally lift 68 pounds from desk to chair level, 58 pounds above his shoulders, 53 pounds from chair to floor and carry 42 pounds. He went on to state:

> "Activities such as R foot repetition (such as braking in a car) are recommended on an occasional basis, due to demonstrated functional deficits. Occasional is defined as 1-33% of the time. Stairs/climbing, crouching, balancing activities and squatting are recommended on a minimally occasional basis. Kneeling and crawling are recommended 'not at all.' Mr. Steffan simply stated he could not perform these activities without significant pain. Mr. Steffan had a low tolerance to standing, walking and turning towards his R foot throughout the entire assessment."

PX 6, pp. 90-99.

On September 24, 2013, Petitioner appeared at Respondent's personnel office and met with Rosemarie Nolan. T. 28. He also underwent a drug screening. T. 28. Petitioner testified that Nolan ordered him to return to work that day but he did not return because he did not have a release from his own doctor or the "personnel doctor." T. 29. Rosemarie Nolan issued a memorandum to John Murphy the same day indicating Petitioner was not authorized to carry a weapon due to an "expired F.O.I.D. card" and stating Petitioner needed a cane in the workplace and would be assigned to the visitation center.

Petitioner acknowledged he did not begin working on September 24, 2013. At the advice of his union and attorney, and "because [he] did not have a release from" his own doctor or "the County doctor," he began calling in sick that day. T. 30. He was still subject to Dr. Roland's restrictions at that time. T. 30.

On January 20, 2014, Petitioner underwent gastric bypass surgery.

On May 23, 2014, Nancy Bourque, chief of Respondent's human resources office, sent Petitioner a letter informing him he was "currently in an unauthorized no pay status" and requiring him to report to a medical unit no later than June 6th "with a comprehensive diagnostic medical statement" from his physician covering the time he had been away from work. PX 13.

Petitioner testified he went to the medical unit on June 6, 2014, per Bourque's directive. He brought in paperwork (see PX 14, p. 11) and was prepared to see Dr. Mankowski, "the personnel doctor for the County," but was told his paperwork was insufficient. He was directed to the personnel office. He went to that office and met with Sean Lynch. He told Lynch his doctor needed a job description. Lynch "flat out refused" to give him a job description. Instead, Lynch gave him a packet of forms to be completed by his doctor in order for him to return to work. T. 32-33. Petitioner acknowledged he did not give Lynch a copy of the most recent functional capacity evaluation. He testified Lynch "didn't ask for" this. T. 33. He did provide the County physician his restrictions and a copy of the functional capacity evaluation. T. 33.

Surveillance video obtained on the afternoon of Friday, July 25, 2014, is of very brief duration. It shows Petitioner (now thinner) walking a short distance between a vehicle and a barn-like building. He does not have a cane. RX 4.

Surveillance video obtained at approximately 11:30 AM on Friday, August 1, 2014, is also of short duration. It shows Petitioner getting out of an SUV/van at a gas station, standing for a couple of minutes, getting back in the vehicle and driving away. Petitioner is wearing flip flops. He does not have a cane. RX 4.

On August 15, 2014, Dr. Roland's office issued a note directed to Emily Bourque, Respondent's bureau chief, indicating he was "going to defer to the results" of the functional capacity evaluation. The note goes on to state:

> "In regards to 'return to work status' . . . . our office does not perform any long or short term testing with regards to limitations of returning to work. The patient was already off of work when he first presented in 2011. Dr. Roland is a specialist, not a primary care provider, and will not be making any judgment on how, if or when his patient is capable of returning to work."

PX 14, p. 8.

Petitioner testified that, "eventually," he was returned to work as of September 17, 2014. He received no salary or temporary total disability benefits from Respondent between September 24, 2013 and September 30, 2014. T. 33-34.

On September 30, 2014, Dr. Powell issued a one-paragraph letter in which she addressed Petitioner's condition and work capacity. She indicated Petitioner was being released to work as of September 30, 2014 "with the restrictions outlined in his most recent functional capacity assessment dated October 4, 2013." She summarized these restrictions as follows:

> "Standing limited to 2 hours a day, walking 3-4 hours a day for moderate distance. He must be allowed to use a cane for walking and standing the entire work day. He can use his right foot for 2 hours a day. He is able to drive but is limited to 2 hours a day. He can crouch and climb stairs and squat for 1 hour a day. He is not permitted to kneel or crawl. He has no restrictions on carrying or using his service weapon."

Dr. Mankowski, a physician affiliated with Respondent's medical division, examined Petitioner on September 30, 2014. His examination notes (PX 14, p. 5) reflect he reviewed Dr. Powell's restrictions. He specifically indicated Petitioner reported no restrictions due to the gastric bypass. He essentially adopted Dr. Powell's restrictions and indicated Petitioner should be re-evaluated in one year. PX 14, p. 6.

Petitioner testified he resumed working on September 30, 2014. [See a "return to work" human resources form that Petitioner apparently completed on September 30, 2014, indicating he was taking Tylenol and using a topical cream and had undergone gastric bypass surgery on January 20, 2014. PX 14, p. 4] At that point, Respondent told him he was "being placed in a permanent ADA spot" in the call center on the south campus. T. 34. The job consisted of answering phone calls, running background checks for personnel and visitors and transporting personnel and officers to a parking lot via a van. Petitioner testified he had to drive the van "roughly two blocks." T. 35-36. He further testified the call center job was within the restrictions of the functional capacity evaluation. T. 35.

Surveillance video obtained on the morning of October 31, 2014 shows Petitioner's vehicle, initially moving along a road and then in a lot. A woman and child (in costume) get out of the vehicle. The woman later gets back in (on the passenger side) and the vehicle exits the lot. At approximately 8:50 AM the same day, Petitioner can be seen walking across a street with a woman and a child. He appears to be wearing shoes or boots. He does not have a cane. RX 4.

At Respondent's request, Dr. Lee re-examined Petitioner on November 6, 2014. Petitioner testified this re-examination lasted fewer than five minutes. T. 40-41.

In his report of November 6, 2014, Dr. Lee noted that Petitioner was still seeing a pain physician as well as his primary care physician, Dr. Powell. He also noted that, per Petitioner, "all medications were stopped in January 2014," following the gastric bypass, and that his physician "has restricted him from taking any medication other than Tylenol" since then. He indicated that Petitioner had undergone a functional capacity evaluation and two additional sympathetic blocks since his previous examination, with neither block providing any lasting relief. He noted that Petitioner was waiting for authorization of a spinal cord stimulator trial and had resumed working for Respondent, at an accommodated position, three weeks earlier. He described Petitioner as tolerating this position.

Dr. Lee noted that Petitioner primarily complained of a decreased range of motion in the lateral three toes of his right foot and targeted his right fourth MTP joint as "the area of maximal focus of his symptoms." He indicated that, when Petitioner's symptoms progressed, they radiated up his ankle and leg into his groin. He noted that Petitioner reported regularly using a cane and indicating "he does not leave the house without the cane."

Dr. Lee described Petitioner as wearing work boots, presenting with a cane and now weighing 255 pounds. On examination, he noted symmetric strength of 5/5, no skin discoloration, no difference in sweat or hair growth patterns and no difference in temperature between the right and left legs. He stated that "the only positive findings" on examination were Petitioner's complaint of tenderness in the fourth MTP joint with direct palpation, "with no further discomfort or pain with further palpation," and "slightly diminished range of motion of the MTP joint of the right foot compared to the left."

Dr. Lee obtained right foot X-rays. He interpreted the films as showing no abnormalities or deformities, no edema and no evidence of joint space narrowing or arthritic changes.

Dr. Lee indicated he reviewed "the functional capacity evaluation report." He did not indicate the date of the evaluation.

Dr. Lee again diagnosed "status post right foot contusion with fourth MTP joint pain." He found no need for any additional treatment, based on the largely negative examination findings and the lack of response to the blocks. He noted that Petitioner had taken no pain medication for over 11 months and exhibited no signs of reflex sympathetic dystrophy or complex regional pain syndrome. He saw no indications for a spinal cord stimulator or trial. He found Petitioner to be at maximum medical improvement and capable of full duty. RX 5.

Respondent offered into evidence a revised memorandum authored by Sean Lynch on November 20, 2014. In this document, Lynch stated that Petitioner "has the ability to RTW 11/17/14 full duty based on the results of an IME per risk management." He directed Petitioner to report to Division 8 on November 23, 2014 for a 7 AM to 3 PM shift. RX 3.

Petitioner testified that, at about 6 PM on December 6, 2014, Sergeant Martinez, his supervisor at the call center, handed him a piece of paper directing him to report to full duty on a different shift at a different division. T. 36-37. At this point, he was still subject to Dr. Roland's restrictions. He reported to Division 8, as directed, and presented his restrictions from Dr. Roland and "the County doctor" to the shift commander, Lieutenant Ross. Petitioner testified that Ross refused to look at the restrictions but told him he would "unofficially" put him in an "ADA spot" until "matters got resolved." T. 38. Petitioner testified he was able to perform the duties required in this unofficial position. He continued working in the position until December 9, 2014, at which point Lieutenant Pullman, a day shift supervisor, told him Respondent could no longer accommodate him.

Petitioner testified he has received no salary or other benefits from Respondent since December 9, 2014.

Dr. Roland testified by way of evidence deposition on March 23, 2015. The doctor testified he practiced emergency medicine in Ohio between 1982 and 1984, before doing a second residency, this time in anesthesiology, at the Cleveland Clinic Foundation. After he completed this residency, he moved to the Kankakee area and practiced anesthesiology and pain management between 1986 and 2000.

Since 2000, he has practiced pain management exclusively. PX 15, pp. 5-6. He is board certified in anesthesiology and planned to sit for recertification in pain management later in 2015. PX 15, p. 6.

Dr. Roland testified he has an independent recollection of Petitioner. He first saw Petitioner on April 18, 2011. Dr. Martin referred Petitioner to him. PX 15, p. 7. Petitioner complained of right foot pain secondary to a work accident in which a cart "rolled over and clipped his right foot." Petitioner indicated he was told he had a stress fracture. PX 5, p. 8.

Dr. Roland testified his examination notes from the initial visit do not mention any significant right foot findings. At that visit, he diagnosed complex regional pain syndrome involving the right lower extremity. This syndrome can occur in any extremity and can occur after a traumatic event. The pain will "typically outlast what would be considered the normal healing time" and can progress. PX 5, p. 9. His notes do not show whether he imposed any work restrictions at the initial visit. PX 5, pp. 9-10.

Dr. Roland testified that, at the next visit, on May 16, 2011, Petitioner complained of 5/10 burning pain in his right foot that was worse in the evening and moderately limiting his activities. The complaint of burning pain was consistent with complex regional pain syndrome. PX 5, p. 10. He suggested that Petitioner try a topical cream on his foot. He does not know whether Petitioner actually obtained this cream. He also reviewed a triple phase bone scan, which was abnormal, "showing a bony reaction at the fourth metatarsal on the right side." He is not a radiologist but, with complex regional pain syndrome, you can see findings within the bone, depending on the timing of the scan vis-à-vis the injury. PX 5, p. 12. He recommended a lumbar paravertebral sympathetic block.

Dr. Roland testified that, in June and July 2011, he refilled Petitioner's medication, which at that time included Lyrica and Tramadol. On August 18, 2011, he performed a right lumbar paravertebral sympathetic block. This involved injecting medicine to the front and side of the vertebral body between L2 and L4 which transmits pain impulses from an extremity. On August 29, 2011, Petitioner's pain was 6/10 and still "over the right fourth toe." PX 5, p. 13. Petitioner reported some relief from the Lyrica and felt he was able to move his toes a little more easily. PX 5, p. 14. Dr. Roland recommended more blocks. He administered additional blocks on October 13 and 24, 2011 and on November 3, 2011. On November 17, 2011, Petitioner again rated his pain at 6/10 and told him the last three injections helped for only a few days, after which his pain returned to its original level of intensity. PX 5, p. 15. He recommended another block, this time using needles at both L2 and L5. He administered this type of block on December 1 and 15, 2011. On January 19, 2012, Petitioner again rated his pain at 6/10 and stated the last blocks "did not offer any additional relief." At this point, Petitioner was complaining of his right leg as well as his right foot. He indicated his right leg was weak and numb and occasionally giving out on him. Dr. Roland testified he prescribed a lumbar spine MRI and functional capacity evaluation. He also discussed the possibility of Petitioner using a spinal cord stimulator. PX 5, p. 18. He believes he had Petitioner off work during the time he was administering the various injections. PX 5, p. 19. He has had other patients with complex regional pain syndrome who have benefited greatly from spinal cord stimulators. PX 5, p. 19.

Dr. Roland testified the lumbar spine MRI was normal. On April 12, 2012, he started Petitioner on Topamax. On May 14, 2012, he reviewed a functional capacity evaluation which indicated that Petitioner was severely limited as to standing and walking. Because he did not know how much walking Petitioner had to do at work, he asked Petitioner to provide him with a formal job description. PX 5, pp. 21-22. He discontinued the Topamax because Petitioner told him it was causing mood changes. PX 5, p. 22. He started Petitioner on Neurontin and continued the Tramadol. Petitioner asked him for a

handicapped sticker "because he was having a lot of difficulty walking any distance." He told Petitioner he had to go to the DMV to obtain a form for such a sticker. PX 5, p. 22. He based any ongoing restrictions on what the functional capacity evaluation showed. PX 5, p. 23.

Dr. Roland testified he next saw Petitioner on July 9, 2012. Petitioner reported being able to stand a little longer due to the Neurontin but was experiencing swelling when he stood for a long period. He switched Petitioner from Neurontin to Cymbalta and continued the Topamax. PX 5, p. 24. He was still waiting to receive a formal job description from Petitioner's employer so he did not change Petitioner's work status. He again recommended a spinal cord stimulator. PX 5, pp. 24-25.

Dr. Roland testified he next saw Petitioner on December 6, 2012. On that date, Petitioner rated his pain at 8/10. He indicated that Petitioner would be scheduled for a spinal cord stimulator trial. PX 5, p. 25.

Dr. Roland testified he did not see Petitioner again until July 15, 2013. Petitioner's complaints were unchanged and the stimulator had not been approved. He again recommended the stimulator. PX 5, p. 27.

Dr. Roland testified that, at the next visit, on September 23, 2013, he prescribed a repeat functional capacity evaluation because Petitioner brought in a work form that he wanted him to complete. Petitioner underwent the repeat evaluation on October 4, 2013. On November 7, 2013, he again recommended the stimulator. Petitioner did not come back again thereafter until July 7, 2014. He rated his pain at 6/10 at that visit. Petitioner reported he had undergone gastric bypass surgery and had been taken off all pain medication other than Tylenol. He prescribed a topical neuropathic cream. PX 5, pp. 29-30. He again recommended the stimulator.

Dr. Roland testified he first reviewed the repeat functional capacity evaluation at Petitioner's last visit, on August 14, 2014. He did not recommend any permanent restrictions on that date. He is still waiting for a job description. PX 5, p. 31. He might recommend restrictions, depending on what the job description says. PX 5, p. 32. As of August 14, 2014, he was still recommending the stimulator because he thought it would benefit Petitioner. He still thinks it is worthwhile for Petitioner to undergo a stimulator trial, assuming Petitioner remains symptomatic. PX 5, pp. 32-33.

Dr. Roland opined that the crush injury from the work accident brought about the need for the treatment he rendered. Petitioner's complaints were consistent with a crush injury and he never provided a history of any trauma other than the work accident. PX 5, p. 33. At no point did he think Petitioner was malingering. PX 5, p. 33. He has not seen Petitioner in a long time. If Petitioner came back to him and was "still asking" to be taken off work, he would want to see the job description before addressing the need for any restrictions. PX 5, p. 34.

Under cross-examination, Dr. Roland testified that Petitioner has no upcoming appointments to see him. He released Petitioner from care on a PRN basis in August 2014. Petitioner has not contacted him since then. PX 5, pp. 34-35. Petitioner is not seeking any prescriptions from him. PX 5, p. 35. After Petitioner complained of his right leg, he ordered a lumbar spine MRI. Petitioner also had an EMG. Both the lumbar spine MRI and the EMG were normal. The EMG, which he did not order, did not show any evidence of radiculopathy. He is not sure who ordered the EMG. It was done early on, in 2011. PX 5, p. 36. Petitioner never brought a job description to him. He never had any contact with anyone at

Petitioner's workplace. To the best of his knowledge, Petitioner never returned to work during the time he was treating Petitioner. PX 5, p. 37.

Dr. Roland identified RX 1 as a note he wrote on January 9, 2014. In this note, he indicated Petitioner could work within the guidelines of the functional capacity evaluation. He also indicated he had not received a job description. He further stated he did not take Petitioner off work and would not be involved in returning Petitioner to work. Petitioner "repeatedly" asked him to say he could not work and he was not willing to say this. Petitioner asked him to say this multiple times and he was "just not willing to do that." This is why he "insisted" on a functional capacity evaluation and requested a job description. PX 5, p. 39. He was not willing to keep Petitioner off work indefinitely. He generated the note in January 2014 because Petitioner kept asking him about his work status. He hoped the note would lay that issue to rest. PX 5, p. 39.

Petitioner identified PX 1 as an unpaid bill relating to the physical therapy he underwent at ATI. T. 41.

Petitioner testified he continues to experience pain in his right foot. He uses a cane (which he had at the hearing) at Dr. Roland's recommendation. He uses this cane "every day." He testified he needs the cane because his right leg "will go numb on its own," causing him to lose control over the leg. T. 43. Dr. Roland gave him a handicapped placard, which he continues to utilize. Dr. Roland has recommended he undergo a spinal cord stimulator trial. He wants to undergo this. T. 42.

Under cross-examination, Petitioner testified he believes he last saw Dr. Roland in August 2014 to address return to work issues. He has not returned to Dr. Roland because there is "nothing left to do." He last saw Dr. Powell of Riverside Medical Center around September 2014, before he resumed working. Dr. Powell was not his family physician at the time of the accident. She took over for that physician. It was actually Dr. Powell, not Dr. Roland, who approved his handicapped placard. Dr. Roland recommended the placard but told him that, under Illinois law, it is the family physician who must prescribe such a placard.

Petitioner denied being released to restricted duty in July 2013. He reported to work and completed a drug screening in September 2013 because Respondent's personnel department directed him to do this but he did not have a release to work from Dr. Roland or "the County doctor" at that time. T. 48. The doctor said he could resume restricted duty but did not fill out any paperwork to that effect. T. 48. Respondent's "GOP" [General Operating Procedures] state than an employee cannot return to work until he is cleared by a Respondent physician. In order to see that physician, he had to have paperwork completed by his own physician. T. 49. Because he did not have any release from his own doctor or the County doctor as of September 2013, he did not report to work after undergoing the drug screening. At the advice of his union and his attorney, he began calling in sick to work in September 2013. T. 49-50. In June 2014, Respondent directed him to report to work. He did not actually begin working in the call center until September 2014 because it took three months to get all the paperwork lined up to resume working. T. 50. Dr. Lee re-examined him in November 2014. Dr. Lee reviewed the functional capacity evaluation that had been conducted in 2013. Dr. Lee had previously agreed with the restrictions recommended by the functional capacity evaluator. T. 52. After the November 2014 re-examination, he learned that Dr. Lee had found him capable of full duty. He reported to work at Division 8 on December 6, 2014 and worked for about two weeks, at which point Lieutenant Pullman told him he "could no longer have [his] cane." At that point, he stopped going to work and started calling in sick again. T. 54. He continued calling in sick until the early fall of 2015, at

which point he stopped calling in. He never returned to work. During the time he saw Dr. Roland, he did not ask the doctor to give him "off work" slips. If Dr. Roland testified to this, he is lying. T. 56. Dr. Roland told him he would not have anything to do with keeping him off work or releasing him to work. T. 56.

Petitioner testified he needs a cane to walk but "only for longer distances." He is able to walk short distances without the cane. T. 57. He is not currently undergoing any treatment. T. 57. He would like to return to work for Respondent. He "never wanted to leave in the first place." T. 57. At times after the accident, Respondent provided him with accommodated work. T. 57. This changed after Dr. Lee found him capable of full duty. T. 58. Since December 2010, he has worked a total of three months or less at Respondent. T. 58. He conducted a job search through GENEX earlier, in 2012, during a time when Respondent had no light position available for him. T. 58. The General Operating Procedures do not require any individual who has been off duty for 180 days due to a work injury to turn in his credentials. T. 59. Sean Lynch refused to provide him with a job description. His doctor never received a job description. He does not know how the functional capacity evaluator did the evaluation without a job description. T. 60.

On redirect, Petitioner testified that, as of June 2014, Respondent had a "packet for return to work" which he needed to pick up and take to Drs. Roland and his family physician. Once those doctors completed the forms in this packet, he had to take the forms "to the Cook County building to see the personnel doctor." T. 61-62.

Petitioner testified that, when he says he can walk short distances without a cane, he means he can walk from a parking lot into a store. Once he gets inside the store, he "needs a cart to walk around." It is painful for him to walk without the cane "but it's better than having to drag a cane around." T. 63.

In response to a question asking about what activities he has engaged in since December 2014, Petitioner testified he has simply been waiting for his case to be heard. T. 63.

Under re-cross, Petitioner acknowledged viewing Respondent's surveillance video over the lunch break, before he resumed testifying. T. 63.

James Martin, a workers' compensation claims adjuster employed by Respondent's risk management department, testified he has handled Petitioner's claim since May 2012. Before testifying, he reviewed his file concerning Petitioner's claim. He identified RX 1 as an accurate copy of a print-out of the temporary total disability and medical benefits Respondent paid in the claim. Respondent paid Petitioner temporary total disability benefits from December 8, 2010 through "at least September 24, 2013." T. 67-68. As of May 2012, when he began handling Petitioner's claim, Respondent was not able to accommodate Petitioner and was therefore paying Petitioner temporary total disability benefits. T. 68. At some point in 2013, Respondent changed its policy and began offering light duty to employees who were subject to restrictions. Respondent "invited" Petitioner to begin a light duty job in 2013. Respondent paid Petitioner temporary total disability benefits through September 24, 2013. It was "sometime after that" that Petitioner "was returned to work" at a center for visitors. T. 71-72. His subsequent note, of May 30, 2014, reflects that Petitioner had not worked since September 24, 2013. He set up an appointment for Petitioner to be re-examined on November 6, 2014, to determine whether Petitioner's condition had changed. T. 76-77. The examiner found Petitioner capable of full duty. On November 17, 2014, he (Martin) notified Respondent of this finding. T. 77.

Martin testified he has sometimes arranged for surveillance of claimants. He does this with employees who "tend to fall outside ..... the normal guidelines of the injury described." The only way he can tell whether an employee is performing activities beyond his claimed limitations is to obtain surveillance. T. 78. He ordered surveillance of Petitioner "on a number of occasions," including June 2013 and July, August and October 2014. T. 78. From the surveillance, he "learned that [Petitioner] does not use the cane when he's away from work." T. 78. The surveillance contradicted Petitioner's claim that he needed to use a cane to walk around. T. 79. He believes Petitioner has not returned to work for Respondent. Petitioner has not contacted him to arrange for any return to work. T. 79.

Under cross-examination, Martin testified that, to the best of his recollection, Petitioner was offered a job that met his restrictions on September 30, 2014. He does not know whether Petitioner actually performed this job. He has nothing to do with payroll. Once a claimant returns to work, he simply provides medical management. T. 86-87. On November 17, 2014, he notified Respondent, via E-mail, of Dr. Lee's opinion that Petitioner was capable of full duty. T. 88. His file contains a couple of notes from Dr. Roland. T. 89. The restrictions Dr. Roland imposed contradict Dr. Lee's opinion that Petitioner can perform full duty. T. 90. When he sent Respondent the E-mail, on November 17, 2014, it was his understanding Petitioner was not working in any capacity. T. 91. He reviewed some of the surveillance footage but has not seen the entire CD. T. 92. The footage he saw showed Petitioner without a cane. He does not know whether Petitioner used a cane on other occasions outside those shown on the video. T. 92-93.

On redirect, Martin testified he believes Dr. Roland last saw Petitioner a year before Dr. Lee's November 2014 re-examination. T. 93-94. He obtained the re-examination to try to update Respondent with respect to the issue of whether Petitioner required restrictions. T. 94.

Sean Lynch, a human resources generalist employed by Respondent at the Department of Corrections, testified he handles a variety of "return to work" issues for employees who are returning to work after duty and ordinary disability, military or maternity/paternity leaves. T. 96. Before such an employee can return to work, he is required to obtain a medical update from his primary physician and take it to Respondent's medical unit, which used to be in Room 849 at the Cook County building. T. 97. Once the employee presents the update to the medical unit, a nurse evaluates the employee and presents paperwork to the human resources department, which has to clear the employee to return to work. T. 98.

Lynch testified that, on June 21, 2013, James Martin of the risk management department contacted him, following a Section 12 examination, to determine whether Respondent could accommodate Petitioner. He or his department then did research to determine whether Petitioner's restrictions could be met. On July 15, 2013, he sent a letter to Petitioner directing him to report to personnel a week later concerning an accommodated work position. Petitioner failed to show up on the date he was told to report. Petitioner did not report until September 24, 2013, at which time an individual named Nolan, who was then head of personnel, "completed the return to work process." Lynch testified that, once an employee is cleared to return to work based on an independent medical examination, the employee is not required to see "the County doctor" before reporting to work. T. 101. On September 24, 2013, Petitioner was returned to a light duty job in Division 5 "at the visitation center." T. 101. Petitioner did not actually begin working, however. Petitioner completed the return to work process at the Daley Center and was then sent for drug testing but did not go to work. Instead, Petitioner began calling in sick to the medical department. In May 2014, Respondent sent Petitioner a letter requiring him to provide a statement from his primary care physician explaining what was

happening with him medically. Petitioner "ran out of medical time" as of November 18, 2013. Between September 24, 2013 and November 18, 2013, Petitioner had three unpaid days, two "absent late calls" and one "absent no call." T. 104. After November 18, 2013, Petitioner "was carried no sick time all the way through the 29th of September of 2014." During that period, Petitioner had five "absent late" calls and eleven "absent no calls." Petitioner "called in meticulously every single day to cover his absence" but it is not clear why he did this, because Respondent had made a job available to him. Respondent requires any individual who is away from the workplace for 180 days or more, due to a work injury, to turn in his credentials. T. 105. This requirement applies to all sworn personnel. T. 104-105.

Lynch testified that Petitioner returned to an accommodated job at Respondent on September 30, 2014. Petitioner performed that job thereafter through November 22, 2014, "with restrictions presented by his physician that were more elaborate than the IME restrictions." Ironically, however, the restrictions that Petitioner's physician provided did not address the issue of whether Petitioner would be able to protect himself in the event of bodily harm, even though the IME, Dr. Lee, addressed this issue. T. 107.

Lynch testified he prepared a "return to work release" after he learned from James Martin, on November 17, 2014, that the IME had found Petitioner capable of full duty. On November 20, 2014, he sent Superintendent Brown a memorandum notifying him of the IME's finding and indicating Petitioner had been directed to report to full duty at Division 8 on November 23, 2014. He sent a separate E-mail to Jennifer Black, who was then the director of the visitation center, to ensure that Petitioner was properly informed of his new job assignment. Petitioner called in "IOD duty injury" on November 23, 2014. Petitioner was "coded IOD" between November 23 and 29, 2014. He reported to work on November 30, 2014. Between November 30 and December 27, 2014, Petitioner worked five days, called in sick four days and took eleven "no sick" days. He also called in medical time but did not actually have such time available. T. 112. The last day Petitioner actually worked was December 21, 2014. Since December 28, 2014, he has been "carried no sick time and absent no call." T. 112.

Lynch testified he never refused to provide a job description to Petitioner's doctors. No one ever asked him to provide such a description. T. 113.

Under cross-examination, Lynch testified he is aware that Petitioner looked for work via GENEX for a period. He believes Respondent no longer utilizes GENEX. He did not issue a letter to Petitioner in September 2013, offering him a light duty job. T. 115. Rosemarie Nolan sent Petitioner a letter on July 15th, giving him one week to report to the personnel department. The letter advised Petitioner that a position was available. To his knowledge, no other letter was sent to Petitioner at that time. T. 117-118. After April 2012, Dr. Lee did not re-examine Petitioner until September 2013. Between September 2013 and the re-examination in November 2014, he did not receive any revised restrictions from Dr. Roland. T. 119.

On redirect, Lynch testified he does not fully understand what type of services GENEX provided to Respondent. T. 120. He does not know whether Respondent had light duty positions available for Petitioner in 2012. The Sheriff's office went through a transition after a new Sheriff came in. There was a period in the past, however, when an employee could resume working only after being released to light duty. He does not know exactly when this period ended. T. 120-121. Petitioner received temporary total disability benefits from December 8, 2010 through September 24, 2013, when he was offered an accommodated job. T. 121.

Arbitrator's Credibility Assessment

As noted at the outset, the Arbitrator has based this decision on the transcript and exhibits, at the request of the parties. The Arbitrator did not participate in any way in the hearing held on February 17, 2016 and has had no interaction with Petitioner.

The credibility-related evidence is mixed.

Petitioner's pain management physician, Dr. Roland, did not perceive Petitioner as malingering. However, at his deposition, he expressed frustration with Petitioner's repeated requests to be kept off work. He deferred to the functional capacity evaluations while simultaneously attempting to distance himself from the issue of Petitioner's work capacity. Under cross-examination, Petitioner denied asking Dr. Roland for "off work" notes. He indicated the doctor was lying if he testified to this. The Arbitrator accepts Dr. Roland's version of events.

Petitioner testified that Dr. Roland prescribed a cane for him. Dr. Roland did not testify to this. The Arbitrator finds no evidence of such a prescription in the doctor's records. PX 8.

Dr. Lee examined Petitioner on three occasions. He never noted symptom magnification. He twice found Petitioner capable of only restricted duty, per the recommendations of the functional capacity evaluator, but ultimately found him capable of full duty, while continuing to diagnose a pain condition.

Chad Koch, the individual who conducted both of Petitioner's functional capacity evaluations, rated the evaluations as valid. He did not note any inconsistencies. In his report concerning the second evaluation, he recommended that Petitioner perform no kneeling or crawling, indicating that Petitioner "simply stated he could not perform these activities without significant pain."

The surveillance videos do not show Petitioner engaging in work, walking long distances or performing activities outside those recommended by the functional capacity evaluator. They do, however, conflict with Petitioner's alleged statement to Dr. Lee that he "does not leave his house without a cane." RX 5.

Arbitrator's Finding Concerning Accident Date

The parties stipulated to an accident occurring on December 9, 2010 but various documents in evidence, including forms completed by Petitioner, reflect the accident took place on December 7, 2010. The Arbitrator finds an accident date of December 7, 2010.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident and any claimed current condition of ill-being?

The Arbitrator finds that Petitioner established causation as to a right foot contusion and right fourth metatarsal pain condition which remained symptomatic as of the hearing. The Arbitrator finds that Petitioner ultimately did not establish causation as to complex regional pain syndrome but that it was reasonable, in 2011, for his treating physicians, Drs. Martin and Roland, to order studies to check for

this syndrome. Respondent's examiner, Dr. Lee, concluded Petitioner does not have CRPS but he never found Petitioner to be asymptomatic.

On the issues of diagnosis and causation, the Arbitrator assigns greater weight to Dr. Lee's opinions than to those voiced by Dr. Roland. Dr. Roland opined that Petitioner has complex regional pain syndrome but he did not explain this opinion at his deposition. He simply indicated that Petitioner's subjective complaint of burning pain was consistent with the disorder. He did not point to any unusual examination findings. In fact, he conceded that nothing stood out in his mind with respect to his initial examination. Only two of his notes specifically mention the right foot. The first, dated August 29, 2011, indicates he noted no allodynia and no nail or hair changes. The second, dated July 7, 2014, reflects that the foot was not discolored and only minimally swollen. The doctor noted no allodynia but indicated the right leg was "slightly smaller than the left from the knee down." PX 8, p. 95. At his deposition, Dr. Roland conceded that individuals who have complex regional pain syndrome typically experience some relief from sympathetic blocks and that Petitioner, who underwent several such blocks, reported only transient relief from the earliest interventions and no relief from the later ones.

Is Petitioner entitled to the expenses associated with the physical therapy he underwent at ATI in 2011?

Petitioner claims one medical expense, namely a $10,745.67 bill from ATI for physical therapy he performed in the spring of 2011 at Dr. Martin's recommendation. PX 1. The ATI records reflect that "Theresa," a nurse affiliated with GENEX, authorized this therapy and that a utilization review physician certified the need for an initial twelve visits and partially certified additional visits. PX 6, pp. 43-45. In his report of April 24, 2012, Dr. Lee characterized the treatment to date as reasonable and necessary.

The Arbitrator awards Petitioner the ATI bill of $10,745.67, subject to the fee schedule.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from December 9, 2010 through September 30, 2014 (the day he started a light duty assignment) and from December 9, 2014 (the last day he performed the light duty assignment) through the hearing of February 17, 2016. Respondent claims it owes Petitioner no benefits after September 24, 2013, based on the surveillance and its offer of light duty employment. The parties agree Respondent paid temporary total disability benefits through September 24, 2013 and is entitled to credit in the amount of $105,283.81 for the benefits it paid through the hearing. Arb Exh 1.

The Arbitrator finds that Petitioner's causally related right foot contusion and right fourth metatarsal condition stabilized as of October 4, 2013, the date of his second functional capacity evaluation. The Arbitrator finds it reasonable for Dr. Roland to have recommended a second evaluation, given that eighteen months had passed since the previous evaluation in March 2012. While Respondent's examiner, Dr. Lee, found Petitioner to be at maximum medical improvement in his formal report of April 24, 2012, he indicated in his "quick report" of the same date that Petitioner needed more pain management.

Although the parties disagree on various issues, they agree Petitioner showed up to work on September 24, 2013, underwent a required drug screening and then began calling in sick. Petitioner testified he did this at the advice of his attorney and union and because he had not been cleared by the

County physician. Sean Lynch, a human resources generalist for Respondent, testified Petitioner did not have to obtain this clearance because Respondent was offering an accommodated position based on a Section 12 examination. T. 101. The Arbitrator finds Lynch more credible on this issue. The Arbitrator finds it likely that part of Petitioner's reason for calling in sick rather than beginning an accommodated job because he was anticipating a significant surgery, i.e., a gastric bypass. He underwent this surgery in January 2014. Petitioner also offered no rational explanation for the delay in transmittal of the results of his second functional capacity evaluation. If any uncertainty about Petitioner's need for restrictions remained as of September 24, 2013, it should have resolved as of October 4, 2013. When Dr. Roland saw Petitioner on November 7, 2013, he noted that Petitioner had recently undergone a second evaluation but he did not reference any results. He directed Petitioner to return in three months. Petitioner did not do so. He did not return to Dr. Roland until July 7, 2014, well after the bypass surgery. As of that date, Dr. Roland still did not have the results of the evaluation. The doctor testified he did not learn of these results until Petitioner's last visit, on August 14, 2014. [This testimony coincides with the records. See PX 8, p. 104.] Petitioner's passivity between September 24, 2013 and September 30, 2014 is not well-explained.

With respect to the first claimed interval (much of which is stipulated), the Arbitrator finds Petitioner was temporarily totally disabled from December 8, 2010 through October 4, 2013.

The Arbitrator finds that Petitioner is entitled to additional weekly benefits, in the form of maintenance rather than temporary total disability, from December 10, 2014 (the day after Petitioner was told he would no longer be accommodated) through the hearing of February 17, 2016. This is a period of 62 1/7 weeks. The Arbitrator finds Dr. Lee persuasive insofar as diagnosis and treatment needs are concerned but is not persuaded by the doctor's opinion that Petitioner was capable of full duty as of November 6, 2014. Petitioner is a guard in a maximum security prison. As Dr. Lee conceded in his April 24, 2012 report, that job involves security concerns. Petitioner could be called upon to defend himself or come to the aid of inmates, other guards or visitors. Both of his functional capacity evaluations were valid. Both showed he has a limited tolerance for standing, walking and climbing. Dr. Lee's diagnosis did not change between his second examination of April 24, 2012 and his last examination of November 6, 2014. He diagnosed a right foot contusion and right fourth metatarsal pain condition on both dates. He referenced valid functional capacity evaluations on both dates. It makes no sense to the Arbitrator that he would find Petitioner capable of only restricted duty on April 24, 2012 but capable of resuming his full correctional officer duties as of November 6, 2014. His opinion on that issue also conflicts with that expressed by "the County physician," Dr. Mankowski, only six weeks earlier, on September 30, 2014. PX 14, pp. 5-6. Dr. Mankowski recommended multiple restrictions, consistent with the second functional capacity evaluation.

Is Petitioner entitled to prospective care in the form of a spinal cord stimulator trial?

The Arbitrator has previously found that Petitioner established causation as to a right foot contusion and right fourth metatarsal pain condition that remained symptomatic as of the hearing but failed to prove causation as to chronic regional pain syndrome. The Arbitrator declines to award the spinal cord stimulator trial that Dr. Roland recommended for this syndrome. Dr. Roland failed to adequately explain the basis for his diagnosis. He conceded Petitioner did not respond to a series of blocks that typically help people who have the condition.

A stimulator could, potentially, allow an individual to wean off narcotic pain medication but Petitioner already did this, at the direction of his primary care physician, following his January 2014

gastric bypass. As of Dr. Lee's last examination, on November 6, 2014, Petitioner was taking only Tylenol for his symptoms and successfully performing an accommodated job. At the February 2016 hearing, he did not testify to taking any pain medication, prescription or otherwise. He failed to establish the need for a spinal cord stimulator.

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

MAZEN HASAN,

Petitioner,

vs. NO: 18 WC 2799

EAGLE SPORTS RANGE,

Respondent.

19IWCC0436

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 accident, causal connection, medical expenses, temporary total disability, prospective medical care, and penalties and 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. 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, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes that Petitioner was a recipient of public aid and that Advocate Christ Medical Center accepted reduced payment of its bill for services rendered Petitioner from October 25, 2017 through October 31, 2017. The Commission modifies the Arbitrator's Decision on the issue of medical expenses and awards the full amount of $70, 999.45, subject to the medical fee schedule, for the Advocate Christ Medical Center bill, with the expectation that the provider will reimburse the Illinois Department of Public Aid the sum of $19, 481.23 it was paid on Petitioner's behalf. Thus, Respondent will not benefit from the reduced reimbursement rate

the provider accepts from Illinois Department of Public Aid at the expense of the taxpayers of the State of Illinois.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 27, 2018 is hereby modified as stated herein and is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses incurred as provided under Section 8(a) and 8.2 of the Act for the following unpaid medical expenses: City of Oak Forest $1,625.00; IICIIA Imaging Consultants-$161.00; Advocate Medical Group- $1,508.00; and Midland Orthopedics- $9,441.45; Advocate Christ Medical Center- $70,999.45.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $324.48 per week for 24 1/7 weeks commencing October 26, 2017 through April 12, 2018 as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize, approve and pay for the recommended post-surgical treatment recommended by Dr. Lieder in his chart note of January 23, 2018, along with related services, in accordance with sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for penalties and attorney's fees is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court 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 $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.

19IWCC0436

DATED: AUG 16 2019
o-06/19/18
SM/msb
44

Stephen Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/ DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

HASAN, MAZEN
Employee/Petitioner

Case# **18WC002799**

EAGLE SPORTS RANGE
Employer/Respondent

19IWCC0436

On 7/27/2018, 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 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

1596 MEACHUM & STARCK
JAMES JANNISCH
225 W WASHINGTON ST SUITE 500
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)/8(a)

Mazen Hasan
Employee/Petitioner

v.

Eagle Sports Range
Employer/Respondent

Case # 18 WC 02799

19IWCC0436

An *Application for Adjustment 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 **April 12, 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **10/25/2017**, 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* 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 **$25,309.96**; the average weekly wage was **$486.73**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **no** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $324.49/week for 24-1/7 weeks commencing October 26, 2017 through April 12, 2018, as provided in §8(b) of the Act.

Respondent shall pay Petitioner reasonable and necessary medical services of $32,216.68, as provided in §§8(a) and 8.2 of the Act, for the following unpaid medical expenses: City of Oak Forest-$1,625.00; IICHA Imaging Consultants-$161.00; Advocate Christ Hospital-$19,481.23; Advocate Medical Group-$1,508.00; and Midland Orthopedics-$9,441.45.

Respondent shall authorize, approve and pay for the recommended post-surgery treatment prescribed by Dr. Lieder in his chart note of January 23, 2018, along with all related services, in accordance with §§8(a) and 8.2 of the Act.

Petitioner's claim for penalties and attorney's fees is denied.

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

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

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

Signature of Arbitrator

July 26, 2018
Date

JUL 27 2018

FINDINGS OF FACT

Petitioner was employed by Respondent as a salesman and firearms instructor. He was hired in September of 2016. His job duties included selling guns and ammunition and teaching firearms proficiency and concealed/carry classes. Respondent is a gun store with an on-site firing range. Petitioner has an Illinois Concealed/Carry permit and an instructor's permit. He obtained the concealed carry permit in 2014, before he began working at Respondent.

Petitioner and many other employees of Respondent carried loaded weapons on their person when they were in the store. They were mostly carried as sidearms, in a holster. Petitioner's testimony was that Respondent encouraged its employees to carry guns on premises. Petitioner testified that he carried a loaded gun for his protection, the protection of customers and the protection of Respondent's business. Obviously, having its salesmen and other staff carrying holstered guns provided a marketing benefit to Respondent and operated to increase security at the store.

Respondent did not require its employees to be armed at the store. Respondent did not prohibit employees from carrying loaded weapons on its premises. Petitioner was not disciplined for not carrying a weapon on premises. He did not receive any bonus for being armed at Respondent's store. Petitioner's choice to have a loaded, holstered, weapon on his person while working in Respondent's store was clearly his own. Management at Respondent did seem to criticize Petitioner for not carrying a weapon when working in the store.

Petitioner does not unholster his personal weapon as a part of his job duties as a salesman or instructor.

The Arbitrator finds that the culture at Respondent was for employees to carry holstered handguns while working at the store.

Prior to his accident, Petitioner had seen other employees accidentally discharge their weapons at the store. They were not asked to stop carrying loaded weapons on their person at work. Petitioner never saw any security working for Respondent, other than the employees who carried loaded firearms on their person. Petitioner testified that almost all other employees carried loaded firearms at work and were encouraged to do so by the owner of Respondent's business.

When Petitioner arrived at work each morning, he would clock in and then load and holster his gun before going out onto the store floor. Petitioner carried his weapon unloaded, with the clip out and no bullets in the clip when he traveled to work. He always placed the firearm into a holster on his hip at work, as there is no other place he could keep the firearm on his body while working.

On the morning of October 25, 2017, Petitioner clocked in at work. He then loaded bullets into the ammunition clip and loaded the clip into the pistol. Petitioner "racked" the pistol, advancing a bullet into the firing chamber. As Petitioner was holstering his firearm around 8:30-8:45 AM, the firearm discharged. He immediately felt pain in his right hip and thigh. Petitioner reported the accident to his supervisors and he was taken by Oak Forest Fire Rescue to Advocate Christ Hospital.

The records from Oak Forest Fire Rescue indicate that Petitioner had a "work-related" broken femur and deep laceration to his left index and middle fingers, from a self-inflicted gunshot wound. (PX 1)

At the hospital, Petitioner was examined by Dr. Charles Lieder, who noted that Petitioner had been injured that morning when holstering his firearm which discharged and struck him in the right thigh and left middle finger. X-rays of the right leg showed a mildly comminuted mid to distal right femoral diaphyseal fracture with minimally improved apex lateral angulation; medial displacement by one third bone width and overriding by approximately 2.2-cm; slight apex angulation; bullet projecting into the anterior soft tissues medial to the patella; and several punctate dispersed shrapnel fragments scattered about the right thigh. (PX 1)

On October 26, 2017, Petitioner underwent surgery, performed by Dr. Lieder, including right femur IM nail; removal of bullet fragment; right knee arthrotomy due to intra-articular bullet. The bullet path appeared to be through the knee joint, and the bullet was found in the extracapsular knee. (PX 1)

From October 27, 2017 through October 30, 2017, Petitioner underwent physical therapy at Advocate Christ Hospital. On October 31, 2017, Petitioner was discharged from the hospital with instructions to bear weight as tolerated, use a walker, and follow up at the orthopedic clinic. (PX 1)

On November 14, 2017, Petitioner followed up with Dr. Lieder at Midland Orthopedics with decreased swelling in the right leg and limited range of motion being noted. The diagnosis was status post right femur IM nail and interarticular bullet removal. Dr. Lieder recommended that Petitioner continue weight bearing as tolerated and begin physical therapy for gait training and strengthening. On December 12, 2017, Petitioner saw Dr. Lieder, who again recommended physical therapy to increase the range of motion in his right knee. Petitioner was performing home exercise therapy because insurance would not pay for therapy. (PX 2)

On January 23, 2018, Petitioner saw Dr. Lieder for the last time. Petitioner was bearing weight on his leg, but struggling with stiffness and pain in his right knee. Upon examination, Petitioner was able to get full knee extension, but exhibited significant weakness in his quads. Dr. Lieder again recommended therapy and indicated that Petitioner was to remain off of work from 10/25/17 until he is seen for a follow up. (PX 2)

Petitioner testified that he has not gotten further physical therapy or orthopedic treatment because he did not have any other insurance that would cover it. He does want to undergo the recommended physical therapy and follow up treatment with Dr. Lieder.

Petitioner testified that, prior to the accident on October 25, 2017, he was not having any problems with his right leg. He currently has trouble sitting for a long time. He gets pain and swelling in his right leg if he sleeps on his right side at night. After walking for about a block or standing in one place for ten to fifteen minutes, he gets increased pain in his right leg. He has difficulty going up and down stairs because he can't lift up his right leg as much and bend it to go up. His muscle in the right leg is still weak.

Petitioner called David Lyon ("Lyon") as a witness. He testified that he is currently employed as a social worker. He worked for Respondent as Chief Range Safety Officer from August 2016 to March of 2017. Prior to working for Respondent, Lyon worked as a police officer for Marseilles and Minooka, Illinois for over five years. Lyon testified that he was not subpoenaed or paid for his testimony. He was not working for Respondent when Petitioner's accident occurred. Lyon met Petitioner for the first time while working for Respondent. He testified that he occasionally saw and talked to Petitioner, but that was the extent of their relationship.

When Lyon was employed by Respondent, he carried a loaded firearm on his person every day, for personal defense and protection of other persons and customers in case someone tried to rob the store or started shooting at other people. He always carried his firearm in a holster on his hip. Lyon testified that he would not feel comfortable coming into work at Respondent without a loaded firearm on his person. Lyon had witnessed a man

tell a sales employee that "this would be a good chance to rob the store" and reach into his jacket. He described another incident in which a customer pointed a loaded firearm at him on the shooting range. Lyon asked that the customer be removed, but the customer was allowed back onto the range.

Lyon testified that he was not hired by Respondent to be security. He never saw any security on the premises, other than the employees with loaded firearms. Almost all employees carried loaded firearms on their person, including sales employees, and including Petitioner. Lyon said that he would see sales people and instructors bring customers onto the shooting range with loaded firearms on their hips. The sales persons and instructors did not take their firearms off their hips or use their personal firearms on the range.

Customers were invited in to fire live ammunition on the shooting range. Lyon said said that the only defense if someone decided to start shooting at people would be the employees with their loaded firearms. Lyon was never told by Respondent what to do if customers started shooting at other people. Lyon testified that he knew those situations had happened at other firearms ranges. If that happened, he would use his own firearm to protect himself as a last resort. Lyon was never told not to wear a loaded firearm on his person or asked to remove his loaded firearm from his person. Lyon testified that he was told by coworkers that Respondent wanted the employees to carry firearms, so he talked to the owner. The owner told Lyon that he was allowed to carry a firearm for personal protection and protection of the store's assets because the people who came there could cause harm. Prior to Petitioner's accident, other employees had their firearms discharge on accident, including sales employees. Lyon testified that one of those employees was fired, but none of the other employees were asked to stop carrying loaded weapons on them at work afterwards. Lyon talked to the owner about firearm safety, and he was asked to put some employees through a proficiency course.

Respondent called Jordan Dale ("Dale") as a witness. She has been employed as a manager for Respondent for about two years. She testified that she is familiar with FOID cards and she obtained a concealed-carry permit about five months prior to the hearing. Since then, she has carried a loaded firearm, holstered on her hip, when she is at work. She holsters the firearm when she gets to the store. She had never received a reprimand for not wearing a firearm or a bonus for carrying a firearm at work. She testified that she brings her loaded firearm to work for safety.

Dale testified that employees had the option to carry loaded firearms at work, for personal safety, if they had a valid FOID and concealed-carry permit. She had seen sales employees, including Petitioner, carrying loaded firearms on their person at work. The sales staff and instructors were not required to take firearms out of their holsters. She agreed that, while working, the employees should keep their firearms in their holsters. Dale never told Petitioner not to carry a loaded firearm at work. She never reprimanded Petitioner for not carrying a firearm on his person. She could not confirm or deny whether Petitioner or other employees were asked by Respondent's owner to keep loaded firearms on their person. Other employees had discharged their firearms accidentally at work. One such employee was terminated, but no other employees were disciplined or asked to stop carrying loaded firearms at work. Dale was aware of Petitioner's accident. Dale agreed that the possibility of a customer shooting at other people was realistic. She believed that Respondent was required to have safety policies and procedures in place. She was not aware of any policy or instruction of what to do if customers started shooting. She agreed that the employees with loaded firearms were the only security in the event a shooting occurred. No other outside security was hired. Dale agreed that if a salesman has a firearm on their hip, it lets customers know that the employee has a concealed carry permit and the option to carry a loaded firearm. She agreed that customers would prefer to purchase firearms from someone who has experience with firearms and concealed carry permits.

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 his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 25, 2017.

Petitioner's accident occurred in the course of his employment. He was on Respondent's premises and had clocked in. He was holstering his loaded gun, so that he could go out on the floor and perform his job duties as a salesman/instructor.

Petitioner's accident arose out of his employment by Respondent. The risk of injury was incidental to Petitioner's employment by Respondent. Respondent's business is that of a gun shop and firing range. Respondent's owner encouraged employees to carry loaded firearms on its premises. Respondent benefited from having armed employees on the store floor. First, this likely discouraged robbery or other criminal acts by those entering the store. Second, it had a positive marketing effect, in that it likely encouraged the sale of weapons by making customers comfortable around people with guns, reinforced that people can function happily in an environment where almost everyone has a holstered firearm displayed and likely increased customer comfort in going in Respondent's store due to the likelihood that criminal acts by a third party in the store are discouraged by the armed employees. Of course, the risk of being wounded by an accidentally discharged gun is a risk that all members of the public at large face, albeit ever so slight. Here the risk is increased by Respondent encouraging its employees to carry loaded guns on its premises.

The injury did occur as a result of Petitioner's unique employment by Respondent and, thus, it arose out of Petitioner's employment by Respondent.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS:

Petitioner gave Respondent timely notice of the accident, within the meaning of §6 of the Act.

This finding is based upon the unrebutted testimony of Petitioner and Respondent's Exhibit 1.

Petitioner's testimony was that Omar, Respondent's owner, visited him at the hospital on the date of accident. Respondent's Exhibit 1 is a denial letter, issued by Respondent's workers' compensation insurance carrier, dated November 30, 2017 (some 36 days after the accident). Clearly, Respondent had notice of the accident within 45 days of its occurrence.

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

Petitioner's current condition of ill-being (to wit: status post gunshot wound to the right leg and left middle finger, with surgical repair of the right femur and knee, as described in the records of Advocate Christ Hospital and Midland Orthopedics) is causally related to the injury based upon the unrebutted testimony of Petitioner and the medical records.

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:

The treatment rendered to Petitioner is reasonable and necessary to cure or relieve the effects of the injury. This finding is based upon Petitioner's testimony and the medical records.

Petitioner's claimed medical bills were submitted as Petitioner's Exhibit 3. Based on the Arbitrator's findings in Section "F", Petitioner is awarded the following bills:

1. City of Oak Forest—DOS 10/25/17: $1,625.00.
2. IICIIA imaging consultants—DOS 10/25/17: $161.00.
3. Advocate Christ Hospital—DOS 10/25/17-10/31/17: $19,481.23 (Bill of $54,264.00 reduced by Public Aid negotiated rate, See: Perez v. The Illinois Workers' Compensation Commission, 2018 Illinois App (2d) 170086 WC (2018))
4. Advocate Medical Group—DOS 10/25/17-10/31/17: $1,508.00.
5. Midland Orthopedics—DOS 10/26/17-1/23/18: $9,441.45.

TOTAL BILLS AWARDED: $32,216.88

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS:

Petitioner is entitled to prospective medical care, based upon the Arbitrator's findings regarding accident, notice and causation, above.

Petitioner needs follow up care with Dr. Lieder and the recommended PT. If appropriate PT is not given, Petitioner's knee will have significant deficits. Thus, Respondent shall authorize, approve and pay for the PT and recommended follow-up care prescribed by Dr. Lieder in his January 23, 2018 chart note.

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

Petitioner claims that he is entitled to TTD benefits for the period between October 26, 2017 and April 12, 2018, a period representing 24-1/7 weeks. Respondent disputes liability for any TTD benefits. On October 25, 2017, Petitioner was taken to Advocate Christ Hospital to undergo surgery and was not discharged until October 31, 2017. He was released with limited weight-bearing with use of a walker. Dr. Lieder continued Petitioner's restrictions of limited weight-bearing and indicated on January 23, 2018 that Petitioner was to remain off of work starting October 25, 2017 until further notice. Petitioner has not been released by any doctor to return to work. He has been completely off work from the date of the accident until the date of hearing.

Accordingly, based upon the testimony of Petitioner and the medical records, Respondent shall pay Petitioner TTD benefits for 24 and 1/7 weeks, representing the period between October 26, 2017 and April 12, 2018.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS:

Even in light of Respondent's seemingly specious notice defense, the Arbitrator denies Petitioner's claim for penalties and fees.

Respondent did comply with Rule 9110.70 in denying the claim (RX 1). Further, there is a legitimate issue as to whether Petitioner's injuries arose out of his employment. Accordingly, Respondent's non-payment of benefits was not in bad faith and penalties and fees are not awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SLADANA RADOSAVAC,

Petitioner,

vs.

NO: 16 WC 17561
16 WC 17562

ADVOCATE CHRIST MEDICAL CENTER,

Respondent.

19IWCC0437

DECISION AND OPINION ON REVIEW

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

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I. FINDINGS OF FACTS

A. Background

Petitioner was a 33-year-old employee of Respondent at the time of her accepted accidents on February 10, 2016 and April 6, 2016. She was employed as an equipment distribution and processing (EDP) technician that also performed patient transport.

Petitioner's job as an EDP technician mainly involved patient transport. She explained that the physical requirements of the position included a lot of lifting, pushing and pulling of beds, equipment, and patients. Petitioner's duties also included lifting and moving heavy patients from side to side and from one bed to another.

Petitioner testified that if a patient to be transported was overweight, they had to transport the patient in the bed itself. She transported patients to the Imaging Center, surgery, and for any testing. Heavier patients were mostly transported to the testing and surgery areas. Petitioner transported 17 to 21 patients per day.

Petitioner explained that the patient was initially in bed when she arrived. She used her whole-body force to get the patients on the stretcher and lift with the sheet, and sometimes she needed help to get the patients on the stretcher, which was easier to maneuver. Petitioner testified that, given her short stature, she had to lift from across the bed and pull using force. She extended her arms and sometimes got on top of the stretchers to pull them out to not use too much of the weight. Petitioner would then move the patient on the gurney to whatever area was required maneuvering through hallways and elevators throughout a hospital with nine floors.

Petitioner worked for Respondent from 2:00 p.m. to 10:30 p.m., five days per week and every other weekend. She was also employed elsewhere on a part-time basis at Miller's Ale House as a server/trainer. Petitioner acknowledged that her job there included taking orders, training people, greeting people, and bringing out drinks.

B. Accidents and Interim Medical Treatment

On February 10, 2016, Petitioner sustained an undisputed accident. She testified that she went to transport a heavy, comatose patient from intensive care to interventional radiology requiring extreme caution. Petitioner explained that there was not enough lifting help with only three individuals in the respiratory department, so they used a board requiring Petitioner to lean over (the patient). As Petitioner was getting ready to pull the sheet under the heavy patient, with the initial pull, her whole body went numb and she felt pain all over.

Petitioner went to Respondent's emergency room reporting the incident and her symptoms. After an examination, she was prescribed Hydrocodone, Norco and Flexeril, and placed on light duty work restrictions.

Petitioner then went to the employee health department the next day at the hospital and saw Dr. Greene. She described her pain and was examined. Dr. Greene placed her off work for three days followed by a return to work with a 20-pound lifting restriction and no patient transfers. On February 22, 2016, Dr. Greene recommended that Petitioner try to return to regular work. Petitioner did so and continued with further follow-up visits until her second accident.

While doing her regular work, Petitioner reported that she was very sore, with constant pain, a lot of headaches, and a shooting sensation down her back. She indicated that it was getting very hard to get up in the morning without pain. Petitioner localized the pain in her back from her neck to her lower back shooting down her spine to her buttocks.

On April 6, 2016, Petitioner sustained a second undisputed accident. She testified that she went to move a patient from the transfer room and followed patient protocol given the lack of help. They set the gurney closer to the bed putting a sheet underneath the patient as they did not have a board to use. Petitioner was holding the sheet and, as they were leaning over to pull the patient, she could not move at all once she picked up the patient. She explained that she had been leaning over the stretcher, bent at the waist when they moved the patient. Petitioner testified that she experienced that same numbness as she was pulling her whole body in this process.

C. Subsequent Medical Treatment

Petitioner returned to Respondent's emergency room where she was examined, given medication, and instructed to follow-up with employee health department. Petitioner reported an injury while transferring a patient resulting in a back injury and subsequent neck to lower back pain as well as headache. She also reported that she felt a "pull" in her left upper back while engaged in transferring the patient. Petitioner was diagnosed with a left upper trapezius back injury and prescribed Ibuprofen, Norco, Cyclobenzaprine (Flexeril). She was also instructed to use ice as needed and placed on light duty work restrictions with no lifting or pushing/pulling with her left arm. Petitioner remained off work from April 7, 2016 through April 10, 2016 as Respondent did not have work within the restrictions.

Petitioner returned to Dr. Greene on April 11, 2016 at which time she reported symptoms including neck, upper back and back pain, worse with moving left shoulder, and a worsening headache; No radiating leg symptoms were noted. After an examination, Dr. Greene diagnosed a muscle strain of the low back, thorax, and shoulders. He prescribed additional medications and continued light duty work restrictions. Respondent was able to accommodate the work restrictions including no overhead pushing, pulling, or lifting with her left arm. On April 18, 2016, Dr. Greene referred Petitioner to an orthopedic surgeon. Thereafter, Petitioner returned to employee health

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on April 25, 2016 at which time another physician continued her medications and work restrictions.

On April 28, 2016, Petitioner saw Dr. Ojiako at Employee Health with continued complaints of numbness and tingling in her left shoulder and leg. At the time, Petitioner was working light duty performing equipment and medication delivery. She lifted infusion pumps weighing 5-10 pounds, channels [equipment], anything a patient needed in the room as in-patient, and sometimes heavier things, but within her restrictions. He diagnosed Petitioner with a muscle strain, fascia and tendon at neck level, strain of muscles and tendons of the rotator cuff left shoulder and ordered Ibuprofen, Cyclobenzaprine, and physical therapy. Dr. Ojiako also continued work restrictions of no pushing/pulling with the left upper extremity and no overhead work.

On May 2, 2016, Dr. Greene continued Petitioner's medication regimen and physical therapy noting her continued symptoms. He then placed her off work effective May 2, 2016 to May 9, 2016. Petitioner testified that she has not returned to work for Respondent since that time.

Petitioner continued to see Dr. Greene, and, on May 23, 2016, he maintained Petitioner's diagnosis of muscle strain, fascia and tendon at neck level, strain of muscles and tendons of the rotator cuff left shoulder. He ordered continued therapy and work restrictions with no lifting over five pounds. Dr. Greene also referred Petitioner to an orthopedic surgeon providing a list of prospective providers. Petitioner was not offered light duty by Respondent at the time.

Petitioner then saw Dr. Lim, an orthopedic surgeon on staff at Respondent's hospital with whom she was familiar. On June 1, 2016, she presented to Dr. Lim's physician's assistant reporting sharp and throbbing pain symptoms, constant, severe headaches, and radiating pain left arm at times. After an examination, Petitioner was diagnosed with cervical disc disorder with radiculopathy, cervicothoracic region C5-6, degenerative disc disease, and kyphosis, prescribed medications and kept Petitioner off work. A cervical MRI was also ordered, which Petitioner underwent at Respondent's hospital on June 15, 2016. The interpreting radiologist noted cervical disc disorder with radiculopathy, cervical degenerative disc disease with changes at C5-6, C6-7 causing mild canal stenosis, a C5-6 broad based disc osteophyte complex with large focal central disc extrusion, a focal central disc protrusion mildly pressing on the ventral cord, and a C6-7 focal central/left disc protrusion and left uncinate arthropathy with the disc protrusion contacting the adjacent cord, mild stenosis.

On June 24, 2016, Petitioner saw Dr. Lim for the first time. He noted both of her injuries at work involving patient transfers, and Petitioner's chief complaint of neck pain with suboccipital headaches, left arm numbness, pins and needles sensation, and left lower extremity symptoms. Dr. Lim examined Petitioner noting a positive Spurling's sign on the left and weakness of the left wrist extensors graded 4/5. He also reviewed the MRI finding two herniated discs at C5-6 and C6-7, with C6-7 eccentric to the left and C5-6 more central, but causing spinal cord impingement. Dr. Lim diagnosed Petitioner with cervical pain with radiculopathy and cervical herniated nucleus pulposus at C5-6 and C6-7. He also stated that Petitioner's symptoms were a direct result of her

work-related injuries in February and April of 2016 and was concerned about the manifestation of long tract signs in the lower extremity which most likely is associated with impingement on the spinal cord secondary to the disc herniations. He noted that Petitioner did not have clear objective signs of myelopathy but, recommended close follow up to confirm there were no worsening symptoms of the lower extremity symptoms. Dr. Lim recommended an epidural steroid injection (ESI) and placed Petitioner on sedentary work restrictions with no use of her left arm and no overhead work.

Petitioner testified that Respondent did not offer her work within the restrictions. She underwent the recommended injection shortly thereafter and returned to see Dr. Lim on September 2, 2016 at which time he diagnosed cervical disc disorder with radiculopathy, mid-cervical region. Dr. Lim noted Petitioner then had not improved with nonsurgical management and further options, including surgery were discussed. Petitioner opted for another ESI and Norco was refilled.

On September 2, 2016, Dr. Lim noted Petitioner's continued symptoms (not specific) and pain reported at a level of 9 out of 10. Diagnosis was cervical disc disorder with radiculopathy, mid-cervical region. He recommended surgery if a second epidural steroid injection did not provide relief. Dr. Lim then released Petitioner back to work with restrictions including no work above shoulder level.

With regard to the work restrictions, Petitioner testified that she placed the restriction script on the table by the doctor's office fax and she was given a confirmation that it was sent. She testified that this was true for every visit. Petitioner testified that she never received a letter or call from her department regarding Respondent offering work within her restrictions.

On October 14, 2016, Petitioner obtained a second opinion from Dr. An at Midwest Orthopedics at Rush regarding her neck. Dr. An examined Petitioner and reviewed the MRI. He recommended a Medrol dose pack, Ultram, and possibly Neurontin. Dr. An noted Petitioner may be a candidate for ESI; surgery as a last resort.

Petitioner returned to Dr. Lim on November 23, 2016 and Dr. Lim asked if Petitioner had the second epidural steroid injection, and it was noted that Petitioner had not received that injection which she wished to still undergo. Dr. Lim ordered a second cervical MRI, continued medications, and he placed Petitioner off work.

D. Secondary Employment and Continued Medical Treatment

From May 2, 2016 through November 23, 2016, Petitioner continued to work part-time at Miller's Ale House while she was authorized off work or on work restrictions, that Respondent could not accommodate. Petitioner last worked at Miller's Ale House on November 26, 2016.

Petitioner underwent the second cervical MRI at Christ Hospital. In the December 12, 2016 report, the interpreting radiologist noted C5-6 degenerative disc disease with an uncovertebral disc bulge, a central disc protrusion with migration that indents the ventral thecal sac and anterior spinal cord, moderate stenosis, and mild C6-7 degenerative disc disease with an uncovertebral disc bulge without stenosis. The radiologist noted that these findings were similar compared to those in the June 15, 2016 study.

Petitioner then returned to Dr. Lim on December 19, 2016 at which time he examined her, reviewed the updated MRI, and recommended surgery in the form of decompression addressing the herniated disc. Dr. Lim also recommended sedentary work, which Respondent did not offer. Miller's Ale House did not have sedentary type work for Petitioner given her position there as a server.

Petitioner again saw Dr. Lim January 4, 2017. He maintained her diagnosis of cervical disc disorder with radiculopathy, mid-cervical region. The medical records reflect that he reviewed her MRI and again restricted her to sedentary work. Petitioner testified that by this visit, her temporary total disability benefits were discontinued. She lived alone at that time, so she started looking for another job.

Petitioner was able to find a suitable job within Respondent's Advocate Health System starting January 16, 2017 as a patient service representative. In this full-time position, she scheduled appointments, answered phone calls from patients, and connected patients with their doctors via a messaging system. Petitioner explained that the position was 40 hours per week, Monday through Tuesday and Thursday through Saturday from 8:00 a.m. to 4:30 p.m. The facility at which she worked was in Rosemont, Illinois.

Petitioner also worked at Miller's Ale House part-time through March 25, 2017. Over two days per week, Petitioner estimated that she worked six hours. At the restaurant, Petitioner did some training and wrote orders. She testified that her shift ended at 11:00-11:30 p.m. and 1:00-2:00 a.m. on the weekends. Petitioner would get home from Miller's Ale House at about midnight. Given that she resides south in Palos Heights, she testified that she then woke up at 4:30-5:00 a.m. and left her home at 5:30-6:00 a.m. to avoid traffic with a commute lasting an hour to an hour and a half. Petitioner agreed she was making 50 cents more per hour working in this position but explained that she did have to pay tolls to get there. By contrast, when she did work at the hospital she would start at 2:00 p.m. so she would sleep until she had to go to work at the restaurant and she was able to get 4-5 hours more sleep.

Petitioner testified that she stopped working at the restaurant on March 25, 2017 because it was very physical, and she was very tired going from one job to another due to her lack of sleep. Petitioner has not worked at Miller's Ale House since March of 2017 and she continued to work for Respondent in Rosemont.

Petitioner *last* saw Dr. Lim on April 5, 2017 at which time he prescribed medications, Norco and muscle relaxers. She reported that she was still in a lot of pain with continued soreness, constant headaches, and numbness on her left side. Petitioner also reported that she was extremely tired, sometimes requiring pain medication to go to sleep. Dr. Lim last recommended the second epidural steroid injection and further therapy, which she testified that she wanted to undergo. Dr. Lim had been recommending that ESI since November 23, 2016.

Regarding her current condition of ill-being, Petitioner testified at work now, "[i]t's getting really heavy. I have to stand up several times a day to stretch. My left side goes numb." She explained that she experienced numbness from her left shoulder/neck to her feet, and attributed the tingling, numbness, and pain to the entire left side including her arm and fingers.

E. Testimony of Mr. Weinstein

Respondent called Brett Weinstein as a witness. He is employed with Miller's Ale House in Lombard and had been so employed for about 8½ years in the position of assistant general manager over the last several months. Mr. Weinstein testified that he had been in management for over three years with prior experiences as a bartender. Currently, Mr. Weinstein oversees day-to-day operations, scheduling, inventory, running the front of the house, dealing with customers and employee issues.

Mr. Weinstein testified that he was familiar with Petitioner as an employee of Miller's Ale House. He did not know her socially, only through work. Mr. Weinstein stated that Petitioner was one of the servers and he wrote Petitioner's schedule and dealt with issues that arose. He was familiar with the duties of a server, as he oversaw their work. He had also done the job previously. Mr. Weinstein testified that the server position involved dealing with guests, helping run food, performing side work, and cleaning silverware and tables. Servers also waited on tables, took and entered orders, brought out food and drinks, checked back on the tables, and ensured payment. Mr. Weinstein testified that a server could carry out one to three plates at a time, depending on the server and use trays for two or more drinks. Servers would also pre-bus tables and, if no busboy was available, fully bus the tables, wipe them down, and put out silverware.

Mr. Weinstein was aware Petitioner had suffered injuries while working for another employer as Petitioner had let them know. He believed it was about February 2016 and testified that she performed restricted work thereafter at the restaurant. Mr. Weinstein testified that he was involved with that ensuring that Petitioner was following those guidelines for restricted work. He testified that Petitioner could not lift anything heavy, so she dealt with tables and not with anything heavy. Mr. Weinstein testified that Respondent provided work within her restrictions and were able to accommodate her. They had received paperwork regarding the restrictions. He believed that Petitioner was on restrictions from February of 2016 until she ended employment with the restaurant.

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F. Testimony of Ms. Love

Respondent called Catherine Love as a witness. She testified that she was employed by Respondent for approximately 19 years spending about 15 years as the manager of the equipment processing distribution and patient transportation department. In this position, Ms. Love testified that she oversees the associates/employees who transport patients, deliver medical equipment, and pick up soiled linens and dirty equipment for cleaning. Ms. Love stated that the employees also run around the campus for wheelchairs and picking up transport carts.

Ms. Love testified that she was familiar with Petitioner as an EDP technician who worked in her department. She did not know Petitioner outside of work. Petitioner performed the patient transportation and equipment duties as she noted. Ms. Love also testified that there is light duty available within the department and they would always take a light duty associate, whenever possible. She explained, however, that they cannot provide light duty with no pushing, no pulling, no lifting, no anything.

Ms. Love stated they did have restricted work for Petitioner. She explained that, if she was provided with a medical note from Petitioner's doctor with no above-shoulder work, she would go through Kim Salazar, manager of workers' compensation, and take directives from her. If Ms. Salazar said that Petitioner could work that way, Ms. Love would have provided Petitioner with work.

Ms. Love testified she was not handed any note with restrictions for Petitioner to return to work after September of 2016, and Petitioner never attempted to return to work after September 2, 2016. They did not provide Petitioner with light work after April of 2016. Ms. Love believed that Petitioner was in the department a couple weeks in April on light duty delivering equipment.

Ms. Love testified that, had they received a restriction with no above-shoulder work in September, they would have continued having Petitioner do equipment runs. She explained that the department had two people performing that work, and it would not involve overhead work. Ms. Love explained that the equipment was located on counters and such work did not involve lifting heavy equipment over the shoulders. She acknowledged that there may be some items that the employee would have to reach from a rack with a CMP machine being the heaviest piece to obtain from a shelf.

G. Respondent's Section 12 Examination & Deposition Testimony – Dr. Hsu

While Petitioner was undergoing medical treatment, she submitted to a Section 12 examination with Dr. Hsu at Respondent's request on December 10, 2016. Dr. Hsu issued a report dated December 15, 2016. After an examination, reviewing various treatment records, and taking a history from Petitioner, Dr. Hsu diagnosed Petitioner with cervical strains from the accidents that had resolved. He opined that Petitioner's current condition was not related to the accidents. He

also placed Petitioner at maximum medical improvement and indicated that she could return to work without restrictions at that time.

Dr. Hsu later gave testimony at an evidence deposition on March 22, 2017. He is board-certified spine surgeon and has been for 10 years. Dr. Hsu testified consistent with the opinions in his report and gave certain opinions regarding Petitioner's condition and its relatedness, if any, to her accidents at work.

Dr. Hsu obtained a history from Petitioner regarding her accidents as noted in his reports. He noted that both accidents involved primarily low back and neck pain followed by medical treatment including therapy, an epidural steroid injection and light duty work restrictions. Petitioner only noted the headaches and neck pain at the time of his exam, which revealed decreased motion of the lumbar spine. However, Dr. Hsu did not believe that Petitioner gave her full effort as it was not consistent with how she walked outside the exam room. He also noted a grossly normal neurological exam and cervical rom, but positive Waddell's sign with axial compression and hip rotation. Dr. Hsu noted his review of medical records, including Petitioner's MRI films showing C5-6, C6-7 posterior osteophyte complexes (bone spurs). He noted that the C5-6 bone spur was causing what he considered to be moderate stenosis as well as narrowing of the canal and mild central stenosis at C6-7. Dr. Hsu also viewed surveillance video of Petitioner performing different activities in which he saw no inability to work related to the injury.

Dr. Hsu opined that Petitioner had sustained cervical strains and soft tissue injuries from the incidents at work. He maintained that she was at maximum medical improvement six weeks after the second accident. Dr. Hsu further opined that the incidents did not aggravate her pre-existing spondylotic, bone spur condition as the accidents were of low impact. He attributed Petitioner's symptoms as secondary to her cervical spondylotic changes (i.e., chronic degenerative wear and tear) which pre-existed and was in no way related to her accidents.

On cross-examination, Dr. Hsu acknowledged that he only brought his report with him to the deposition. He testified that any handwritten notes that he took during the examination would have been shredded after he formulated his dictation. Although he testified that Petitioner did not complain of pain down the left arm with numbness at the time of his examination, he acknowledged that he did not have his handwritten notes from the date of his examination. Dr. Hsu acknowledged that he did not have the job description that he was provided. Dr. Hsu acknowledged that he did not review the films or disk from Petitioner's December 6, 2016 MRI, but he agreed with the interpreting radiologist's findings from the report. He also acknowledged that he did not know what work restrictions Dr. Lim had placed on Petitioner at the time she was under surveillance in July and November of 2016.

On cross-examination, Dr. Hsu also acknowledged that spondylosis and bone spurs can possibly be aggravated or made symptomatic by trauma. He acknowledged that he saw no evidence of neck or back symptoms prior to her accident in February of 2016. Regardless of causal connection, as of December 15, 2016, Dr. Hsu believed that Petitioner had not exhausted all

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conservative care and he would probably send her back to physical therapy if she were his patient. He also believed that she might be a candidate for a second epidural steroid injection.

H. Deposition Testimony – Dr. Lim

Dr. Lim gave testimony at an evidence deposition on March 7, 2017. He is board-certified spine surgeon and has been for 18 years. Dr. Lim testified regarding his treatment of Petitioner and gave certain opinions regarding her condition and its relatedness, if any, to her accidents at work.

Dr. Lim noted that he first saw Petitioner on June 1, 2016 with an initial presentation for shoulder pain. He obtained a history of Petitioner's accidents, noting neck pain to be almost immediate and severe enough to stop working. Petitioner's MRI as ordered by his physician's assistant showed two herniated discs at C5-6, C6-7 with C6-7 eccentric to the left and C5-6 more central, but with cord impingement. Dr. Lim confirmed the presence of a C5-6 herniation with spinal cord compression with overall moderate stenosis.

Ultimately, Dr. Lim opined that Petitioner had spinal cord compression secondary to an acute herniated disc at C5-6 that caused her ongoing symptoms since February 2016. He noted that her pathology was directly correlated given Petitioner's subjective complaints and physical examination findings. Dr. Lim found that there was a causal connection between the two work accidents and her disc herniation although he could not state to which accident. Regardless, he maintained that the cumulative trauma to her cervical spine caused the disc herniation and subsequent condition of ill-being.

II. CONCLUSIONS OF LAW

Petitioner gave uncontroverted testimony regarding both accidents at work while moving patients and her ongoing symptoms thereafter. Her testimony is supported by the medical records reflecting continued pain and symptoms since the accidents necessitating active treatment. While Petitioner had degeneration as reflected in her MRI's, the record is devoid of evidence that she had symptoms prior to her accidents impeding her ability to work full duty, and there is no evidence that Petitioner underwent any prior medical treatment for such degeneration.

Once referred for an orthopedic evaluation, Petitioner began treatment with Dr. Lim on June 1, 2016, a surgeon on staff at Respondent's hospital. He had the opportunity to examine and evaluate her on a regular basis noting her ongoing complaints and his clinical findings corroborating a diagnosis cervical disc disorder with radiculopathy, mid-cervical region. Dr. Lim also opined that there was a causal connection between Petitioner's accidents at work, her current condition of ill-being and the need for further medical care including an epidural steroid injection and possibly surgery if that was not successful. He confirmed the presence of a C5-6 herniation

with spinal cord compression with overall moderate stenosis as reflected in Petitioner's MRI, and opined that Petitioner had spinal cord compression secondary to that acute herniated disc. Dr. Lim testified that it was this herniation that caused her ongoing symptoms since the time of her first accident in February of 2016. While Dr. Lim could not attribute Petitioner's herniation and ongoing symptoms to one or the other accident specifically, he found that there was a causal connection between the two work accidents noting that Petitioner's pathology was directly correlated to her subjective complaints and physical examination findings after her injuries at work. With regard to the time between both accidents, the record reflects that Petitioner underwent uninterrupted medical treatment immediately after her first accident at Respondent's hospital or with its physicians up through the time of her second accident at work. Regardless, Dr. Lim maintained that the cumulative trauma to Petitioner's cervical spine caused the disc herniation and subsequent condition of ill-being.

Respondent offered the opinions of its Section 12 Examination examiner, Dr. Hsu, into evidence. Dr. Hsu opined that Petitioner only sustained a cervical strain and that she was at maximum medical improvement no later than six weeks after the second accident. He believed that the incidents were low impact, so they did not aggravate Petitioner's pre-existing condition. However, Dr. Hsu acknowledged that he did not have the job description that he was provided, he specifically admitted that he did not review the December 6, 2016 MRI films, and he did not know what work restrictions Dr. Lim had placed on Petitioner at the time she was under surveillance in July and November of 2016. He further acknowledged that spondylosis and bone spurs can possibly be aggravated or made symptomatic by trauma and that there was no evidence of neck or back symptoms prior to Petitioner's first accident at work. Regardless of causal connection, Dr. Hsu believed that Petitioner needed additional care, albeit, from the pre-existing condition. Nonetheless, Dr. Hsu attributed only strain-type injuries to Petitioner's accidents at work, which he opined had resolved and at "some point" he opined that the pre-existing condition became symptomatic resulting in her current condition of ill-being.

In contrast, Petitioner's treating physician, Dr. Lim, confirmed the presence of a C5-6 herniation with spinal cord compression with overall moderate stenosis after reviewing her MRI films. He opined that Petitioner had spinal cord compression secondary to an acute herniated disc at C5-6 that caused her ongoing symptoms since February of 2016. Dr. Lim noted that Petitioner's pathology was directly related to her accidents at work noting that her subjective complaints and physical examination findings correlated. Dr. Lim could not state specifically which accident caused her condition but testified that the cumulative trauma to her cervical spine caused the disc herniations and subsequent condition of ill-being. Dr. Lim had testified at deposition that the MRI showed two herniated discs, C5-6. C6-7 (C6-7 eccentric to the left).

The opinions of Dr. Lim is more persuasive given the totality of this record. Petitioner had no prior complaints or treatment to the neck or back before her accidents at work. Between her accidents she underwent continuous treatment at Respondent's hospital or with its physicians. She had an ongoing condition with increasing symptomatology after her first, and second, accident that included radicular symptoms into the left upper extremity correlating to her left sided disc

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herniations and the spinal cord compression noted by Dr. Lim. The opinions of Dr. Lim are fully supported in the evidence and history and more persuasive than Dr. Hsu opinions. The opinions of Dr. Hsu are not persuasive in this case given the two undisputed accidents at work, lack of prior symptoms or treatment, uninterrupted medical treatment after both accidents, and lack of review of Petitioner's MRI films.

As to the surveillance video, Petitioner is observed dancing and holding a tray of food at one point, but not engaging in physical activities beyond her restrictions.

Thus, the Commission finds that Petitioner met her burden of proving an ongoing causal relationship between the undisputed accidents at work, her current condition of ill-being, and the need for further treatment as ordered by Dr. Lim. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection.

Temporary Total Disability Benefits

As to issue of temporary total disability (TTD), the Commission finds that Petitioner was off work from Respondent's employment for a period of 37 and 4/7th weeks (April 7, 2016 through April 10, 2016, May 2, 2016 through January 15, 2017) at $350.07 per week. (total TTD $13,152.63) The Commission herein, affirms and adopts the Arbitrator's decision regarding the temporary total disability benefits totaling $13,152.63. Respondent entitled to credit for TTD paid of $10,602.12

However, as to Petitioner's claim of testified that during her concurrent employment at the restaurant, the Commission notes that Petitioner began losing time from work on November 27, 2016 when she was placed on sedentary restrictions. Mr. Weinstein (from Miller's Ale House), who is not employed by Respondent, testified that he was involved with that ensuring that Petitioner was given work within her restrictions after she was placed on restrictions in the spring of 2017. The Commission notes that Petitioner was working for Advocate in Rosemont under sedentary work restrictions making slightly more per hour at that time.

Petitioner had concurrent employment with Miller's Ale House at the time of the accident. Petitioner began losing time from that employer November 26, 2016. She then returned to work at Miller's February 5, 2017 (while still on sedentary restrictions). Petitioner, therefore, is entitled to TTD/TPD as to lost wages from Miller's November 26, 2016 through February 5, 2017 (10-1/7 weeks at $197.74; total regarding Miller's concurrent employment $1,975.22). Any claimed temporary total disability/temporary partial disability while employed by Miller's Ale House thereafter is denied.

Thus, the Commission, herein, affirms in part, and modifies in part as to the issue of temporary total disability/temporary partial disability as noted herein.

Medical Expenses/Prospective Medical Treatment

The Commission with the above finding of an ongoing causal connection to Petitioner's current condition of ill-being, in reliance on the opinions of Petitioner's treating physician Dr. Lim, further finds that Petitioner met her burden of proving entitlement to prospective medical treatment awarded by the Arbitrator. The record evidences the need for the care ordered by Dr. Lim for the further therapy and epidural steroid injections, as his last recorded recommendation; Petitioner would be a candidate for discectomy per Dr. Lim's June 24, 2016 record; Petitioner was to return after the ESI was done. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to Petitioner's claim for medical expenses and prospective medical treatment as ordered by Dr. Lim.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $350.07 per week for a period of 37 and 4/7th weeks regarding lost time from Respondent, and the sum of $197.74 per week for a period of 10-1/7 weeks (regarding lost time from Miller's Ale House [prior concurrent employment-TTD/TPD]), 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. Respondent shall be given credit of $10,602.12 for temporary total disability paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the physical therapy and epidural steroid injection to Petitioner's cervical spine that Dr. Lim has ordered, pursuant to Section 8(a) and subject to Section 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 $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 16 2019

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

BNF/jsf
6/20/19
045

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

RADOSAVAC, SLADANA
Employee/Petitioner

Case# **16WC017561**

16WC017562

ADVOCATE CHRIST HOSPITAL
Employer/Respondent

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On 10/18/2017, 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 1.24% 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:

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL J UGASTE
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
19(b)

Sladana Radosavac
Employee/Petitioner

v.

Advocate Christ Hospital
Employer/Respondent

Case # **16** WC **17561**

Consolidated cases: **16WC 17562**

19IWCC0437

An *Application for Adjustment 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 IL**, on **6/26/17**. 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 _____

FINDINGS

On the date of accident, **2/10/16**, 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 $**41,099.22**; the average weekly wage was $**824.92**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

The disputed issues of causation and prospective medical care are addressed in the decision for consolidated case 16WC 17562.

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

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

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



Signature of Arbitrator

10/18/17
Date

ICArbDec19(b)

OCT 18 2017

SLADANA RADOSAVAC v. ADVOCATE CHRIST MEDICAL CTR.
16WC 17561 & 16WC 17562

CONSOLIDATED STATEMENT OF FACTS

On February 10, 2016 and April 6, 2016, Petitioner was employed by Respondent as an EDP technician. Her job consisted of transporting patients to and from their rooms to the imaging or surgical centers, and distributing equipment, carts, and other commodities to and from assigned areas. (Tr. 11, RX2) Petitioner testified that the job required much physical activity in lifting patients from their bed to a cart (stretcher) for transport. (Tr. 10) She would, at times, reach across the cart or bed to lift and move a patient. (Tr. 12) She pushed the cart by herself through the hospital turning corners and getting in and out of elevators. She transported 17-21 patients per day. (Tr. 11-12) Petitioner worked from 2:00 p.m. to 10:30 p.m. five days per week which included every other weekend. (Tr. 13)

Petitioner held concurrent employment at Miller's Ale House as a server/trainer. She testified that her work shift ended at 11:00 p.m. or at 1:00 or 2:00 a.m. on weekends. After work, she would drive home to sleep prior to starting her shift for Respondent at 2:00 p.m. (Tr. 13) At Miller's, she would serve food and drinks to patrons. (Tr. 14)

Petitioner testified that on February 10, 2016, she leaned forward to lift a heavy, comatose patient when she experienced pain and numbness in her whole body. (Tr. 15) Four hours later, she went to Respondent's emergency room where she complained of neck pain and bilateral shoulder pain that radiated to her lower back after assisting with pulling a patient onto a cart at work. (PX3) After he examined Petitioner, the ER physician prescribed light-duty work, Hydrocodone, and Cyclobenzaprine, and advised her to follow up with Employee Health. (PX3)

Petitioner saw Andrew Greene, M.D., at Christ Employee Health on February 11, 2016. Dr. Greene found muscle spasms over her lumbar and thoracic spine. Petitioner was tender to palpation of the shoulders. Dr. Greene diagnosed strains of the lumbar and thoracic spine. He advised Petitioner to stay home for two days and to return to work on light duty on February 13, 2016. He prescribed Flexeril and Ibuprofen. Petitioner continued on these medications and performed light-duty work until February 22, 2016, at which time Dr. Greene advised her to try to return to regular duty. On February 29, 2016, Petitioner advised Dr. Greene that she was performing regular-duty work with little difficulty. Dr. Greene gave Petitioner a home stretching program and discharged her from care. (PX5)

Petitioner testified that between February 29, 2016 and April 6, 2016 she experienced constant pain from her neck to low back with headaches while performing her usual job duties. (Tr. 18)

Petitioner testified that on April 6, 2016, as she was bending at the waist and leaning over a stretcher to pick up a patient, her previous pain recurred. (Tr. 19) That evening, she presented to Respondent's emergency room where the staff took the following HPI:

> "Patient is a 33-year-old female history of upper back pain (sic), presenting with similar complaints. Patient states she was transferring a patient care oh 4 PM (sic) she felt a 'pull' in her left upper back. Patient states this is similar to her pain in the past. Patient states the pain is now giving her a mild aching headache. Patient denies any neurological symptoms such as numbness, tingling, shooting pains down either extremity, vision changes. Patient was seen early February for similar complaints." (PX3)

The ER physician examined her, gave her medication, and advised her to follow up with Employee Health. (PX3)

Petitioner saw Dr. Greene at Employee Health on April 7, 2016, who prescribed Ibuprofen, Norco, and light-duty work. Petitioner was off work on April 7, 8, 9 and 10 because Respondent could not accommodate the restriction of no use of the left arm. (Tr. 21) On April 11, 2016, Dr. Greene renewed her medications and prescribed physical therapy and light-duty work. Petitioner returned to work on a light duty basis. (Tr. 21, PX5)

On May 2, 2016, Petitioner complained to Dr. Greene of worsening neck pain that radiated through her left arm. Upon examining Petitioner, Dr. Greene found 90 degrees of abduction in the left arm. He continued his prescription for physical therapy and medication. He took Petitioner off work. (Tr. 25, PX5)

On May 23, 2016, Dr. Greene advised Petitioner to continue with the medication and physical therapy. He released Petitioner to light-duty work with no lifting over five pounds. Respondent did not provide work within those restrictions. (Tr. 25, PX5) Petitioner testified after May 2, 2016, she never returned to work for Advocate Christ Hospital. (Tr. 25)

On May 23, 2016, Dr. Greene gave Petitioner a list of orthopedic surgeons to see for treatment. She chose Dr. Lim but Respondent made an appointment for her to see Dr. Leonard, a shoulder surgeon. (Tr. 52)

On June 1, 2016, Michael Olschansky, Dr. Leonard's Physician's Assistant, noted Petitioner complaints of 10/10 neck pain radiating into the left arm. He ordered a cervical spine MRI and referred Petitioner to Dr. Lim. (PX4) MR images of the cervical spine were taken at Advocate Christ Hospital on June 15, 2016 was interpreted as showing a broad-based disc osteophyte complex at C5-6 with a larger focal central disc extrusion that mildly impresses upon

the ventral cord with mild canal stenosis. The interpretation of the images at C6-7 was that Petitioner had a focal central/left paracentral disc protrusion which contacts the adjacent cord. (PX4)

Petitioner saw Richard D. Lim, M.D., for the first time on June 24, 2016. Dr. Lim noted radiating pain in the bilateral upper extremities and in the left leg. After a review of the MRI films of June 15, 2016, Dr. Lim ordered a cervical spine epidural steroid injection and released Petitioner to return to work with no use of the left arm and no overhead work. Petitioner returned to Dr. Lim on September 2, 2016, after having undergone the steroid injection to the cervical spine. Dr. Lim noted no improvement and discussed further options including surgery. Dr. Lim noted that Petitioner would like to try a second epidural injection. He prescribed Norco and a topical pain cream to see if it would help her symptoms. (PX4) Dr. Lim released Petitioner to return to work with no work above the shoulders. Petitioner testified that she was given a sheet of paper that described her restrictions after each visit and that a copy was placed next to the fax machine in Dr. Lim's outer office. Petitioner testified that she was given a fax confirmation after each visit. (Tr. 31) Petitioner further testified that Dr. Lim's staff gave her the file and the fax confirmation number each time she visited and allowed her to compare it with the number at Advocate Health to see if the fax went through. (Tr. 53-54)

On October 14, 2016, Petitioner obtained a second opinion from Howard An, M.D., at Midwest Orthopedics at Rush. (PX6) Dr. An reviewed the MRI films prior to his examination of Petitioner. Dr. An found some disc degeneration at C5-6 and C6-7 with some foraminal stenosis on the left. He did not find significant central canal stenosis or spinal cord compression. Dr. An recommended continued physical therapy and medication. Dr. An opined that should Petitioner

fail to respond to conservative care, she should receive a second epidural steroid injection, and, as a last resort, a cervical fusion from C5 to C7. (PX6)

Petitioner returned to Dr. Lim on November 23, 2016. Dr. Lim ordered a repeat MRI study of the cervical spine and prescribed Norco. Dr. Lim advised Petitioner to remain off work. (PX4) Petitioner testified that while she was off work for Respondent between May 2, 2016 and November 23, 2016, she continued to work at Miller's Ale House. She stopped working at Miller's on November 26, 2016, based on Dr. Lim's advice. (Tr. 35)

Petitioner underwent a repeat MRI on December 8, 2016 at Advocate Christ Hospital. The radiologist interpreted the images as showing, at C5-6, a degenerative uncovertebral disc bulge, central disc extrusion with inferior and superior migration that indents the ventral thecal sac and the anterior spinal cord. There was moderate central canal stenosis, and mild bilateral neuroforaminal stenosis. The radiologist interpreted the images as showing, at C6-7, a mild degenerative uncovertebral disc bulge, with no central canal stenosis, no neuroforaminal stenosis. (PX4)

Dr. Lim reviewed the repeat MRI on December 9, 2016 and recommended surgery to relieve the spinal cord compression secondary to an acute disc herniation at C5-6. He explained the potential risks associated with the condition left untreated, including paralysis. Petitioner was hesitant to undergo surgery at that time as she wanted to return to work. He advised her against any type of patient lifting or transfers or overhead work. He recommended that she perform low impact exercises such as the Stairmaster, exercise bike or swimming. He released Petitioner to a primarily sedentary-type job. (PX4)

Petitioner testified that on December 15, 2016, Dr. Wellington Hsu, an orthopedic surgeon, examined her. Petitioner testified that her workers' compensation benefits were stopped after she

saw Dr. Hsu. As she is the head of the household, and lives by herself, she began looking for another job. (Tr. 36) She saw Dr. Lim on January 4, 2017, who released her to a sitting job and renewed her medications.

Petitioner testified that she started employment with Advocate Health System as a Patient Service Representative on January 16, 2017. (Tr. 37) She works in a seated position while she answers phone calls from patients and helps them schedule appointments. (Tr. 37) She works an 8-hour day (8 a.m. to 4:30 p.m.), and a 40-hour week. on Mondays, Tuesdays, Thursdays, Fridays and Saturdays. (Tr. 38) She leaves her house at 5:30-6:00 a.m. so that she may avoid traffic. She testified that her morning commute is 1-1½ hours long. (Tr. 38-39). Petitioner testified that, previously, her shifts at Miller's Ale House ended at 11:00-11:30 p.m., which allowed her to get enough sleep prior to her 2:00 p.m. starting time at Respondent. However, the starting time of 8:00 a.m. at her new job did not allow her to get enough sleep to do both jobs. She testified that she would get home from Miller's at 12:00-12:30 a.m. Petitioner testified that she worked a few hours training staff at Miller's in February and March 2017. (PX1) She testified that she had to stop working the part-time hours at Miller's because it got very physical on her body and she was extremely tired going from one job to another. (Tr. 46-47)

Petitioner testified that she currently, her job in Rosemont has gotten "really heavy," and that she has to stand up several times a day to stretch. She testified that her left side - from the top of her shoulder through her arm to her feet - goes numb. She also feels tingling and pain, and a lot of cramping in her legs. She experiences numbness in the entire left side of her body. She sometimes types with only her right hand when she experiences numbness in her left hand. She experiences constant headaches. (Tr. 47-49). Petitioner wishes to proceed with the epidural injection and physical therapy that Dr. Lim has prescribed. (Tr. 50)

Deposition of Dr. Richard Lim
Petitioner's Ex. #8

Direct Examination

Richard D. Lim, M.D., testified that he is a board-certified spine surgeon. (PX8, p. 5) He first saw Petitioner on June 24, 2016, after she had undergone an MRI examination of the cervical spine. (Id., p. 7). He personally reviewed the films (Id., p. 10), which showed a central herniation at C5-6 causing spinal cord impingement and a herniated disc at C6-7, which was eccentric to the left. (Id., p. 7) Examination revealed a decreased range of flexion, extension and rotation of the cervical spine. Petitioner has 4/5 weakness in her left wrist. She also had a positive Spurling's test on the left, which is indicative for a pinched nerve. (Id., p. 10) After conducting an examination and reviewing the MRI films, Dr. Lim diagnosed Petitioner as having herniated disks at C5-6 and C6-7 with radiculopathy. (Id., p. 11) Dr. Lim causally related Petitioner's symptoms to her work injuries in February and April 2016. (Id.) Dr. Lim expressed concern that Petitioner demonstrated long tract signs in the left leg which was most likely associated with spinal cord impingement secondary to disc herniation. (Id.) He prescribed sedentary duty with no use of the left arm or overhead work and an epidural steroid injection. (Id., p. 13)

Petitioner returned to Dr. Lim on September 2, 2016 after receiving an epidural steroid injection. Petitioner complained that her symptoms had not improved. Her physical examination was unchanged. (Id.) Dr. Lim prescribed a topical cream to see if it helped, to be followed by a second epidural injection. (Id., p. 14) Dr. Lim restricted Petitioner from overhead work. (Id.)

Dr. Lim testified that Petitioner returned to him on November 23, 2016, and reported that she did not receive a second epidural steroid injection due to lack of authorization. (Id., pp. 15-16). Dr. Lim took Petitioner off work, prescribed Norco and ordered a repeat cervical spine MRI. Such repeat MRI was done on December 8, 2016. (Id., p. 16) Dr. Lim found, on December 9, 2016,

that the repeat MRI confirmed the presence of a C5-6 disc herniation with spinal cord compression. There was moderate stenosis and a C6-7 disc protrusion. (Id., p. 17) Dr. Lim recommended surgical intervention because of the spinal cord compression. He placed Petitioner on sedentary duty. (Id.)

Petitioner reported no improvement on January 4, 2017. Her examination and diagnosis remained unchanged. Dr. Lim again prescribed surgery based on an MRI that clearly showing a disc herniation with nerve root impingement and mild cord abutment of the disc. Dr. Lim explained that at the normal disc levels, the anteroposterior diameter of the spinal column was 12 millimeters. At the level with spinal cord impingement, the anteroposterior diameter was 6 millimeters due to significant neural impingement. (Id., p. 19) He ordered physical therapy and advised Petitioner that she could perform sedentary duty at a new position at a call center. (Id.)

Dr. Lim opined that Petitioner's subjective complaints correlate with her physical examination and MRI findings. (Id., p. 20) He also opined that a causal connection exists between the accidents of February 10, 2016 and April 6, 2016 and Petitioner's condition of ill-being. The cervical disc herniations were a direct result of the combined injuries. (Id., p. 21)

Cross-Examination

Dr. Lim testified that the C5-6 dermatome goes into the forearms to the dorsum or back side of the wrist and results in the weakness of the wrist that he found on examination. (Id., p. 24) The C6-7 dermatome goes to the triceps region. (Id., p. 25) Dr. Lim testified that Petitioner's disk herniations are central, which can produce symptoms bilaterally, although the C5-6 herniation is eccentric to the left. (Id., p. 25) Dr. Lim testified that he would recommend surgery to a patient if the radiculopathy followed the findings of the MRI studies. (Id., pp. 25-26)

Dr. Lim could not opine as to whether or not Petitioner was capable of working as a server in a restaurant without knowing her exact job duties (Id., p. 28) because some servers only take orders and other people bring the food out. (Id., p. 27) Dr. Lim stated that he has not seen Petitioner since January 4, 2017 at which time she did not want to have surgery. (Id., p. 30) Dr. Lim testified that his chart notes lead him to believe that he personally reviewed the two MRI examination films because he makes a notation when he reviews only the report. (Id., p. 31)

Re-Direct Examination

Dr. Lim opined that Petitioner has exhausted non-surgical care (Id., p. 32) but that it would not be unreasonable for her to attempt a second epidural steroid injection to relieve her symptoms. (Id., p. 33) He prescribed physical therapy on January 4, 2017 to ameliorate her symptoms. (Id., p. 34)

Deposition of Dr. Wellington Hsu
Resp. Ex. # 1

Wellington K. Hsu, M.D., testified that he was board-certified as an orthopedic surgeon in 2010. (RX1, p. 5) He spends 10% of his work week performing examinations for litigation purposes. (Id., p. 6) He personally obtained a history from Petitioner on December 15, 2017, in which she complained only of neck pain and headaches with no pain elsewhere following her two work accidents. (Id., p. 8) On examination, Dr. Hsu found a decreased range of lumbar motion but he suspected that Petitioner did not give a full effort. (Id., p. 9) He found two positive Waddell signs. The neurological examination of the spine was grossly normal but he found that the strength shown on examination was inconsistent with her ability to walk. (Id., p. 10) The examination of the cervical spine was normal. (Id.)

Dr. Hsu reviewed the films and report of the MRI of June 15, 2016, but only the report and not the films of the repeat MRI of December 8, 2017. (Id., p. 11) Prior to his examination of Petitioner, he reviewed the office notes of Dr. Lim and Dr. An, as well as the surveillance videos. (Id.)

Dr. Hsu opined that the MRI study of June 15, 2016 showed posterior osteophyte complexes (bone spurs) at C5-6 and C6-7 that caused moderate canal stenosis at C5-6 and mild stenosis at C6-7. (Id., p. 12) He also reviewed surveillance video clips from May, July and November 2016 that showed Petitioner running errands, getting in and out of a car, bending, twisting, lifting and moving without difficulty, doing laundry, serving food and dancing at a bar. (Id.)

Dr. Hsu opined that the accidents of February and April caused soft tissue cervical strains. (Id., p. 13) He further opined that the symptoms that Petitioner described to him were secondary to a pre-existing cervical spondylotic condition that was in no way related to her work-related injuries. (Id.) Dr. Hsu disagreed with the notion that Petitioner had acute herniated discs. He opined that Petitioner suffers from unrelated bone spurs that have formed over a period of time (Id., p. 14) and that Petitioner suffered only cervical strains from her work injuries. (Id.) Dr. Hsu opined that Petitioner recovered from her cervical strains and was at MMI for her work-related injuries six weeks after the accident of April 6, 2016. Dr. Hsu testified that since Petitioner was still symptomatic from her unrelated cervical spondylosis, he would treat her with physical therapy and epidural injections with surgery as a last resort. (Id., p. 17) Dr. Hsu found that Petitioner could work in an unrestricted fashion based upon his examination. He did not need the surveillance video to reach that conclusion. (Id., p. 18)

Cross-Examination

Dr. Hsu testified that he performs 4-8 Section 12 examinations per week. He receives exam requests from third-party companies such as MES, Exam Works, Corvel and MCN. (Id., p. 22) The report in this case was addressed to a Ms. Salazar, who propounded a number of interrogatories to be answered by him. (Id., p. 26, Dep. Ex. 2)

Dr. Hsu testified that he did not review any medical records after the November 23, 2016 chart note of Dr. Lim. (RX1, p. 24) He did not review the films of the updated MRI of the cervical spine that were taken on December 8, 2016. (Id., p. 27) He did review the report and agreed with the conclusion of the radiologist. (Id., p. 28)

Dr. Hsu testified that compression of the cord from a moderate cervical stenosis could produce arm pain, neck pain, difficulty with balance or walking. (Id.) Dr. Hsu testified that Petitioner did not complain to him of a radiating left arm pain at the time of his examination, but he did not have his handwritten notes from the examination. (Id., p. 30)

Dr. Hsu testified that a spondylosis or bone spurs can be aggravated or made symptomatic by trauma. (Id, pp. 31-32) If Petitioner were his patient, he would send her for physical therapy and perhaps a second epidural injection.

Re-Direct Examination

Dr. Hsu opined that the accidents of February 10, 2016 and April 6, 2016 did not aggravate her spondylosis based on the low impact mechanism of the accidents, as well as on the symptoms described and activity performed after those injuries. (Id., p. 33) Dr. Hsu saw no evidence of any cervical spine condition prior to the two accidents. (Id., p. 34)

Re-Cross Examination

Dr. Hsu opined that the two accidents did not cause pre-existing conditions to become symptomatic. It is not his testimony that the spondylosis coincidentally and spontaneously became symptomatic on the dates of accident. (Id., p. 35) He considered each of these accidents to be a low impact accident, as opposed to high impact accident, such as a rollover car accident. (Id., p. 35)

Further Re-Direct Examination

Dr. Hsu opined that the work-related injuries caused soft tissue injuries and that at some point the soft tissue injuries resolved and that her unrelated spondylosis was currently responsible for her continued symptoms. (Id., p. 37)

Brett Weinstein

Mr. Weinstein testified that he was Petitioner's manager at Miller's Ale House. (Tr. 93) Weinstein testified that Petitioner advised him of her occupational injuries at Advocate as early as February 2016. Petitioner brought restricted-duty slips, which Weinstein implemented; he made sure Petitioner followed the restricted-duty guidelines. (Tr. 98) Weinstein modified her job so that she did not carry anything heavy. (Tr. 100) Petitioner was terminated in December 2016 and April 2017, because the scheduling computer automatically terminates any employee who does not schedule a shift for 30 days. (Tr. 106)

On cross-examination, Weinstein stated that Petitioner requested modified work after her injuries at Christ Hospital. As a server, Petitioner had the option of serving dinners one plate at a time. (Tr. 108) Weinstein testified that although Respondent tailored Petitioner's job duties to

whatever the doctor's note said, they would not be able to provide modified-duty work for someone with a "no work" restriction, or a "sitting work only" restriction from his or her doctor. (Tr. 109)

Catherine Love

Ms. Love testified that she has been the manager of the Patient Transport and Equipment Distribution Department for 15 years. (Tr. 112) Petitioner was one of her employees. There is light- duty work available within her department. (Tr. 114) Love testified that she will always accept a light-duty associate because the injured employee's wages are charged to workers' compensation and are not taken out of her department budget. (Tr. 122) Love takes her directives on light-duty issues from Kim Salazar, who is the manager in charge of workers' compensation. (Tr. 122). If Salazar gave Love paperwork that Petitioner could work in her department, she would provide light-duty work as long as she could keep Petitioner in the department. (Tr. 122-123) Love testified that she was not provided a note stating Petitioner could return to work after September 2016. (Tr. 123)

Cross-Examination

Love testified that she never communicated a light-duty job or the availability of light duty directly to Petitioner unless the job were sent to her by Kim Salazar. The light-duty slips went to Salazar and she would then contact Love to implement the light-duty work. (Tr. 133) Love does not contact injured employees to notify them to come in for light-duty work. She believes Salazar is the one who communicates the availability of light duty to injured employees. (Tr. 134) Everything concerning light duty is routed through Salazar. (Tr. 134) Love did receive an email from Salazar on November 21, 2016 communicating a transitional work agreement for Petitioner. Love believed Salazar was also sending such agreement to Petitioner. Prior to November 21, 2016,

she had last received a transitional work note from Salazar concerning Petitioner in April 2016. (Tr. 135)

Surveillance Films

Respondent offered surveillance video of Petitioner serving food at Miller's Ale House, doing laundry at a laundromat, running miscellaneous errands, and dancing at a bar. (RX2, RX3) Petitioner was shown bending approximately 45 degrees at the waist, picking up a jug of liquid laundry detergent, lifting pieces of laundry a little above shoulder level, and pushing a young woman in a wheelchair. The video was taken over several months in 2016. The last date of surveillance was November 10, 2016.

FINDINGS OF FACT & CONCLUSIONS OF LAW
16WC 17561 AND 16WC 17562 (CONSOLIDATED)

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

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accidental injuries of February 10, 2016 and April 6, 2016.

The Arbitrator finds the opinions of Richard D. Lim, M.D., that Petitioner's disc herniations at C5-6 and C6-7 are causally related to the combined injuries, to be persuasive. (PX8, p. 21) Dr. Lim testified that Petitioner's subjective complaints of a radiating cervical pain with numbness correlate directly with the disc pathology based upon his understanding of spinal cord compression, disc compression and radiculopathy. (PX8, p. 20). The Arbitrator also finds that Dr. Lim's opinion is consistent with the chain of events.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove

a causal nexus between the accident and the employee's injury. *International Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982)

In the case at bar, there is no history of any pre-existing complaints or medical care relating to the cervical spine. Prior to the accident, Petitioner worked full time for Respondent and as a server at Miller's Ale House on her days off from Respondent. She sustained two accidents to her cervical spine for which she has received consistent medical care up through the date of arbitration. Petitioner has never returned to her pre-accident baseline condition of well-being.

Moreover, there is no evidence of any intervening, non-work-related injury to Petitioner's cervical spine that broke the causal chain.

The Arbitrator notes that Dr. Lim's curriculum vitae states that he is President-Elect of Respondent, Advocate Christ Medical Center. (PX8, Dep. Ex. 1, p. 2)

The Arbitrator finds the opinion of Wellington K. Hsu, M.D., that Petitioner sustained cervical sprains which resolved six weeks after the accidents, to be unpersuasive. (RX1, p. 13) Furthermore, the Arbitrator finds unconvincing the testimony of Dr. Hsu that Petitioner's current symptoms are the result of an unrelated cervical spondylotic condition that became symptomatic "at some point" after she received treatment for her soft tissue injuries. (RX1, p. 36). Both Dr. Lim and the radiologist at Respondent's hospital viewed the repeat MRI and found that an extruded disk, and not an osteophyte complex, indented the thecal sac and the anterior spinal cord.

Dr. Hsu's opinion is also contrary to the chain of events which shows a condition of well-being followed by two accidents that resulted in consistent symptoms in the neck and left arm.

(J) WERE THE MEDICAL SERVICES THAT WERE RENDERED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Petitioner submitted the bill of Dr. Lim in the amount of $161.72 for follow-up visits on January 4, 2017 and April 5, 2017. (PX9) Respondent objected to liability. (Tr. 151)

Based on his findings and conclusions on the issue of causation, the Arbitrator finds that Petitioner is entitled to receive from Respondent $161.72 for the medical services rendered to her by Dr. Lim, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Petitioner submitted the bill of Midwest Orthopedic Consultants in the amount of $3,224.98 for a topical analgesic compound cream, flurbiprofen, which was prescribed by Dr. Lim on September 2, 2016 to help relieve Petitioner's pain. (PX8, p. 14, PX10) Respondent submitted into evidence a utilization review report that was authored by Grace Hunter, D.O., an osteopathic physician. Dr. Hunter is board-certified in physical medicine and rehabilitation. (RX4) Dr. Hunter, citing ODG guidelines, non-certified payment for the medication. Dr. Hunter wrote:

"There is little to no research to support many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm." (RX4)

There is no evidence that Petitioner actually applied the flurbiprofen topical cream.

There is no evidence that Dr. Lim contacted Dr. Hunter to discuss the matter.

Based on the foregoing, the Arbitrator denies payment of $3,224.98 by Respondent to Petitioner for a topical analgesic compound cream, flurbiprofen, which was prescribed by Dr. Lim.

(K) IS PETITIONER ENTITLED TO PROSPECTIVE MEDICAL CARE?

Dr. Lim testified that it would not be unreasonable to attempt a second epidural steroid injection and more physical therapy prior to surgery. (PX8, p. 33) Dr. Lim recommended surgical intervention because of the spinal cord compression.

Dr. Hsu, setting aside the issue of causal connection, testified that if Petitioner were his patient, he would prescribe more physical therapy and send Petitioner for a second epidural injection. (RX1, p. 32) Dr. Hsu would consider surgery to be a last resort after Petitioner had exhausted conservative care. (RX1, p. 31)

The Arbitrator notes that Dr. Lim and Dr. Hsu agree on the best course of treatment for Petitioner.

Based upon his findings and conclusions on the issue of causation, the Arbitrator finds that Respondent is liable for prospective medical care in the form of additional physical therapy and a second epidural steroid injection, as prescribed by Dr. Lim.

(L) WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner did not claim any temporary disability benefits following the first accident of February 10, 2016, case number 16WC 17561. (AX1)

For the second accident of April 6, 2016, case number 16WC 17562, the parties stipulated that Petitioner had an average weekly wage of $817.22 that included her average weekly wage of

$525.11 from Respondent combined with her average weekly wage of $292.11 from her concurrent employment at Miller's Ale House. (AX2)

Petitioner was authorized off work from April 7, 2016 through April 10, 2016 (4/7 week) by Dr. Greene at Employee Health (PX5) and is entitled to TTD benefits for that period.

Petitioner testified that she was again taken off work by Dr. Greene at Employee Health on May 2, 2016 and then placed on light duty on May 23, 2016. (PX5)

On June 1, 2016, P.A. Olschansky at Midwest Orthopedic Consultants (PX4) took Petitioner off work until Dr. Lim saw her on June 24, 2016. (3-2/7 weeks). Petitioner came under the care of Dr. Lim on June 24, 2016, who prescribed light-duty work until November 23, 2016 at which time he took Petitioner off work. (Tr. pp. 33-34) On December 9, 2016, Dr. Lim released Petitioner to a sitting job.

Dr. Hsu examined Petitioner on December 15, 2016 and opined that Petitioner could have returned to regular work from her cervical strain injury approximately six weeks after the accident. The Arbitrator, having found that Dr. Hsu's causal connection opinions are not persuasive as to the nature of the injuries sustained, finds Dr. Hsu's opinion as to the attainment of maximum medical improvement to be unconvincing.

The Arbitrator viewed the surveillance videos and does not find any instance where Petitioner exceeded her light-duty restrictions or demonstrated any activity that exceeded her stated limitations to her treating doctors. However, from a layman's point of view, the Arbitrator finds that Petitioner did not demonstrate any pain behaviors such as grimacing, stretching, or rubbing her neck, left arm or left hand, or "shaking out" her left hand.

Petitioner testified on direct examination that she stopped working at Miller's Ale House because of the toll it was taking on her and the shortened hours of sleep. She testified that on the

nights that she worked, she did not leave Miller's Ale House until 11:00-11:30 p.m. However, on cross-examination, Respondent asked her about six instances in which she clocked out before 11:00 p.m. (Tr. 56-58)

With regard to her home address, Petitioner testified as to the discrepancy between her testimony on direct and the paperwork she completed for Miller's Ale House in February 2017. Petitioner testified that she lived in Wheeling temporarily - - in January and February of 2017. (Tr. 58-60, 80-81)

Petitioner testified that she continued working at Miller's Ale House from May 2, 2016 to November 26, 2016. Brett Weinstein, her manager, testified that Miller's could accommodate the restrictions from Dr. Lim with the exception of the off-work restriction of November 23, 2016 and the sitting restriction of December 9, 2016. (Tr., p. 109)

Respondent paid Petitioner TTD benefits from November 23, 2016 through December 22, 2016. (Tr. 140)

The issue presented is whether Respondent made light-duty work available to Petitioner from May 2, 2016 through November 22, 2016 (29-2/7 weeks) and from December 9, 2015 through January 15, 2017 (5-3/7 weeks). Petitioner testified that she was given a sheet of paper that described her restrictions after each visit and that a copy of that sheet was placed next to the fax machine in Dr. Lim's outer office. Petitioner testified that she was given a fax confirmation after each visit. (Tr. 31)

However, at arbitration, Petitioner did not produce such fax confirmations.

Petitioner further testified that Dr. Lim's staff gave her the file and the fax confirmation number each time she visited and allowed her to compare it with the number at Advocate Health

to see if the fax went through. (Tr. 53-54) The Petitioner did not know to whom the modified or off-work slips were faxed.

The Arbitrator notes that the off or restricted-duty work slips submitted into evidence by Petitioner (PX4) and by Respondent (RX5) indicate that the insurance company was Advocate Risk Management and that the contact person there was Kim Salazar, whose fax number appears on every such slip.

The Arbitrator makes the reasonable inference that the staff for Dr. Lim, who is President-Elect of Respondent, faxed Petitioner's work restriction slips to Respondent.

Catherine Love, Petitioner's department manager, testified that Ms. Salazar in the manager of workers' compensation for Respondent. (Tr. 139) Love testified that she had light-duty work available for Petitioner but that she must take her directions from Kim Salazar, manager of workers' compensation, as to whom light-duty work is made available. (Tr. 122) Love testified that she never communicated a light-duty job to Petitioner unless being told to do so. (Tr. 133) The standard procedure was that the light-duty work slips were sent to Kim Salazar, who would then contact Love to implement the light duty. (Tr. 134) Love testified that everything concerning light-duty work is routed through Salazar. (Tr. 134) Love did receive an email from Salazar concerning light-duty work for Petitioner on November 21, 2016, which was two days before Dr. Lim took Petitioner off work completely. (Tr. 134) Prior to that, Love testified that she last received an email from Salazar concerning light-duty work for Petitioner in April 2016.

Respondent did not call Kim Salazar to testify as to any offers of light-duty made to Petitioner. Although Love had modified work available to Petitioner, Respondent's procedure, according to department manager Love, was that offers of modified-duty originated from Salazar. Love did not hear from Salazar from April 2016 to November 21, 2016.

Petitioner testified that after she was given light-duty restrictions on April 18, 2016, she did not think to call the hospital to see if they had any work for her as of September 2, 2016. (Tr. 55-56) Petitioner testified that Kim Salazar left a voice mail message for her, but instead of returning to work, she saw Dr. Lim, who changed her restrictions from no working above the shoulder to completely off work. (Tr. 65-66)

On December 9, 2016, Dr. Lim released Petitioner to return to work at a sitting job. Respondent offered no evidence that such work was offered to Petitioner and Weinstein testified that Miller's could not provide sitting-only work. Petitioner started a sitting job within the Advocate Health System on January 16, 2017. Petitioner lost time from working at Miller's beginning on November 26, 2016 and carrying through February 5, 2017, when she returned to work, contrary to her sitting job restrictions. Petitioner worked at Miller's for six weeks from February 6, 2017 until March 19, 2017, when she quit because work became very painful for her and she had a lack of sleep. Petitioner submitted her payroll records from Miller's for the period in question. (PX1) Her earnings at Miller's were as follows:

Pay Period Ending	Gross Earnings
02/12/2017	$30.94
02/19/2017	$24.75
02/26/2017	$91.58
03/03/2017	$50.74
03/19/2017	$59.74
03/25/2017	$45.13
	$302.88

Petitioner did not work at Miller's during the week of March 6 through March 12, 2017.

Based on the above, the Arbitrator finds that Petitioner is entitled to receive from Respondent the following amounts in temporary total disability and temporary partial disability:

For lost earnings from Respondent:

1. Temporary total disability benefits of $350.07 per week from April 7, 2016 through April 10, 2016 (4/7 weeks) $200.04

2. Temporary total disability benefits of $350.07 per week from May 2, 2016 through January 15, 2017 (37 weeks) $12,952.59

Total TTD due from employment at Respondent: $13,152.63

For lost earnings at Miller's Ale House:

1. Temporary total disability benefits at $194.74 per week from November 27, 2016 through February 5, 2017 (10-1/7 weeks) $1,975.25

2. Temporary total disability benefits at $194.74 per week from March 6, 2017 through March 12, 2017 (1 week) $194.74

3. Temporary total disability benefits at $194.74 per week from March 26, 2017 through June 26, 2017 (13-2/7 weeks) $2,587.32

Total TTD due from Miller's Ale House employment: $4,757.31

Temporary Partial Disability benefits as follows:

	Period Ending	Average Weekly Wage	Earnings	2/3 Lost Wages
1.	02/12/2017	$292.11	$30.94	$174.11
2.	02/19/2017	$292.11	$24.75	$178.24
3.	02/26/2017	$292.11	$91.58	$133.69
4.	03/03/2017	$292.11	$50.74	$160.91
5.	03/19/2017	$292.11	$59.40	$155.14
6.	03/26/2017	$292.11	$45.13	$164.65

Petitioner is entitled to a total TPD amount of **$966.74**.

CONCLUSION AS TO ISSUE "L"

Petitioner is entitled to receive from Respondent TTD and TPD benefits that total **$18,876.68**, as shown above.

Respondent is entitled to a credit in the amount of **$10,602.12** for TTD benefits previously paid to Petitioner.

19IWCC0437

Brian T. Cronin
Arbitrator

10-18-17
Date

19IWCC0437

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

RADOSAVAC, SLADANA
Employee/Petitioner

Case# **16WC017562**
16WC017561

ADVOCATE CHRIST HOSPITAL
Employer/Respondent

19IWCC0437

On 10/18/2017, 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 1.24% 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:

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL UGASTE
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
19(b)

Sladana Radosavac
Employee/Petitioner

v.

Advocate Christ Hospital
Employer/Respondent

Case # **16** WC **17562**

Consolidated cases: **16WC 17561**

19IWCC0437

An *Application for Adjustment 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 IL**, on **6/26/17**. 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 _____

FINDINGS

On the date of accident, **4/6/16**, 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 $**42,945.11**; the average weekly wage was $**817.22**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

Respondent is entitled to a credit of $**10,602.12** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**10,602.12**.

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

ORDER

1. *Respondent shall authorize and pay for the physical therapy and the epidural steroid injection to Petitioner's cervical spine that Dr. Lim has ordered, pursuant to Section 8(a) and subject to Section 8.2 of the Act.*

2. *Respondent shall pay $161.72 (PX9) to Petitioner for the treatment rendered by Midwest Orthopedic Consultants, pursuant to Section 8(a) and subject to Section 8.2 of the Act.*

3. *Respondent shall pay Petitioner temporary total disability benefits, in accordance with Section 8(b) of the Act, of $350.07 per week for 37-4/7 weeks for the periods commencing April 7, 2016 through April 10, 2016 (4/7), and from May 2, 2016 through January 15, 2017 (37 weeks) for her employment with Respondent.*

4. *Respondent shall pay Petitioner temporary total disability benefits, in accordance with Section 8(b) of the Act, of $194.74 per week for 24-3/7 weeks for the periods commencing November 27, 2016 through February 5, 2017 (10-1/7 weeks); commencing March 6, 2017 through 12, 2017 (1 week), and March 26, 2017 through June 26, 2017 (13-2/7 weeks) for her employment at Miller's Ale House.*

5. *Respondent shall pay Petitioner temporary partial disability benefits, as provided in Section 8(a) of the Act, of $966.74 as calculated in issue (L) of the attached Findings of Fact & Conclusions of Law.*

6. *Respondent shall be given a credit of $10,602.12 for temporary total disability benefits that have been paid to Petitioner.*

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

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

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

Signature of Arbitrator

10/18/17
Date

IC ArbDec 19(b)

OCT 18 2017

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Mounts,
Petitioner,

vs. No. 17 WC 13982

General Mills,
Respondent.

19IWCC0438

DECISION AND OPINION ON REVIEWPURSUANT TO §19(B) AND §8(A)

Timely Petition for Review under §19(b) and §8(a) 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 disability and denial of request for a bifurcated hearing, and being advised of the facts and law, affirms and modifies the reasoning of the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying facts of this claim were well laid out in the Arbitrator's decision. Petitioner, a 33-year-old technician, testified that while working on February 14, 2017, he pulled on a heavy steel door and felt a shock go up his left wrist to his elbow. The Arbitrator denied all benefits noting that Petitioner's credibility was "severely tarnished" during the course of his testimony. The Petitioner claims the Arbitrator erred by giving improper weight to his social media posts and by denying his request for bifurcation of the trial in order to obtain other evidence to rebut said posts.

The Commission acknowledges that Petitioner's testimony on cross examination– that the video showing him repeatedly tossing a 75-lb. medicine ball was *recorded* before his accident and only *posted* to his Instagram account the day after his accident – was not rebutted by other testimony. The Commission further agrees that Petitioner's caption which accompanied that video post, "#Wednesday," did not necessarily prove the video was recorded on the Wednesday after his accident, as the Arbitrator seemed to believe.

Notwithstanding the above, the Commission finds that the evidence as a whole supports the Arbitrator's finding that Petitioner's did not prove accident or causal connection, and that his credibility was severely tarnished.

Multiple physicians found that Petitioner's subjective complaints exceeded his objective findings. On March 22, 2017, Dr. Long was unable to correlate the intensity of Petitioner's symptoms to the results of Petitioner's diagnostic testing and clinical exam. On April 18, 2018, Dr. Heller reported that he could not explain Petitioner's persistent subjective left wrist complaints. On May 4, 2017 Dr. Prinz, Petitioner's treating hand surgeon, reported that his palpation of Petitioner's wrist elicited pain out of proportion to what he would expect. The Commission finds this evidence more credible than Petitioner's testimony.

Petitioner admitted that after his accident, he continued working out at his gym, despite testifying that merely moving his arm caused, "significant pain." He denied doing pushups after his accident. He also denied using his left arm during his workouts, although he then admitted that he did use his left arm, "very lightly." On April 20, 2017, Petitioner posted a message that he was going to do a workout which included 100 push-ups a day, for 30 days.

Although Petitioner testified that he abided by his doctor's restrictions, other evidence contradicts his testimony. On May 4, 2017, Dr. Prinz provided Petitioner with and directed him to wear a rigid splint. Further, he restricted Petitioner from using his left arm. At Petitioner's follow-up exam two weeks later, Petitioner admitted he had not been wearing the splint. Dr. Prinz then gave Petitioner a cock-up splint and advised him to wear it at all times except for hygiene. Petitioner testified that he wore the splint 99 percent of the time. However, Petitioner posted a photo of himself on June 9, 2017, in which he was not wearing his splint. That photo also showed him using a shovel with both hands to dig in his garden, contrary to his doctor's recommendation.

The burden is on the Petitioner to prove by a preponderance of credible evidence all of the elements of his claim, including that his injury arose out of and in the course of his employment. *Martin v. Industrial Commission,* 91 Ill.2d 288, 63 Ill.Dec. 1 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission,* 98 Ill.2d 20; 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence. *U.S. Steel v. Industrial Commission,* 8 Ill.2d 213; 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal v. Industrial Commission,* 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). In the instant case, the Commission does not find Petitioner credible.

With regard to the issue of causal connection, the Arbitrator found Dr. Heller's opinions credible. The Commission, however, finds inaccurate Dr. Heller's conclusion that Petitioner's MRI was "normal" and that Petitioner's radiologist, Dr. Quraishi, reported Petitioner's MRI to be "unremarkable." The Commission's basis for finding that Petitioner did not prove causal connection is simply his lack of credibility, as noted above. Petitioner did not meet his burden of proving that any condition of ill being was caused by his alleged accident.

Finally, the Commission affirms the Arbitrator's denial of Petitioner's request to bifurcate the arbitration hearing. Petitioner did not make that request until after he rested his case. Petitioner only sought the bifurcation in order to have an opportunity to review and obtain possible rebuttal evidence from his own Instagram account. The Commission finds Petitioner's request for bifurcation was untimely. The Instagram postings which Petitioner sought to review as possible rebuttal were readily available prior to the start of the arbitration hearing.

In light of the foregoing, the Commission finds all other issues moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2017, is hereby affirmed and adopted.

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

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

DATED: AUG 16 2019

o-06-20-19
mp/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOUNTS, KEVIN
Employee/Petitioner

Case# **17WC013982**

GENERAL MILLS INC
Employer/Respondent

19IWCC0438

On 8/29/2017, 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:

0293 KATZ FRIEDMAN EAGLE ET AL
FRANK J BERTUCA
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
TIMOTHY FURMAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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

KEVIN MOUNTS,
Employee/Petitioner

v.

GENERAL MILLS INC.
Employer/Respondent

Case # **17** WC **13982**

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 **JESSICA A. HEGARTY**, Arbitrator of the Commission, in the city of **WHEATON, ILLINOIS**, on **JUNE 22, 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 - Nature and Extent.

FINDINGS

On the date of accident, **2/14/17**, 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 $**62,226.84**; the average weekly wage was $**1,196.67**.

On the date of accident, Petitioner was **33** years of age, *single* with **0** dependent children.

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

Petitioner's injury is not causally related to his employment with Respondent.

ORDER

Because Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment on 2/14/17 as alleged, 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.

Jessica A. Kozoty

Signature of Arbitrator

8/28/17
Date

AUG 29 2017

STATE OF ILLINOIS)
)
COUNTY OF DUPAGE)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KEVIN MOUNTS)
)
Petitioner,)
vs.) **17 WC 13982**
)
GENERAL MILLS INC.,)
)
Respondent.)

19IWCC0438

ADDENDUM TO THE DECISION OF THE DECISION OF ARBITRATOR

The parties stipulated that Petitioner was employed by Respondent on the alleged accident date. (Arb. Ex. 1).

Petitioner testified that on the morning of 2/14/17 he was at work, attempting to open a steel door, when he experienced a "shock like" sensation in his left wrist that extended to his elbow and shoulder. (T. 8). Petitioner reported the accident to his supervisor and plant nurse, Debbie Canalini who rendered minor first aid, provided a brace and recommended that Petitioner go to Tyler Medical Center. (T. 8-10). Petitioner testified that he reported to Tyler Medical that day. (T. 23).

Records from Tyler Medical Services reveal that Petitioner first presented to Robert Long, DO on 2/27/17, at which time, complaints of left wrist pain were noted. X-rays were negative, a left wrist sprain was diagnosed, Petitioner was provided with an elastic "wrist wrap" and he was instructed to alternate ice and moist heat after completion of the workday. (P. Ex. 2).

Petitioner returned to Tyler on 3/2/17 where George Pappas, DO noted persistent left wrist complaints. (Id.). Petitioner was provided and instructed to wear a thumb spica brace in addition to the elastic wrist support and was advised he could continue working with the braces. (*Id.*).

On 3/7/17, Petitioner returned to Tyler Medical for an unscheduled evaluation due to increased pain in his left wrist. (Id.). An MRI was recommended and work restrictions of no lifting greater than 10 pounds were instituted. (*Id.*).

Petitioner testified he was kept off work from 3/8/17 through 3/12/17 and was paid temporary total disability benefits for these days. (T. 11).

On 3/17/17 a left wrist MRI noted mild tenosynovitis at the second extensor compartment and edema dorsally at the level of the scaphotriquetral ligament, a "suspect sprain" was noted. (P. Ex. 2).
On 3/22/17, Dr. Long diagnosed tenosynovitis, referred Petitioner to an orthopedic specialist and continued Petitioner's work restrictions. (*Id.*).

Respondent accommodated Petitioner's restrictions from 3/12/17 to 3/31/17, when the plant closed. (T. 11, 13). Respondent then paid temporary total disability from 3/31/17 through 4/23/17. (T. 14).

On 5/4/17, Petitioner presented to Dr. Paul T. Prinz of Special Care Orthopedics & Hand Surgery for initial consult. (P. Ex. 3). The doctor reviewed the recent MRI noting likely second extensor compartment tenosynovitis. Dr. Prinz recommended a steroid injection for diagnostic and therapeutic reasons which Petitioner declined. (Id.). A new rigid splint was provided and Petitioner was instructed he could continue to work with no use of the left arm. (Id.).

Petitioner testified that he wears the splints provided to him 99% of the time. (T. 16).

On 5/18/17, Dr. Prinz administered a steroid injection to Petitioner's left wrist and continued the prior work restrictions. (Id.).

Petitioner's testified that his current pain level in his left wrist ranges from a 3-5/10.

He further testified his grip strength has significantly decreased and that the day before the hearing he attempted to lift an empty sauté pan, experienced "severe pain" and dropped the pan. (T. 18-19, 37).

Dr. William A. Heller, an orthopedic physician who specializes in hand, wrist, elbow and shoulder surgery performed an IME at Respondent's request on 4/18/17. (R. Ex. 2). Dr. Heller examined Petitioner's left wrist and reviewed the 3/17/17 left wrist MRI, concluding it was an essentially unremarkable study, noting there "may be some mild dorsal tenosynovitis that could be normal anatomy" with congenital ulnar variance. (Id.). In the doctor's opinion, Petitioner likely sustained a left wrist sprain that had since resolved. There were no objective left wrist findings at the time of his exam and it was his opinion that Petitioner had reached MMI and could return to full duty work without restrictions. (*Id.*).

Respondent's Exhibit 4 is a video depicting Petitioner using both hands to throw a 75-pound ball forward, lunging towards the ball, picking it up and repeating the process. The video was posted from the "from_nacho_to_macho" Instagram account, the day after his alleged accident on 2/15/17. (R. Ex. 4, 8). The video was accompanied by the caption:

> *I am trying to fight off the winter blues and stay sane during a busy schedule. #motivation isn't always there, but when I push myself it feels sooooo [sic] good to be a better Kevin than yesterday. 75lbs squat throws with forward lunges. '#workout' '#xsportfitness' '#fitness' '#squats' '#strength' '#weightloss' '#spartan' '#keto' '#wednesday' '#godisgood' '#fitfam' '#running' '#cardio' '#crossfit' '#fit' '#lifting' '#winter' '#blues' '#solomon' '#gncbatavia'* (R. Ex. 8) (emphasis added).

Petitioner testified that he posted the video to his Instagram account on 2/15/17 but the video was filmed two weeks prior to the accident. (T. 27).

The Arbitrator takes judicial notice that 2/15/17 was a Wednesday. (T. 28).

Respondent's Exhibit 5 is a photograph depicting a workout regimen consisting of 100 push-ups, 100 sit-ups, 100 squats and a 10k run. The photograph was posted from the "from_nacho_to_macho" Instagram account on 4/20/17. (R. Ex. 5). The photograph was accompanied by the caption:

> *CHALLENGE! I enjoy challenges, and I thought...I've been out of my routine with lots of life stuff going on, so as lame as the picture might be, the workout involved is pretty solid! (Sorry, I'm not a fan of One Punch Man ☺) I challenge you to this for at least 7 days. I am going to go 30 days and work up to a half marathon distance with my runs. Split them up into different reps throughout the day if you want/need to! Who's with me? '#challenge' '#spartan' '#workout' '#goals' '#onepunchman' '#fitness' '#run' '#marathon' '#squats' '#situps' '#pushup' '#getfit' '#summeriscoming' '#summer' '#wedding' '#weddingseason' '#crunchtime' '#godisgood' '#fitfam'* (Id.). (emphasis added).

Petitioner testified that he posted the picture to his Instagram account on 4/20/17. (T. 33). Petitioner further testified that he did not complete the exercises depicted in the picture, other than running. (T. 35). Petitioner testified that the hashtags pertaining to a wedding were referencing his own upcoming wedding. (T. 36).

Respondent's Exhibit 6 is a photograph depicting Petitioner holding a shovel, which is being used to dig into the ground. (R. Ex 6). Petitioner is not wearing a brace in the photograph. *(Id.)*. The photograph was posted from the "from_nacho_to_macho" Instagram account on 6/9/17. *Id.* The photograph was accompanied by the caption:

> *Making the house a home...with style! ☺☺Making our backyard garden, with tomatoes, squash, zucchini, kale, lettuce, and peppers. With @activefingers Nomnomnom (dat [sic] John Cena headband tho [sic] haha) '#garden' '#home' '#michigan' '#puremichigan' '#planting' '#gardening' '#healthy' '#vegetables' '#veges' '#backward' '#summer' '#outdoors' '#workout' (Id.).*

Petitioner testified that he took and posted the picture to his Instagram account on 6/9/17. (T. 38). Petitioner also testified that he was not wearing his brace in the picture. *(Id.)*.

On re-direct, Petitioner stated that he was also moving top soil and using a rake. (T. 43). Petitioner acknowledged that the shovel weighed between 5 and 10 pounds and that the garden he was shoveling and raking was 4 foot by 4 foot. (T. 50-51).

CONCLUSIONS OF LAW

Regarding Issue (C): Whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent:

The Arbitrator finds that Petitioner failed to sustain his burden with respect to this issue. In so finding, the Arbitrator notes that Petitioner's credibility was severely tarnished during the course of his testimony:

Petitioner's testimony was inconsistent regarding both his pain level and adherence to his treating physician's work restrictions following the accident.

Petitioner testified that his pain was so severe that he was unable to lift a pan over the stove just a week prior to trial which is contradicted by Petitioner's 6/9/17 photograph which depicts him shoveling dirt and planting a vegetable garden.

Petitioner testified that he wears his brace 99% of the time and adheres to Dr. Prinz's restrictions of no use of the left arm. This too is contradicted by the above-mentioned 6/9/17 photograph depicting shoveling and gardening activities, while not wearing a brace.

Following his alleged 2/14/17 accident, Petitioner was referred to Tyler Medical Services but failed to pursue this recommendation for 13 days.

Petitioner testified that he did not complete any of the exercises (sit-ups, push-ups and squats) depicted in his 4/20/17 Instagram post, other than running. This testimony is at odds with his own words as stated in the post's caption. Relevant portions read:

> "I am going to go 30 days and work up to a half marathon distance with my runs." "Who's with me?" "#pushup," "#summeriscoming," "#summer," "#wedding," "#weddingseason," "#crunchtime."

Petitioner testified that the 2/15/17 video depicting himself working out was filmed several weeks prior. The video's caption contained the phrase "Wednesday." The arbitrator takes note that 2/15/17 was a Wednesday.

Assuming arguendo, that Petitioner sustained his burden with respect to accident, the arbitrator notes the preponderance of medical evidence contained in the record, including Dr. Heller's findings and opinions, which the Arbitrator found credible, do not support a finding that Petitioner's current condition is causally related to the alleged accident. In support, the Arbitrator notes Dr. Heller's 4/18/17 report finding no objective left wrist symptoms and an essentially normal MRI. Dr. Heller further concluded that any symptoms relating to the 2/14/17 incident had since resolved; and Petitioner had reached MMI and could return to work without restrictions.

Because Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment on 2/14/17 as alleged, all benefits are 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 Accident/causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK KENNEDY,

Petitioner,

19IWCC0439

vs.

Nos: 11 WC 2121 &
11 WC 2946

STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner sustained his burden of proving he sustained a compensable accident on June 18, 2010 causing a condition of ill-being of his cervical spine, and awards benefits.

I Testimony

Petitioner testified that he worked as a carpenter for Respondent for 25 years. On June 18, 2010, he was working at Reed Mental Health Center. He was using a metal tool cart, which he estimated weighed 300 or 400 pounds. As he was pushing the cart from one job to another, his "knee started to buckle," he "was already sweating," he "felt numbness and like a light behind" his eyes, and he had a headache. When asked what part of his body bothered him, Petitioner responded his neck. He asked a housekeeper nearby if there was a doctor present, and he went and saw Dr. Carag. When he came to her, she said "what's wrong with you, you don't look good, sit down." He described some symptoms, she said something about a heart attack, put a Nitroglycerin pill in his mouth, and told somebody to call 911.

He was taken to the Resurrection Hospital Emergency Department by ambulance. Petitioner testified he was given a blood test and a doctor said "you didn't have a heart attack. He goes, but you should follow up with your doctor, and there's a doctor you should go to follow up with for your heart attack." He was released from the hospital. Petitioner followed up with Dr. Fisher and Dr. Tenzer. He was referred to Dr. Katznelson, a neurologist.

He told Dr. Katznelson that he had numbness in his left arm/hand, "had the dropsies," and felt faint occasionally. Petitioner thought it was something neurologic and wanted an MRI. He had an MRI of his neck and thoracic spine and returned to Dr. Katznelson on September 23, 2010 to discuss the MRI findings. Dr. Katznelson told him "that there was discs" in his neck. He took Petitioner off work and prescribed physical therapy. Later, he prescribed medication, which appears to have been Neurontin. The physical therapy concentrated on his neck.

Petitioner also complained about his symptoms to his primary care physician, Dr. Pitlosh. He referred Petitioner to Dr. Yapor, a neurosurgeon. Petitioner gave Dr. Yapor his MRI. He told Petitioner he needed cervical fusion surgery. He also provided Petitioner a traction machine. He still uses the machine a couple of times a day.

Petitioner returned to Dr. Pitlosh and informed him that Dr. Yapor recommended surgery. Dr. Pitlosh wanted Petitioner to get a second opinion before major surgery, and referred him to Dr. Deutsch, whom he saw on March 11, 2011. He concurred with the recommendation for surgery. Petitioner has not had the recommended surgery. At the request of his lawyer, Petitioner saw Dr. Palacci in 2016.

Petitioner testified he was off work from June 18, 2010 to July 7, 2011, when he was released to work after he declined surgery. He returned to work at full duty. He noticed that he "wasn't moving as quick," "everything seemed to be a chore," he "had to rethink things twice," and he "had to lighten" his loads. Petitioner testified he never had any problems with his neck, left shoulder, thoracic area, or numbness down the left side of his back prior to the accident. When he came to work on that day, he "was feeling really good, grateful to have a job."

Currently, Petitioner depends on the traction machine. Just holding his head up is a problem, he still had the "dropsies," more in his left hand, and sensitivity in his hands causes problems with his work as a locksmith. He is in pain every day but does not take medication. He has some difficulty with activities of daily living.

On cross examination, Petitioner testified he never weighed his tool cart. He felt neck pain but did not have chest pain when he moved the cart. He denied he asked Dr. Carag to test his blood pressure; they already were without him asking. He denied telling Dr. Carag that he had chest pain on and off that morning. Rather, they told him he had chest pains, he did not tell them.

Petitioner testified that he never told the paramedics on the ambulance about episodes of chest pain, they never asked him any questions, and did not provide any treatment. He also denied that he reported chest pain. Petitioner also denied he reported chest pains at the hospital emergency department. Petitioner just told them, "they think [he] was having a heart attack." He reported left arm numbness at the emergency department but not to the ambulance crew or Dr. Carag; as he did not have a chance to do so.

Petitioner acknowledged that he "guessed" he reported chest pain at the emergency department when presented with their records. However, he testified that he reported pain in his head, neck, and arm. The pill, presumably the Nitroglycerin, did not resolve his pain and he "still felt bad." Petitioner did not remember undergoing a stress test or that doctors wanted to admit him. Petitioner denied refusing treatment at the emergency department, but acknowledged signing a Release and Refusal of Treatment document. He was told he should see his heart doctor and testified he was never told he needed x-rays or an MRI at the emergency department, and neither was taken at that time.

Petitioner testified that he saw Dr. Katznelson two or three times. He did not recall whether he saw him on August 31, 2010.

Petitioner also saw Dr. Butler for a Section 12 examination. While he was off work he could "barely" perform activities at home and while he did do gardening he did not do "the heavy lifting part, just the harvesting." His garden is about 40 x 40 and he puts it up and takes it down every year. He uses a rototiller weighing 45 pounds.

Petitioner agreed that in March 2000 he was "crushed by a building" while serving in the Navy, but denied he had numbness in his upper body as a result. He was not diagnosed with a disc protrusion at that time. A physical therapy record indicating that he made such a statement was incorrect. A Veterans' Administration doctor told him had a trapezius problem.

Petitioner agreed that he saw Dr. McCall but denied that he told him that he had a workup for a similar condition while in the Navy and got 20% disability upon discharge. He got 10% disability for his trapezius. Petitioner also testified that the diagnosis that his condition would worsen as he got older referred to arthritis in his lower back.

The last time he saw Dr. Pitlosh for his current injury was July 6, 2011. He had a couple of off-work notes from medical providers and turned them over. Petitioner denied that he demanded that Dr. Katznelson order an MRI due to his 1999 or 2000 injury. When presented with a note from Dr. Katznelson noting as much, Petitioner responded that he thought that they were in mutual agreement that he needed an MRI. He explained that he told doctors about his prior history but did not know which he informed about that previous injury. Petitioner testified that Drs. Yapor, Deutsch, and Pitlosh all told him his condition had nothing to do with his military injuries.

Petitioner denied that he told Dr. Palacci that he had two episodes of chest pain. He did not recall whether he told Dr. Palacci that a building fell on him. Petitioner denied telling Dr. Palacci that he had a disc protrusion and told him that he never had a prior neck trauma because he did not have any.

On redirect, Petitioner testified he left the hospital because they told him he did not have a heart attack. He worked for Respondent as a carpenter without difficulty from the time he left the Navy to the date of his accident. In the Navy, he had problems with his lower back and trapezius. He was never previously diagnosed with a neck-disc problem.

On re-cross examination, Petitioner agreed that he received 10% disability from the Navy and still receives that benefit.

II Medical records

The ambulance records from June 18, 2010 indicate that Petitioner was working when he had two episodes of chest pain that lasted about 20 minutes. He was currently pain free and had no shortness of breath. He was given Nitroglycerin and Aspirin because of the chest pains.

The records from Resurrection Hospital Emergency Department indicated Petitioner presented after two episodes of "CP/pressure, SOB (presumably shortness of breath) @ work," the first at rest and the second while pushing a cart. Pain improved with rest and resolved when given Nitro by EMTs. PTSD from a "brain injury" noted. An ECG/stress test was negative for ischemia. A brain MRA showed no evidence of hemodynamic significant stenosis of the carotid arteries and showed very hyproplastic distal sight vertebral artery which is barely seen. The right distal vertebral artery was not visualized and was very hyperplastic and attenuated. There was no evidence of focal stenosis, occlusion, or aneurysmal dilation. Petitioner refused admission for to the hospital after being told he was not having a heart attack. The hospital staff recommended he be admitted to undergo a stress test.

On July 22, 2010, Dr. Tenzer performed a left heart catheterization, right femoral angiography with placement of angio-seal device for the preop diagnosis of abnormal nuclear stress test with chest pain. The postop diagnosis was "normal cardiac catheterization." On August 12, 2010, a chest CT taken at Resurrection because of chest pain showed no evidence of acute pulmonary disease and no apparent cause of Petitioner's clinical symptoms. He was restricted to no lifting or excessive bending for 48 hours.

On August 4, 2010, Petitioner presented to Dr. McCall. He noted that Petitioner's chief complaint was low back pain, and a "sensation of being crushed left chest into left scapula with numbness in bilateral upper extremities." He characterized Petitioner as a "somewhat difficult historian." Petitioner stated he felt like he was being crushed when pushing a cart at work. "His vision got blurry. His legs gave out." An Angiogram was negative.

Petitioner reported he received 20% medical disability for a similar condition upon discharge from the Navy in 1999. Petitioner reported whatever his prior condition was, he was told his prognosis was going to get "much worse as he gets older and he [was] concerned that these are manifestations of such." He also felt that this was a "work-related injury; though it was not registered as such." Dr. McCall took x-rays which showed disc spaces were fairly well preserved and "there was just a hint of spondylolisthesis at L4 and L5." Currently, Petitioner reported soreness in the low back and hips and felt like he had "weights tied to his hips."

On August 31, 2010, Petitioner presented to Dr. Katznelson "for some neurological symptoms following an episode that occurred at work." Suddenly, he developed chest pain, blurred vision, numbness in the left arm/leg, and "his left face felt like a blow torch as well." He was given Nitroglycerin and taken to an emergency department. Since, he felt "like his left arm and leg do not work right," and he has "continual numbness in the left side of his face." He was under the care of a psychologist for PTSD. "On motor exam, he exerted very poor effort with his left arm and left leg and weakness had a give way type quality to it, probably 4/5 in every muscle."

Dr. Katznelson's greatest concern was that he had a "small infarct" and that he was going to get a brain MRI. Petitioner also requested cervical and thoracic MRIs because of his pain, which Dr. Katznelson ordered. Petitioner indicated he took a lot of aspirin for his pain, and Dr. Katznelson advised him to only take a baby aspirin. He also strongly advised him to get a psychiatric consultation for non-occupationally related conditions, his PTSD and depression.

A brain MRI, taken on September 10, 2010, showed no evidence of acute intracranial process, abnormal enhancement, or enhancing mas lesions. There was mild central and cortical involutional changes. A cervical MRI was taken on September 16, 2010 for severe neck and back pain, which showed mild-to-moderate degenerative disc disease with disc bulging, probable minimal disc protrusion/spurring C4-T1, with no significant encroachment of the cord or spinal cord abnormality. On the same day, a thoracic MRI showed very mild degeneration with disc bulging at T7-8, with no significant encroachment of the cord or spinal cord abnormality. Later, Dr. Katznelson noted that the brain MRI findings were "nonacute" while the cervical MRI showed some disc bulging (C5-T8) and foraminal narrowing (C5-C7). Petitioner reported "radicular sounding symptoms shooting down his left arm." Dr. Katznelson prescribed Neurontin. He did not formally release Petitioner to work but would consider it if Petitioner felt better the next week.

On October 26, 2010, Dr. Katznelson noted that he had difficulty understanding Petitioner who was very scattered and disorganized. He could not explain all of Petitioner's symptoms based on the cervical pathology. He increased Neurontin, continued physical therapy, ordered an EMG/NCV, and took Petitioner off work "until a diagnosis is more clearly established."

On November 4, 2010, Petitioner presented to Dr. Pitlosh. In handwritten notes which are largely illegible, Dr. Pitlosh indicated that on June 18th Petitioner was lifting a lot of weight, and there became concern about cardiac problems. He mentions radicular pain, and something illegibly "severe" in the left chest/shoulder. He diagnosed cervical degenerative disc disease, referred Petitioner to Dr. Yapor, and restricted him from lifting any weight before being cleared by neurology.

Petitioner presented to Dr. Yapor. He reported being taken out from his job site in an ambulance after injuring himself lifting heavy objects on June 18, 2010. Dr. Yapor noted that Petitioner was previously in perfect health with a non-contributory past medical history. Dr. Yapor found decreased sensation in the C5 and C6 dermatomes of the left arm and decreased cervical range of motion due to pain. He had physical therapy and traction with no benefit. Petitioner indicated, "that he needs to have something done." Dr. Yapor recommended a two-level discectomy/fusion.

On February 11, 2011, Petitioner returned to Dr. Pitlosh. He reported that he continued to drop things. Dr. Pitlosh noted that Petitioner had seen Dr. Yapor at Resurrection, but now wanted a second referral now that he was at Rush. An MRI showed cervical degenerative disc disease with impingement C4-T1. Dr. Pitlosh prescribed Tramadol, recommended physical therapy, and recommended referral to neurosurgery.

On March 11, 2011, Petitioner presented to Dr. Deutsch on referral from Dr. Pitlosh, with the chief complaint of neck and left arm pain. He also complained of diffuse left arm weakness. Petitioner reported a work accident at which time he developed neck and arm pain. A cardiac condition was ruled out.

Dr. Deutsch noted the MRI showed disc herniations at C5-6 and C6-7, with effacement of the C7 nerve root. Besides diffuse neck stiffness, positive Spurling's, difficulty turning his neck, and some triceps weakness, the examination appeared to be normal. Dr. Deutsch diagnosed cervical radiculopathy and noted Petitioner reported the symptoms began with his work accident. He recommended a discectomy at C5-6 and C6-7.

Dr. Deutsch authored a narrative letter in which he noted that Petitioner reported pushing a 300-pound cart when he developed neck pain, left arm pain, and chest pain. He summarized his examination and diagnosis of cervical radiculopathy. He noted that the MRI showed small disc herniations at two levels. He recommended a two-level discectomy and opined that the cervical radiculopathy was related to his work accident based on Petitioner's report of acute onset of pain.

III Doctors' depositions

Dr. Palacci testified by deposition on November 1, 2016. He is board-certified in internal medicine. Currently, his practice involves performing disability evaluations in internal medicine,

providing Section 12 medical examinations, and doing impairment ratings. His experience included cases in which the traumatic injury has been to the neck and back.

At the request of Petitioner's lawyer, he saw Petitioner on April 20, 2016, after he had reviewed his medical records. Petitioner reported he was asymptomatic until he had a sudden onset of neck pain on June 18, 2010 after pushing a 300-pound metal cart full of tools. He had cardiac testing which was negative. It was thought he had a heart attack because he had left arm numbness and possibly chest pains. He had no symptoms prior to his accident.

Petitioner reported to Dr. Palacci current daily 8/10 chronic achy pain. He complained of pain shooting down his left arm, which Dr. Palacci agreed was radicular pain. Petitioner also reported some sharp pain radiating down his left arm several times a week, with some numbness in his fingers. He used a traction device at home. Dr. Palacci noted reduced range of motion, tenderness in the trapezius muscles, positive Spurling's, and normal reflexes/strength.

Dr. Palacci opined that Petitioner's condition was aggravated by the work accident causing it to become permanently symptomatic. He also opined that Petitioner had to be off work for about 12 months after the accident. Dr. Palacci disagreed with the opinion of Dr. Butler who opined Petitioner's condition was not caused by the accident.

On cross examination, Dr. Palacci testified he was not an orthopedic surgeon and about 10% of his practice involves performing Section 12 examinations. He did not currently treat patients, but in the past, he treated patients with neck injuries many, many times. Petitioner did not mention that he was a Navy veteran nor that he had been discharged because of a neck condition. Dr. Palacci acknowledged that he did not review any records prior to an MRA report dated July 3, 2010, or see any medical records from the day of the accident. Dr. Palacci explained that degenerative disc disease symptoms are typically slow in onset, while acute radicular symptoms, like Petitioner's are usually the result of a disc herniation.

Dr. Butler testified by deposition on March 13, 2017. He is a board-certified orthopedic surgeon and independent medical examiner. He sees about 40 patients and performs about 10 IMEs a week. He performed a Section 12 medical examination on Petitioner evaluating his cervical spine on June 29, 2016. Subsequent to the exam, he reviewed his medical records. He did not have the actual MRI films, but only the reports. Petitioner reported pushing a tool cart when he felt a sensation of passing out. Eventually, he was given surgical options from two neurosurgeons.

Regarding Petitioner's work accident, Dr. Butler testified it appeared to him that Petitioner suffered an episode of angina. Later, he was found to have cervical degenerative disc disease and stenosis. The medical records did not support a causal connection between Petitioner's cervical condition and his work accident. Petitioner was at maximum medical improvement and did not need any additional treatment.

On cross examination, Dr. Butler testified he doubted that he had all of Petitioner's medical records. He thought he had sufficient information to arrive at his conclusions on causation but agreed that more information is better. He also agreed that Petitioner reported to him that he was pushing a 300-pound cart and that pushing such a cart was part of his job responsibilities. Pain in his neck and left-arm numbness were part of his complaints he reported from the accident. He also reported some radicular symptoms. However, Dr. Butler disagreed that Petitioner's history was consistent throughout. He noted that his history at the emergency department was different from the histories he gave subsequent doctors. Dr. Butler also acknowledged that he did not see any records noting that Petitioner complained of neck/back pain or hand numbness prior to the date of accident.

Dr. Butler agreed with Dr. Yapor's diagnosis but believed the history he was provided was inaccurate. He also agreed that Dr. Deutsch opined that the accident caused Petitioner's disc herniations. Dr. Butler further agreed that his finding of decreased pin-prick sensitivity was likely due to the cervical pathology noted in the MRI. Petitioner reported working with pain daily since the accident. If he had such pain since 2010, Dr. Butler agreed his condition would be considered permanent. While pushing a 300-pound cart would be consistent with a cervical injury if there was initial complaint of neck pain, there was no such report here. He did not see any report indicating that Petitioner injured his neck.

Dr. Butler did not believe Petitioner's condition was related to his accident at any point in time. He noted that Petitioner did not complain of neck pain until six weeks after the accident, and he first complained of low back pain, for which he had an MRI. While Dr. Butler agreed the treatment Petitioner received was reasonable, he did not believe it was related to a work injury. The Commission notes that Dr. Butler, in his report, which was admitted into evidence at the hearing, stated that Petitioner's accident "is no longer related to the patient's current objective findings…the Patient had not had an MRI since 2010."

IV Conclusions of Law

The Arbitrator found that Petitioner proved neither that he sustained an accident on June 18, 2010 nor that the alleged accident caused his condition of ill-being of the cervical spine. He found Petitioner to not be credible based on his failure to report aspects of his medical history to doctors. He also noted that the initial medical records showed no neck complaints.

On the issue of causation, the Arbitrator found the opinions of Dr. Butler more persuasive that those of Dr. Palacci, noting that Petitioner told Dr. Palacci he did not have any prior problems with his neck and did not mention that he had a medical discharge from the Navy. Similarly, the Arbitrator discounted the opinions of Dr. Deutsch and Dr. Yapor because they also did not have complete information about Petitioner's medical history.

19IWCC0439

The Commission concludes that the Arbitrator erred in finding no accident and no causation. That Petitioner, a veteran and 25-year employee of Respondent, had an onset of multiple symptoms at the time of his accident does not undercut his credibility. Petitioner's testimony about the accident was not disputed. In addition, the fact that doctors initially believed he suffered a heart attack did not contradict Petitioner's testimony that he injured his neck and arm in the accident, and doctors initially concentrating on cardiac issues was understandable and led to overlooking any orthopedic issues at the time. The opinions of Respondent's Section 12 examiner, Dr. Butler, to the contrary are not persuasive. Six years after the accident, Dr. Butler saw Petitioner on one occasion and thereafter opined that Petitioner's condition was not causally related to the accident at work. However, Dr. Butler made admissions limiting the persuasiveness of his conclusions. He testified that he did not review the actual MRI films and doubted that he had all of Petitioner's medical records. Dr. Butler also admitted that pushing a 300-pound cart would be consistent with a cervical injury, that Petitioner's cervical diagnosis was correct, and that the findings of decreased pin-prick sensitivity was likely due to pathology as noted in the cervical MRI (report). The latter admissions buttress the findings and opinions of Petitioner's treating physicians that he suffers from a cervical condition with radiculopathy that requires surgery as a result of the accident at work.

The Arbitrator was very concerned that Petitioner did not report his prior military injury. However, Petitioner testified that the prior injury involved his lower back and trapezius no evidence was presented about any prior cervical or neck issues. In addition, while Petitioner's testimony was somewhat inconsistent it must be considered in overlay of psychological issues noted in the medical records which can affect memory and the ability to communicate effectively. Dr. McCall noted that Petitioner was a poor historian, and Dr. Katznelson noted that he had difficulty understanding Petitioner because he was scattered and unorganized. The ultimate consideration is that prior to the accident Petitioner was able to work as a carpenter despite any pre-existing condition and that after the accident he developed undisputed cervical pathology for which two neurosurgeons recommended two-level fusion surgery.

Regarding the issue of medical expenses, the Commission notes that Respondent's Section 12 medical examiner, Dr. Butler, acknowledged that all treatment Petitioner received was reasonable. Therefore, the Commission finds that all the treatment rendered was reasonable and necessary to treat Petitioner's work-related condition of ill-being and awards all medical expenses submitted into evidence.

Regarding the issue of temporary total disability, Petitioner testified that he was off work from the date of the accident until July 7, 2011. Based on that testimony Petitioner seeks an award of 55 weeks of temporary disability benefits. In our review of the record, the first, and only, off work note we saw was from Dr. Katznelson dated October 26, 2010. We saw no release to work note, however, Petitioner testified that he returned to work on July 7, 2011. Therefore, the Commission awards temporary disability benefits of 36&3/7 weeks.

Regarding the issue of permanent partial disability, the Commission notes that no impairment rating under AMA Guides was presented and no weight is given to that factor. The Commission gives greater weight to the fact that Petitioner was able to return to his previous physically demanding job despite his injury and also therefore did not establish any potential loss of income. The Commission gives some weight to Petitioner's age (53 at the time of accident and over 60 at arbitration) which indicates he would not have to live with the condition for a prolonged future working life. Finally, the Commission gives greater weight to the evidence of disability corroborated in the medical record. Petitioner's testified about his continuing problems and his ongoing complaints were corroborated by the fact that there was sufficient pathology that two neurosurgeons recommended a two-level fusion, though Petitioner declined to proceed with surgery. Based on these statutory factors, the Commission concludes that a permanent partial disability award of 50 weeks representing loss of 10% of the person-as-a-whole is appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated April 16, 2018 is reversed and the Commission finds that Petitioner sustained his burden of proving he sustained a compensable accident on June 18, 2010 causing a condition of ill-being of his cervical spine.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,130.67 per week for a period of 36&3/7 weeks, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,007.60 per week for a period of 50 weeks, as the injuries sustained caused the permanent partial loss of the use of the person-as-a-whole to the extent of 10% thereof under §8(d)2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $35,334.40 in medical expenses submitted into evidence, under §8(a), subject to the applicable medical fee schedule in §8.2.

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

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

DATED: AUG 16 2019

Barbara N. Flores

Marc Parker

DLS/dw
O-6/20/19
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Dissent

I respectfully dissent from the decision of the majority. I would have affirmed and adopted the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving he sustained a compensable accident on June 18, 2010 which caused a current condition of ill-being of his cervical spine and denied benefits.

I agree with the Arbitrator that Petitioner was not credible. His report of the mechanism of injury varied, he did not appear to provide complete medical history to any doctor, and he denied making statements to medical providers that were clearly in their records. In addition, the fact that he was able to work at full duty as a carpenter for seven years despite his subjective complaints of constant pain and disability, seriously undercuts credibility. I also agree with the Arbitrator and find the opinions of Dr. Butler persuasive. He is correct that the medical records do not support the allegation that he suffered any neck injury in the alleged accident.

The only treater who appears to have actually opined that Petitioner's condition was caused by his alleged work accident was Dr. Deutsch and he specifically predicated that opinion on his assumption that Petitioner experienced immediate onset of neck pain after the accident. However, that assumption is completely contradicted by the medical records. Despite Petitioner's testimony to the contrary, the emergency department records do not make any mention of cervical or neck pain whatsoever and there was no treatment or even diagnostic testing of the cervical spine. In fact, the first mention of any neck pain appears to have been six weeks after the accident.

In addition, Dr. Katznelson's evaluation indicated symptom magnification or even malingering. He observed non-organic behaviors and could not explain his symptoms from his cervical pathology alone. When he took Petitioner off work (the only off-work note that appears to be in the record) he did so because he could not explain Petitioner's symptoms or make a definitive diagnosis based on Petitioner's pathology and subjective complaints. In this regard, it is interesting, and perhaps a little concerning, that Petitioner chose to hire a semi-retired internist as a Section 12 examining doctor to evaluate Petitioner's alleged cervical condition rather than deposing one of his treaters, or at least hiring an orthopedic or neurosurgeon to provide expert testimony.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving he sustained a compensable accident on June 18, 2010 which caused a current condition of ill-being of his cervical spine and denied benefits. Therefore, I respectfully dissent from the majority decision.

Deborah L. Simpson

Deborah L. Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mariana Hernandez,

Petitioner,

vs. No. 17 WC 21095

Jetson Mailers,

Respondent.

19IWCC0440

DECISION AND OPINION ON REVIEWPURSUANT TO §19(B) AND §8(A)

Timely Petition for Review under §19(b) and §8(a) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care and 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 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).*

Petitioner, a 48-year-old machine operator, testified that on June 28, 2017, she caught her foot on the edge of a machine and fell on her right side onto the concrete floor. She was treated that day in the emergency room for pain in her right shoulder, ribs and back; she was released with a diagnosis of contusion, sprains and strains. Twelve days later, she went to Premier Occupational Health with ongoing complaints of pain and was prescribed physical therapy. Her MRI's showed bulges and degenerative changes of some discs.

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Petitioner's usual job had been to move boxes of envelopes next to machines, then remove the envelopes by hand from the boxes, and then feed them into the machines. Between July 24, 2017 and July 26, 2017, Petitioner returned to work with restrictions. She testified that Respondent did not accommodate her 10 lb. lifting restriction and made her lift 30 lb. boxes. Jonathan Flores, one of Petitioner's supervisors, testified that he weighed the boxes and they did not weigh over 10 lbs. He testified he also told Petitioner that he would provide any help if she needed any, but she never asked him for help.

On July 27, 2017, Petitioner saw Dr. Pitsilos, who modified her restrictions by ordering her to not do any lifting or bending. Respondent was unable to accommodate those restrictions, and Petitioner was taken off work.

Petitioner returned to her doctor on August 11, 2017. At that time, he relaxed her restrictions and allowed her to repetitively lift up to ten pounds. Upon receiving those restrictions, Respondent witness Thomas Ruscioletti sent Petitioner a certified letter dated August 16, 2017, informing her that Respondent could accommodate her latest restrictions. He asked Petitioner to contact him, but she never did. Petitioner signed for and received the letter.

In August 2017, Petitioner began treating with Dr. Snook, a chiropractor at New Life Medical Center. Dr. Snook referred Petitioner to Dr. Vargas, a pain management physician, who provided prescriptions and administered two lumbar injections. Dr. Vargas has not recommended further treatment, and provided no opinion that the treatment he rendered to Petitioner was causally related to her work accident. Petitioner now seeks to go back to Dr. Vargas for neck and low back complaints she claims are related to her accident.

The Arbitrator found Petitioner's testimony not credible for a number of reasons, and cited examples of her inconsistent or contradicted testimony. One example the Arbitrator gave for questioning Petitioner's credibility, was that she was unable to recall the exact age of her youngest child. At arbitration, Petitioner was asked the ages of her children. She answered, "22, 21 and 15 - -14, 15." The Commission views that testimony of Petitioner differently than the Arbitrator. The Commission does not find that answer by Petitioner to be evidence of a lack of credibility on Petitioner's part; but rather, just a common slip of the tongue.

That said, the Commission does find other instances where Petitioner's testimony was inaccurate, confused or contradicted. Petitioner was uncertain in stating how many boxes she lifted each hour and how much they weighed. She testified she had to move 30 to 40 boxes every hour, and that it took her 20 minutes to empty each box into the machine.

After Petitioner testified she received Respondent's 8/16/17 letter offering light duty work, she claimed she reached out to someone in Respondent's office to discuss that work. She then admitted she wasn't sure whether that was before or after receiving the letter.

19IWCC0440

Petitioner testified further that she had neck pain since her accident. However, her medical records documented no such complaints before she saw her chiropractor for the first time, seven weeks after her accident. Her treating records prior to August 16, 2017, from Bolingbrook Hospital and Premier Occupational Health, documented no complaints of neck pain. Petitioner's neck was examined at each of Petitioner's two visits to Premier Occupational Health between July 10, 2017 and August 11, 2017, and each of those exams were reported to be normal.

Respondent's Section 12 expert, Dr. Wehner, examined Petitioner on November 7, 2017. She opined that while Petitioner should have reached MMI within four to six weeks after her work accident, in any event, she was at MMI and able to work full duty as of November 7, 2017. Dr. Wehner reviewed Petitioner's MRI's and opined that the bulges thereon were mild degenerative changes, were not clinically significant, and were not representative of any pathologic condition. She found no evidence of traumatic injury in Petitioner's thoracic spine. Dr. Wehner noted Petitioner's subjective back pain complaints were in a non-anatomical distribution, and were not supported by objective evidence.

The Commission finds Dr. Wehner's opinions more credible than those of Petitioner's chiropractor, Dr. Snook. Dr. Wehner provided explanations for her opinions whereas Dr. Snook did not. Although Petitioner's pain management physician, Dr. Vargas, provided Petitioner with injections, he provided no opinions regarding causation, or of Petitioner's need, if any, for future treatment.

Based on the record as a whole, the Commission finds that Petitioner attained maximum medical improvement for the sprains and strains she sustained from her June 28, 2017 accident as of November 7, 2017, the date of Dr. Wehner's examination. The Commission finds that all of Petitioner's medical treatment through November 7, 2017 was causally related to her June 28, 2017 work accident. The Commission finds that any conditions of ill-being relating to Petitioner's cervical, thoracic and lumbar spines after November 7, 2017, are not causally related to her June 28, 2017 accident.

The Commission finds Petitioner entitled to temporary total disability benefits from June 29, 2017 through July 23, 2017, and from July 27, 2017 through August 24, 2017, that being the approximate date on which Petitioner received, but never followed up with, Respondent's certified letter advising her they could accommodate her restrictions and asking her to contact them.

Finally, the Commission notes the Arbitrator made a typographical error in stating the amount of §8(j) credit to which Respondent is entitled. The parties stipulated that Petitioner is entitled to a credit of $4,486.92 for TTD Respondent has paid (Arbitrator Exhibit #1). The Commission finds that amount, $4,486.92, is the amount of §8(j) credit to which Respondent is entitled.

19IWCC0440

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 21, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the denial of temporary total disability benefits is reversed. Respondent shall pay to Petitioner the sum of $373.95 per week for a total of 7-5/7 weeks, commencing June 29, 2017 through July 23, 2017, and from July 27, 2017 through August 24, 2017, those being the periods of temporary total incapacity from work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner's outstanding reasonable and related medical bills incurred through November 7, 2017, pursuant to the Fee Schedule and §8(a) of the Act. Respondent shall additionally hold Petitioner harmless with regard to payments made by health insurance for any of those bills, and Respondent is entitled to a credit under §8(j) of the Act, as requested on the Request for Hearing form.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's petition for prospective medical care as provided in §8(a) and §8.2 of the Act is denied.

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 credit for TTD benefits paid is $4,486.92.

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.

19IWCC0440

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,600.00. 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.

AUG 19 2019

DATED:
o-06/20/2019
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

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

HERNANDEZ, MARIANA
Employee/Petitioner

Case# **17WC021095**

JETSON MAILERS
Employer/Respondent

19IWCC0440

On 12/21/2017, 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 1.48% 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:

5551 MENDOZA LAW PC
PAUL LUKA
120 S STATE ST SUITE 400
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
NICOLE BRESLAU
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mariana Hernandez
Employee/Petitioner

v.

Jetson Mailers
Employer/Respondent

Case # 17 WC 21095

Consolidated cases: ___

19IWCC0440

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Geneva**, on **November 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. ☒ 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 **19IWCC0440**

On the date of accident, **June 28, 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* 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 $**29,167.84**; the average weekly wage was $**560.92**.

On the date of accident, Petitioner was **48** years of age, *single* with **1** dependent children.

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

Respondent shall be given a credit of $**4,846.92** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,864.92**.

Respondent is entitled to a credit of $**9,574.44** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove her current condition of ill-being is causally related to her June 28, 2017 accident, all benefits are denied.

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

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

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



Signature of Arbitrator

12/20/17
Date

DEC 21 2017

19IWCC0440

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on June 28, 2017. Respondent disputes Petitioner's claims and the issues in dispute are as follows: 1) causation, 2) medical expenses, 3) TTD, and 4) prospective medical care. Petitioner testified via a Spanish interpreter.

On June 28, 2017, Petitioner worked for Respondent as a machine operator. She had worked in that capacity for about five years. Petitioner testified that on June 28, 2017, she was filling a machine with supplies when her foot got stuck on the edge of the machine and she fell to the concrete floor. Her right arm, buttocks, and back hit the floor.

She notified her supervisor, Delia Rios, and went to the hospital in Bolingbrook. (PX A) She was seen in the Emergency Department, but was not admitted. Petitioner testified that when she went home, her pain increased. Petitioner testified that she had pain in her back and her neck.

Thereafter Petitioner began treating with Premier Occupational Health. (PX B) Petitioner did not report neck pain on her initial visits to Premier. She was diagnosed with a sprain injury and underwent conservative treatment. She was eventually given work restrictions the Respondent could accommodate, i.e. no lifting over 10 pounds.

Petitioner returned to work for the Respondent on July 24, 2017. She testified that she was given the same work on the same machine as before the accident. Petitioner testified that she was lifting boxes weighing between 20 to 30 pounds, moving those boxes 30 to 40 times per hour. She testified that she complained about the work to Delia Rios. She then testified that she was required to work on six machines, more than she ever had before, despite her earlier testimony that she was returned to the same job. She testified that Jonathon Flores told her to load the six machines.

On cross-examination, Petitioner testified that her job involved moving boxes, taking envelopes out of them, and loading the envelopes into a machine. She was unable to recall how many envelopes were in each box. She was not able to recall how long it took her to process each box from start to finish. When pressed, she estimated it took 20 minutes per box. She could not explain how she processed 40 boxes an hour if each one took 20 minutes.

Petitioner worked with restrictions for the Respondent for three days, until July 26, 2017, after which time she stopped appearing for work. She has not returned to work for Respondent.

After Petitioner stopped working she also stopped treating with Premier Occupational Health. She began treating without referral with a chiropractic facility, New Life Medical Center. (PX A) She was treated there by Kenny Snook, D.C. New Life ultimately referred the Petitioner to Dr. Axel Vargas, a pain management specialist, with whom she has undergone two epidural steroid injections in her low back. (PX D) Petitioner testified that the injections have not provided her with any relief, but that she would like to get more of them.

Petitioner was examined at the request of the Respondent on November 7, 2017, by Dr. Julie Wehner, a board certified orthopedic surgeon. (RX 2) Dr. Wehner reviewed Petitioner's records and MRI films and concluded that the Petitioner had degenerative changes in her back, but no evidence of acute trauma. Dr. Wehner stated that some, but not all of Petitioner's medical treatment was reasonable, necessary, and

19IWCC0440

related. Particularly, Dr. Wehner noted that there was no clinical or diagnostic indication for the Petitioner's injections. Dr. Wehner diagnosed the petitioner with contusions and opined the Petitioner would have reached maximum medical improvement no later than six weeks after the injury. Dr. Wehner opined Petitioner now suffered only from subjective complaints of back pain without objective findings.

Jonathon Flores testified on behalf of the Respondent. He has worked for the Respondent for four and a half years. He is a supervisor and shares responsibilities with Delia Rios. Ms. Rios is primarily responsible for supervising the heavier line of work, Mr. Flores is primarily responsible for the lighter line. When Petitioner returned to work in July 2017 for three days, Mr. Flores was her supervisor. Mr. Flores testified that Petitioner was not required to ever lift anything over 10 pounds while she was under restrictions. Mr. Flores testified that he offered Petitioner additional help, which she never requested. There are also material handlers available to help with lifting, if needed. Petitioner never made any complaint about her light duty work to Mr. Flores. If she had asked for help, she would have received it. Mr. Flores testified that he weighed the boxes in question and they weighed less than ten pounds.

Tom Rusciolelli also testified for the Respondent. Mr. Rusciolelli is a payroll manager and has worked in that capacity for about four and a half years. He received Petitioner's work restrictions and checked with Mr. Flores and Ms. Rios to see if the restrictions could be accommodated. Mr. Rusciolelli requested and received a demonstration of the duties Petitioner was asked to perform to ensure they were within the restrictions. He also wrote a letter after Petitioner stopped appearing for work, indicating that light duty work was available. (RX 3) He received no response, despite having confirmation Petitioner received the letter in the form of a signed green card.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding, the Arbitrator relies on various witness testimony and the medical evidence – all of which cast great doubt on Petitioner's credibility. In viewing the medical evidence, the Arbitrator finds persuasive the opinions of Dr. Wehner regarding the question of causation, more so than the opinions of Petitioner's chiropractor, Kenny Snook, D.C. – the only medical provider to attribute her current condition of ill-being to her work injury. Dr. Axel Vargas, from whom Petitioner has received injections, has not addressed causation. The Arbitrator finds it telling that the Petitioner testified she did not receive relief from the injections – which bolsters Dr. Wehner's opinion that said injections were not necessary. Dr. Wehner found that Petitioner should have reached maximum medical improvement by no later than six weeks after her accident, and otherwise suffered from chronic, degenerative changes.

Furthermore, the Arbitrator finds that there are questions as to the Petitioner's credibility. Petitioner was unable to recall many things during her testimony, including the following: the exact age of her youngest child; where she experienced pain after the accident; basic details about a job she has performed for five years; an estimate of how many envelopes were in each box she handled; and how long it took her to work on each box. Although Petitioner eventually estimated that it took her approximately 20 minutes per box, this does not match up with her estimate of processing 40 boxes per hour. She first testified that she was returned to work at light duty in exactly the same position, and later testified that she was given more intense job duties. These inconsistencies and discrepancies in Petitioner's testimony render her testimony incredible.

19IWCC0440

Given the above facts, the Arbitrator concludes that the Petitioner has failed to prove that her current condition of ill-being is causally related to her June 28, 2017 accident. Accordingly, her request for additional benefits is denied.

2. Based on the Arbitrator's findings with regard to the issue of causation, all other issues are rendered 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

Claire A. Williams,
Petitioner,

vs. NO: 14 WC 37356

19IWCC0441

State of Illinois
Department of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical expenses, causal connection, temporary total disability, 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, other than as stated above, the Decision of the Arbitrator filed February 1, 2018, is hereby affirmed and adopted.

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

19IWCC0441

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 19 2019

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/wj
08-15-19
68

STATE OF ILLINOIS)
) ss.
COUNTY OF Cook)

19IWCC0441

☐ 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

Claire William
Employee/Petitioner

v.

Case # **14** WC **37356**

Consolidated cases: _____

State of Illinois Department of Human Services
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 **Kurt Carlson** Arbitrator of the Commission, in the city of **Chicago**, on **12/11/17**. 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 **July 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.

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 **$78,964.08 in the year prior**; the average weekly wage was **$1,518.54**.

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

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

All appropriate charges for all reasonable and necessary medical services have been paid.

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

ORDER

Because the accident did not occur within the course or scope of 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.

Signature of Arbitrator

02-01-18
Date

FEB 1 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Claire William	)	
	)	
Employee/Petitioner,	)	14 WC 037356
v.	)	
	)	
Department of Children and Family Services, State of Illinois	)	
	)	
	)	Chicago, Illinois
Employer/Respondent.	)	

19IWCC0441

Findings of Facts and Conclusions of Law

Claire William ("Petitioner") seeks relief under the Illinois Workers' Compensation Act against the Department of Children and Family Services, State of Illinois ("Respondent") alleging that she was injured at work on July 14, 2014. (Arbitrator's Exhibit 1). A hearing was held before Arbitrator Kurt Carlson on December 11, 2017 in Chicago, Illinois. Petitioner was present and represented by attorney David Martay. Respondent was represented by Assistant Attorney General Stephanie Kevil.

FINDINGS OF FACT

A. Petitioner's Job Duties

Petitioner testified that she has worked for the State of Illinois for 23 years. (T. 8). On July 14, 2017, she was working as a Child Welfare Specialist. (T. 7). Petitioner testified that her job requires travel. (T. 8). She must travel to court on occasion to testify. *Id.* Petitioner testified that she reported to an office at 1911 S. Indiana Street in Chicago, but that she was out of the office about three days per week. (T. 9, 10).

B. Accident

Petitioner testified that she traveled to Belleville, Illinois on July 13, 2014 to attend a court hearing the next day at the 11th District court in Belleville. (T. 10). Petitioner drove her own a four-door sedan, to Belleville. (T. 11). It took her about six or six and a half hours to drive from Chicago to Belleville on July 13th. (T. 23). On July 14, 2014 just after 1:00 p.m., Petitioner testified at the 11th District courthouse. (T.11-12). Afterwards she waited until the court was about to close to get the permanency report from that hearing; however, she does not remember how long she waited. (T. 12 and 23). Then she went to get something to eat. (T. 12 and 23). Afterward, Petitioner drove seven hours back to Chicago without stopping. (T. 12 and 24). She arrived in Chicago at 11:00 p.m. (T. 12). The Arbitrator notes that this must mean that Petitioner left from Belleville around 4:00 p.m. that day. Petitioner did not stop to get out of her car in between Belleville and Chicago. (T. 24).

She finally decided to stop for gas on 47th street just prior to returning home. (T. 13). Her description of where this gas station was in relation to her house changed through her testimony. At first, it was a half a mile away. (T. 13). Then it was close enough to her house that she could see it from her house. (T. 32). Then it was three to three to four blocks away from her house; then it was one and a half to two blocks away from her house. (T. 34).

Petitioner testified that when she was getting out of the car to pump gas, she picked up her "quite heavy" overnight bag that contained her laptop, notebook, papers, and change of clothes. (T. 14). When asked why she would take that bag out of her car to pump gas, she stated that it contained her money and she had to bring the whole thing with her to pay. (T. 24).

Petitioner stated that when she attempted to stand-up and get out of her car with this bag, she could not feel her legs and she stumbled. (T. 14). Petitioner is a Type II diabetic. (Rx # 1 & 2) As she stumbled, everything fell out of her hand. (T. 15). She grabbed the car door and stabilized

herself. *Id.* When asked if there was anything that she tripped on, she testified that her knee just buckled. (T. 24) The medical records reflect that on July 15, 2014, she reported to Dr. Surath that she slipped and fell. (Px 1). She reported to Dr. Diekevers on July 18, 2014 that she twisted her ankle four days prior. (Px 3). On July 21, 2014, Petitioner completed an employee notice of injury stating she was parked in front of her house at the time of the injury. She described how the injury occurred as, "I was stepping out of the car and picked up my briefcase and took a step... As I stepped out of the car, I tripped and twisted my left foot, fracturing my foot." (Rx 1). On August 13, 2014, she told her doctor that she "twisted her foot while walking outside in platform wedge shoes." (Px 2). The medical records show that Petitioner has pre-existing left foot pronation syndrome (Px 2).

At the hearing, Petitioner stated that she did not buy any gas. (T. 16). There is nothing to corroborate her testimony that she obtained petrol for her car that night. Instead, Petitioner stated that she left the gas station, when home and parked the car in her garage. (T. 16).

When asked why the location of the incident in the form was different from her testimony, Petitioner equivocated. She stated "I was confused... I said, well, I just came back from the gas station... I didn't think it was a big deal when I wrote it down... I said yes not too far away from my house, you know, in front of the building." (T. 32-33). She insinuated that her supervisor told her to write down this location, because "this is how you get your workers' compensation." but then stated that her supervisor did not tell her what to write down on that report. (T. 32-33). Then Petitioner stated, "[i]t doesn't matter where it was, but I just put that down, okay, in front of my house." (T. 34)

C. Medical Treatment

On direct examination, Petitioner stated that the pain in her foot was not bad at the time of the injury; it was just a little pain. (T. 16). She sought medical care the next day at Presence Medical group. (T. 16-17.) The medical records entered by Petitioner do not reflect any emergency room visit.

On August 13, 2014, the Petitioner sought treatment with Dr. Sloan Metz (DPM) and stated that "she twisted her foot while walking outside in platform wedge shoes." (Px #2)

The records reflect that Petitioner had an office visit with someone in her primary care group on July 15, 2014 at approximately 11:00 a.m. for pain in her foot. (Px 1). Petitioner has diabetes and knows that she is at increased risk of having medical issues with her feet. (T. 28-29). She acknowledges that her physician examines her feet during routine check-ups. *Id.*

At the office visit on July 15, Petitioner was complaining of pain over the lateral aspect of her foot. *Id.* An x-ray of her left foot was taken and it indicated there was a fracture at the base of the 5th metatarsal with minimal displacement. *Id.* Petitioner was referred to a Dr. Diekevers for treatment of the foot. *Id.* On July 18, 2014, Dr. Diekevers diagnosed Petitioner with a fracture of the 5th metatarsal bone and an ankle sprain. (Px 3). He noted she had been a diabetic for 10 years. *Id.* Dr. Diekevers warned Petitioner against having an acid pad on the 5th toe of her left foot because of a corn on her left small toe. *Id.* He placed an Unna boot and surgical shoe on Petitioners foot and requested that she return for re-evaluation in one week. *Id.*

On July 24, 2014, Dr. Diekevers noted that Petitioner felt improvement. (Px 3). An Unna boot was applied again and Petitioner was allowed to return to work on August 4, 2014. (Px 3; T. 18).

On July 31, 2014, Petitioner was still experiencing some pain and walking with a limp (Px 3). Dr. Diekevers re-applied the soft cast and requested Petitioner to follow-up in one week. *Id.*

On August 1, 2014, Petitioner saw her primary care physician and told her that she would like to see a different podiatrist because she was still having pain in her foot and her right foot was starting to get sore from all the weight on it. (Px 1). Petitioner was referred to Dr. Metz at Parkwest Podiatry. *Id.*

On August 13, 2014, Dr. Metz noted that petitioner's pain was persisting and that she had difficulty walking long distances. (Px 2). Dr. Metz diagnosed Petitioner with a non-displaced fracture of the 5th metatarsal and painful ambulation. *Id.* She advised Petitioner to continue using the surgical shoe, and follow-up in two weeks, when Dr. Metz would review new x-rays. *Id.* On August 27, 2014, Dr. Metz compared x-rays and determined that the fracture lines were still visible. *Id.* She advised Petitioner to remain off work, to limit her activities, to sit, elevate her foot and use the ace wrap and surgical shoe. *Id.* On September 10, Dr. Metz placed an arch strapping on Petitioner's foot. *Id.*

On September 10, 2014, Dr. Metz placed Petitioner in a cam walker and recommended a bony stimulator. *Id.* She continued Petitioner off work. *Id.* Petitioner continued for follow-ups with Dr. Metz. *Id.* On November 25, 2014, Dr. Metz stated that Petitioner noted significant improvement and scheduled a return to work for December 1, 2014. *Id.* Petitioner states that she was fully recovered at her April 2015 visit with Dr. Metz. (T. 31).

D. Time Off Work

Petitioner states that she was authorized off work from July 15 through July 24 of 2014 and then again from August 13 through December 1, 2014. (T. 21). At trial both Petitioner and Respondent agreed that Petitioner had been paid in full for a portion of the time that she is claiming TTD. (T. 6, 20-21). Respondent claims that Petitioner was paid in full for her time off work from

July 15, 2014 through September 21, 2014. (Arb. 1). Respondent's Exhibit 2 is a Payroll System sheet for Claire William for the year of 2014. The last page has explanations for the codes used in the sheet. This was entered into evidence without objection. Respondent's Exhibit 2 shows that Petitioner worked 6 hours of overtime on July 14, 2014. On July 15, Petitioner took a paid personal day. (Rx 2). From July 16, 2014 through September 21, 2014, Petitioner took a combination of paid days off that included vacation time, sick time and compensatory time. *Id.* On September 22, 2014, Petitioner began taking unpaid Illness Leave. *Id.* This continued through November 30, 2014. *Id.* On December 1, 2014, Petitioner returned to work and began working the day shift. *Id.*

E. Current Condition

Petitioner states that she no longer has pain in her foot, except when she wears high heels. (T. 22). She does not wear high heels very often. *Id.*

CONCLUSIONS OF LAW

A. Did an Accident Occur that Arose Out of or In the Course of Employment?

The Arbitrator finds that no compensable accident occurred because of Petitioner's inconsistent and incredible testimony regarding the location and circumstances of the accident. Additionally, the Arbitrator finds no increased risk.

The Worker's Compensation Act was intended to compensate employees for the injuries they received while in three types of situations: 1) where the employee was instructed by her employer to perform an act; 2) where the employee has a common law or statutory duty to perform a certain act while performing duties for her employer; and 3) where the employee might be

reasonably expected to perform a certain act that is incident to her assigned duties. Hoffman v. Industrial Comm'n, 109 Ill. 2d 194, 199 (1985).

Here, Petitioner was a traveling employee on the day that she claims she was injured. Regardless of whether or not Petitioner was a traveling employee, it is her burden to prove that the claimed accident arose out of or occurred in the course of her employment. Hoffman, 109 Ill. 2d at 199; Jensen v. Industrial Comm'n, 305 Ill. App. 3d 274, 278 (1st Dist. 1999); Vernell Dixon v. Chicago Transit Authority, 17 I.W.C.C. 0329 (May 26, 2017). "The phrase 'in the course of' refers to the time place and circumstances under which the accident occurred." Vernell Dixon v. Chicago Transit Authority, 17 I.W.C.C. 0329 (May 26, 2017), citing Orsini v. Industrial Comm'n, 117 Ill. 2d 38 (1987). In order to determine whether a traveling employee has been injured in the course of employment, the Commission, must assess the reasonableness of and foreseeability of the act or acts that the employee was doing at the time of the injury. Hoffman, 109 Ill. 2d at 200.

Due to the many inconsistencies in Petitioner's testimony, the Arbitrator cannot assess the reasonableness and foreseeability of the Petitioner's acts at the time of the injury. The Arbitrator is unable to determine exactly where Petitioner was and what she was doing. A claimant's testimony must be considered with all the facts and circumstances entered into evidence. Hams v. Homewood Memorial Gardens, Inc., 17 I.W.C.C. 0672 (October 25, 2017), citing Neal v. Industrial Comm'n, 141 Ill. App. 3d 289, 296 (1st Dist. 1986). The Illinois Supreme Court has repeatedly held that a claimant's testimony "is not enough where a consideration of all the facts and circumstances shows the manifest weight of evidence is against it." Caterpiller Tractor Co. v. Industrial Comm'n, 83 Ill. 2d 213, 218 (1980). "[T]he connection between the employment and the subsequent problems must be established." Caterpiller Tractor Co., 83 Ill. 2d at 218. An Arbitrator may not rely on speculation of conjecture to make an award.

The Petitioner has not met her burden of proof. The trier of fact is uncertain when she left Belleville, Illinois to return to home. On cross-examination, Petitioner stated she was "unsure what time she departed for Chicago." It is unclear why it took her so long to return home. There is no certainty if the occurrence was at a gas station or in front of her home. Instead, her testimony regarding the time, place, and circumstances of her injury is full of inconsistencies.

The Arbitrator considers Petitioner's differing accounts of where the injury happened and Petitioner's attempts, for whatever reason, to minimize the distance between the alleged gas station and her house. The Arbitrator also considers Petitioner's testimony of the surrounding facts and circumstances; for example: that she, as a 59-year-old woman with diabetes drove seven hours without stopping or getting out of the car; that she was going to take an entire heavy overnight bag with her to pump gas instead of retrieving only her wallet or purse; and that she parked in her own garage that night.

If the internal consistencies were not enough, Petitioner's final testimony regarding the discrepancies in her statements that "[i]t doesn't matter where it was, but I just put that down, okay, in front of my house" (T. 34) leaves the Arbitrator unable to determine where the injury occurred, which is vital to her proving up her case in chief.

It would be easy to speculate that Petitioner's employment ended when she pulled her car into her home driveway that night. "A traveling employee is deemed to be in the course her employment from the time she leaves home until she returns." Pryor v. IWCC 27 NE3d 678, 389 Ill.Dec. 836 (2d Dist. 2015). However, if she was alighting from the car with her overnight bag, then a different conclusion could be made and the case, in theory, would be compensable. But this was not her testimony. And twisting her left ankle while walking in a platform wedge does not seem to be a risk of Petitioner's employment, but an everyday risk of those who wish to wear

fashionable footwear. Petitioner did not describe any defect or irregularity in the surface she was walking on. It is also worth noting that the Petitioner's podiatrist noticed his patient has pronation syndrome, an idiopathic condition. (Px 2) Could that have contributed to accident?

There are far too many unanswered questions, inconsistencies and contradictions in fact to form a firm understanding the details of the occurrence, which should not have been difficult. As a result, compensation is denied under a failure of proof.

All other issues are moot.

Arbitrator Kurt Carlson

02-01-18

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA STRINGER,

Petitioner,

vs. NO: 10 WC 28640

SCHOOL DISTRICT U-46,

Respondent.

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DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, prospective medical care, vocational rehabilitation evaluation and evidentiary rulings, 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).

I. FINDINGS OF FACT

A. Background

Petitioner was a 45-year-old school bus driver employed by Respondent for 12 years. Petitioner testified that she had to pass a driving test for her job and she worked 42 hours per week. When she reported to work on the date of accident, Petitioner testified that her ability to work was unrestricted and she was not under any care for a prior spinal condition.

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On May 24, 2010, Petitioner sustained an undisputed accident while driving. She testified that she was driving when a car flew through the intersection against a red light and struck her bus. After the collision, Petitioner got out of her seat and checked on her preschoolers. She then sat back down in the driver's seat and, at that point, noticed that she was lightheaded, and her spine was hurting really bad. Petitioner testified that she hit her right-side ribs on the steering wheel and was pretty much in shock.

B. Medical Treatment

Petitioner underwent extensive medical treatment with a variety of physicians between May 24, 2010 and the date of the arbitration hearing. Initially, Petitioner underwent emergency medical care, treatment at an occupational health clinic, and chiropractic care. The medical records reflect Petitioner's reports of neck and back pain as well as pain and symptoms in the upper extremities between the date of accident and early October of 2010.

Petitioner saw a chiropractor, Dr. Greener, approximately 37 times between June 1, 2010 and October 4, 2010 during which time she was working her regular job. Petitioner testified that she felt wobbly and noticed that she was falling a little bit. She also continued to experience numbness in her hands and increasing weakness in her arms. Petitioner explained that she was dropping things and could not even carry a gallon of milk as she was very weak. She did not know how many times she fell that year.

Petitioner was then referred by her primary care physician to Dr. Drake for orthopedic evaluation. On October 4, 2010, Petitioner reported bilateral shoulder pain as well as numbness and tingling in the arms. After an examination, Dr. Drake diagnosed Petitioner with bilateral upper extremity numbness, unknown etiology, cannot exclude spinal cord compression and prescribed a cervical MRI and EMG/NCV. The EMG dated October 6, 2010 revealed mild right C6 or C7 radiculopathy to be correlated with an MRI. On October 7, 2010, Petitioner underwent the recommended MRI, which the interpreting radiologist interpreted as showing a moderate size posterior osteophyte complex at C5-6 with "no evidence of significant cord compression."

On October 26, 2010, Dr. Drake noted Petitioner's diagnosis of C6 radiculitis, right upper extremity. He further noted "she certainly has no signs of spinal cord compression" and released her to return to work. However, by November 22, 2010, Petitioner reported that she was not getting any better and Dr. Drake ordered physical therapy. Over the next 14 months, Petitioner underwent approximately 59 therapy sessions of physical therapy at Midwest Physical Therapy from November 26, 2010 through February 6, 2012.

In the interim, Dr. Drake referred Petitioner to Dr. Cherala at Fox Valley Pain Center to address ongoing pain complaints as of January 18, 2011. On February 28, 2011, Petitioner presented to Dr. Cherala for the first time. Dr. Cherala diagnosed Petitioner with degenerative disc disease, cervical radiculopathy, cervical spondylosis. He then administered a series of three injections to the cervical spine on March 1, 2011, April 5, 2011 and April 26, 2011.

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On May 11, 2011, Petitioner returned to Dr. Drake reporting that she was not feeling any better with continued neck pain and symptoms in the shoulders and arms. Dr. Drake placed Petitioner off work. When she returned on June 30, 2011, Dr. Drake diagnosed Petitioner with C5-6 foraminal disc herniation on the right, and scheduled surgery.

On July 22, 2011, Dr. Drake performed a C5-6 fusion surgery with bone graft and plate. Petitioner followed up with Dr. Drake postoperatively through January 6, 2012 while undergoing physical therapy. By February 17, 2012, Petitioner reported continued pain in the right side of her neck, fingertip numbness, and 65-70% overall improvement from her prior visit. Dr. Drake diagnosed Petitioner with cervical degenerative disc disease and cervical disc herniation status post C5-6 ACDF. Dr. Drake placed Petitioner off work and recommended another EMG/NCV.

On January 20, 2012, Petitioner was terminated from Respondent's employment by letter. Her driving permit had lapsed as she was physically unable to drive, and Petitioner testified that she needed a doctor's clearance. Petitioner was unable to get clearance to drive a school bus.

C. *Section 12 Examinations – Dr. Wehner*

At Respondent's request, Petitioner submitted to a Section 12 examination with Dr. Julie Wehner on February 20, 2012. In her report, Dr. Wehner diagnosed Petitioner with cervicalgia from a motor vehicle accident. She recommended work hardening and indicated that an updated MRI and EMG would be reasonable. Dr. Wehner opined that Petitioner had cervicalgia from the accident, but specifically opined that Petitioner's carpal tunnel syndrome was unrelated to accident, the osteophyte pre-dated the accident.

Petitioner underwent the recommended repeat EMG/NCV on March 6, 2012, which was normal. On March 13, 2012, Dr. Drake noted Petitioner's ongoing complaints in the shoulders and upper extremities for which he recommended additional therapy to be followed by a functional capacity evaluation. Petitioner underwent the functional capacity evaluation on March 30, 2012. The evaluating physical therapist found the results to be valid and placed Petitioner at a sedentary work level. Petitioner also had an additional 24 sessions of work hardening through late May.

On May 4, 2012, Petitioner returned to Dr. Drake reporting difficulty during work hardening, sharp neck pain at times, ongoing bilateral arm numbness, and slight increase in pain since fall. He diagnosed a herniated nucleus pulp/lumbar, cervical degenerative disc disease status post cervical fusion C5-C6 and ordered another cervical MRI that was performed on May 15, 2012. The interpreting radiologist found post-operative changes, and some mild bulging evident at C4-5. No significant neural encroachment is evident though evaluation of the lower cervical spine is limited by metallic artifact.

Petitioner underwent a second Section 12 examination with Dr. Wehner on June 25, 2012. She issued a report diagnosing Petitioner with cervicalgia post-surgery. Dr. Wehner noted that Petitioner had postoperative rehabilitation and ongoing pathology that required no further treatment. Dr. Wehner opined that Petitioner was at maximum medical improvement and can return to full duty.

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Petitioner also saw Dr. Drake on May 25, 2012. He recommended another month of work hardening. Petitioner testified that her benefits were discontinued effective July 2, 2012 after seeing Dr. Wehner.

As of July 6, 2012, Dr. Drake diagnosed Petitioner with a herniated nucleus pulposus, cervical degenerative disc disease status post cervical fusion C5 and C6 and placed her at maximum medical improvement with no lifting or other restrictions. The school year ended, and Petitioner testified that she did then re-apply for a driver's job.

D. Other Employment and Continued Medical Treatment

Petitioner testified that she submitted an online application with Respondent for the position of driver. She explained that she called after doing so and spoke with Karen Bjorn soon after July 6, 2012. Petitioner recognized Karen's voice on the phone, who also identified herself. She told Karen that she saw the hiring ad on the internet, applied, and asked if they would hire her back. Petitioner indicated that Karen was the decision maker in the main office and that Andy Martin was the head boss on U-46 for transportation. Petitioner again noted job openings posted online and testified that she submitted her application for any of four driving positions. She was not offered any job.

Petitioner testified that she then started looking for work elsewhere. She applied for a job at Illinois Central Bus Company where she started driving in late August to early September for the 2012-2013 school year. Petitioner testified that she worked 28 hours per week compared to the 42 hours per week that she worked for Respondent. She also testified that at Illinois Central she earned $14.69 per hour. While employed with Respondent Petitioner had an average weekly wage of $808.60 as stipulated by the parties. The next year Petitioner worked at the St. Charles School District, which paid more per hour ($18.69 per hour), but offered less hours driving (21 hours per week).

While working at Illinois Central Bus Company, Petitioner testified that she could hardly walk because her right side, her leg, would give out. She testified that she fell in the parking lot a couple times and experienced daily pain in the lower back, neck, arms, hands and legs as well as spasms. While working at the St. Charles School District, Petitioner testified that she was worsening and could hardly sit for long periods of time such that she would have to get up and walk. Petitioner explained that part of the job was pushing roof patches open to test them, and she could not do that, so the mechanic would do it as part of DOT check of the bus.

Petitioner drove for the St. Charles School District for the 2013-2014 school year and again started driving during the 2014-2015 school year. While employed there, Petitioner returned to Dr. Drake on April 3, 2014, who recommended an updated EMG/NCV. She did not have this test as it was not authorized by workers' compensation and she did not then have health insurance. Petitioner paid Dr. Drake out of pocket. She also returned to Dr. Greener for chiropractic care approximately eight times between May and June of 2013 for neck pain and headaches. On one visit she complained of hand numbness.

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Petitioner further testified that her symptoms were worsening while working for the St. Charles School District in 2014. She asked her attorney for an orthopedic referral who was not in Chicago, and he suggested Dr. Ghanayem at Loyola.

On October 13, 2014, Petitioner presented to Dr. Ghanayem reporting ongoing neck and shoulder complaints. He noted she had some difficulty walking and driving a bus. Dr. Ghanayem's records contain intake forms and a diagram in which Petitioner localized pain in the arm as well as aches in the upper right thigh. She also indicated she had back pain. Petitioner did not identify leg pain. Dr. Ghanayem noted no complaints of leg pain. On physical examination, Dr. Ghanayem found hyperactive reflexes in the biceps and brachioradialis, but normal in the triceps. Petitioner had a positive Hoffman's sign in both hands and a "sense of weakness" in her right upper extremity. She had normal reflexes and motor strength in the lower extremities. He recommended an updated cervical MRI to determine if she has developed any additional compression adjacent to her fusion. Dr. Ghanayem further stated in pertinent part:

> I told her that there are two potential causes for residual symptoms. One is just the fact that she had an injury to begin with and has residuals related to that and the subsequent surgery. The second is that she had developed a transition-type problem. An updated MRI scan (without contrast) of her cervical spine would be helpful in making that determination. From a functional standpoint, as she has these residual symptoms, she may want to think about not driving a school bus, but rather progressing into a related field, such as working as a school bus or other transportation dispatch location for which I am sure she has transferrable skills that would allow her to do so effectively. I would be happy to review her cervical MRI scan once it is complete.

Petitioner underwent an updated MRI on November 29, 2014, which revealed cervical postoperative changes, a mild posterior disc bulge at C5, no stenosis, and no significant interval changes.

On December 22, 2014, Petitioner returned to Dr. Ghanayem once more. He reviewed the MRI and indicated that "[it] reveals some disc degeneration of bulging above her fusion, but fortunately no neurologic compression. Therefore, I believe her residual neurologic symptoms are related to the injury and subsequent surgery. While there are transition-type problems in the way of disc disease, it is not compression. It can contribute to neck pain, but a neurologic issue." Dr. Ghanayem further indicated that Petitioner should not be driving a bus and may perform office-type work.

Petitioner testified that she stopped working for the St. Charles School District because she did not feel it would be safe for her to be driving a school bus. In 2015, Petitioner did have health insurance through Medicare disability. She testified that she had applied for SSDI, which was approved on March 28, 2016 with payments backdated to June of 2015. Petitioner also testified that she had BCBS insurance that she paid for in 2015, through her husband's self-employed option.

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Petitioner received additional medical care in the form of acupuncture treatment with Dr. Hanna in 2014, but when he left the area he took his records with him. She was still working for St. Charles then and Dr. Hanna did not take Medicare.

In the interim, at Respondent's request, Petitioner submitted to a Section 12 examination with Dr. Wellington Hsu on April 13, 2015. In his report, Dr. Hsu diagnosed Petitioner with a C5-6 disc herniation status post C5-6 anterior cervical discectomy and fusion, cervical spondylosis and lumbar spondylosis. He opined that Petitioner likely suffered a C5-6 disc herniation as a result of the work-related injury. Dr. Hsu also opined that Petitioner's work for an alternate employer could not have caused, aggravated, or exacerbated her pre-existing condition of cervical spondylosis. He further opined that Petitioner could return to work without restrictions based on her neurologic examination and he placed her at maximum medical improvement. Dr. Hsu agreed with Dr. Wehner's maximum medical improvement date.

Petitioner then saw her new family doctor, Dr. Joshi, on March 7, 2016 reporting right leg smaller than left, numbness in arms and fingers, among other unrelated complaints including hypertension and forgetfulness. She also reported depression. Dr. Joshi referred Petitioner to Dr. Nicholas Schlageter, a neurologist, who she first saw on March 24, 2016. He ordered a thoracic MRI, lumbar MRI, and brain MRI to rule out MS and address her falls when walking, weakness, and numbness as well as possible myelopathy.

Petitioner underwent the thoracic MRI on December 15, 2016. The interpreting radiologist found mild degenerative disc disease changes. Petitioner underwent the lumbar MRI on December 6, 2016. The interpreting radiologist found mild facet degeneration. Petitioner underwent the brain MRI March 2017. The interpreting radiologist found very small white matter lesions.

Petitioner followed up with Dr. Schlageter on May 5, 2016 at which time he reviewed the diagnostic test results and told her that he suspected multiple sclerosis (MS) and prescribed Ditropan. Petitioner also continued treatment for depression over the next six months with medications prescribed by Dr. Joshi.

On December 7, 2016, Petitioner presented to another neurologist, Dr. George Katsamakis at Northwest Neurology. At that time, she reported progressive, relapsing, chronic symptoms including arm numbness especially when she moved her neck in certain directions, difficulty walking, weakness, and generalized fatigue. Dr. Katsamakis reviewed her recent MRI's and found that they revealed mild degenerative changes in the thoracic spine and mild facet degeneration in the lumbar spine. Dr. Katsamakis also ordered an updated EMG/NCV, which revealed mild ulnar neuropathy and chronic L5-S1 radiculopathy. He noted Petitioner's history of a motor vehicle accident in 2010 and held a low suspicion of MS.

On March 13, 2017, Dr. Katsamakis ordered a repeat brain MRI set for March 1, 2018 in the absence of any new neurologic symptoms. He noted that Petitioner's brain MRI's over the prior 8 months had been stable and he doubted that she had MS.

On October 25, 2017, Petitioner saw Dr. McGonigle, a neurologist colleague of Dr. Katsamakis, who reviewed her most recent cervical, thoracic, lumbar, brain MRI's from December

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2016 and March 2017. He noted the small number of punctate white matter lesions stable compared to the August 2016 brain MRI, the unremarkable lumbar and thoracic MRI's, and the cervical MRI revealing post-operative changes with no significant cord compression or cord pathology. Dr. McGonigle recommended that Petitioner see a psychologist for help coping with her chronic issues and advised her to put a walker in every level of her home and use a power wheelchair. Dr. McGonigle diagnosed Petitioner with multiple sclerosis, a spinal cord injury in the cervical region, lumbosacral radiculopathy L5, and peroneal neuropathy on the right.

On November 6, 2017, Dr. Ghanayem re-evaluated Petitioner at her attorney's request. He noted that he last saw Petitioner in July 2015 and, since that time, Petitioner reported ongoing symptoms. While Dr. Ghanayem states that he last saw Petitioner in July of 2015, there is no treatment record admitted into evidence reflecting this visit. Specifically, Petitioner reported more difficulty walking and standing, use of a rolling walker, ability to drive only short trips, bladder dysfunction, "that her legs feel worse," and numbness in her right arm.

On physical examination, Dr. Ghanayem noted a persistent positive Hoffmann sign in both hands, hyperreflexia, generalized weakness in both upper extremities, and decreased sensation in the C5, C6, and C7 distribution of the right arm. He also noted generalized weakness on neurologic exam of the lower extremities and no hyperreflexia in the lower extremities. Dr. Ghanayem also reviewed Petitioner's April of 2017 cervical MRI showing no technical issues post-surgery and no additional cord compression. He further noted his review of Petitioner's treating neurologist, Dr. Katsamakis', medical records indicating that MS had been ruled out and no significant abnormalities on the brain MRI explaining her current neurologic dysfunction. Dr. Ghanayem deferred to Dr. Katsamakis noting this was outside of his area of expertise.

Thereafter, Dr. Ghanayem drafted a narrative letter in which he opined that Petitioner had residual dysfunction after her cervical disk injury and subsequent decompression and fusion surgery. He also stated that "the residuals are related to the accident and subsequent surgery." Dr. Ghanayem further stated that "[t]here may be some underlying neurologic dysfunction that is occurring that is not readily apparent on the MRI scans."

At Respondent's request, Petitioner submitted to a second Section 12 examination with Dr. Hsu on January 22, 2018. In his report, Dr. Hsu maintained the diagnoses for Petitioner: a C5-6 disc herniation status post C5-6 anterior cervical discectomy and fusion, cervical spondylosis and lumbar spondylosis. Dr. Hsu stated that his opinions regarding Petitioner's condition had not changed in any way. That is, Petitioner's accident at work caused a C5-6 disc herniation requiring surgical and nonsurgical care. However, he also opined that none of Petitioner's falls were related to the accident at work. Dr. Hsu maintained that Petitioner could return to work as a bus driver without restrictions and was at maximum medical improvement with regard to her cervical injury. He stated that her work accident was not causing her any neck pain as those injuries were adequately treated. Dr. Hsu also agreed with Dr. Ghanayem that Petitioner required sedentary restrictions, which was a change from his first report, but he opined that Petitioner's walking difficulties were unrelated to the accident at work.

Petitioner continued under neurological care with Dr. Katsamakis and underwent another cervical MRI on March 13, 2018 following up with Dr. Katsamakis on March 19, 2018. The

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cervical MRI was unremarkable post fusion with slightly worse mild spondylosis at C5-6. Dr. Katsamakis prescribed continued medication to address a neurogenic bladder that started in about 2013. Petitioner testified that she never had any bladder issues before her accident at work. Dr. Katsamakis also prescribed medical cannabis and scheduled a follow up visit for August 11, 2018.

E. Deposition Testimony – Dr. Hsu

Respondent called Dr. Wellington Hsu as a witness and he gave testimony at an evidence deposition on December 14, 2015. Dr. Hsu is a board-certified orthopedic spine surgeon and has been since 2010. He testified about his April 13, 2015 examination of Petitioner, his report, and the opinions that he rendered related to Petitioner's condition and its relatedness, if any, to her accident at work.

Dr. Hsu noted that he reviewed work conditioning records, records from Dr. Ghanayem, and Dr. Wehner's June 25, 2012 report. He diagnosed Petitioner with a C5-6 disk herniation that underwent an ACDF procedure as well as cervical and lumbar spondylosis. Dr. Hsu opined that Petitioner's cervical spondylosis was not related to her accident at work, it pre-existed her accident. He testified that his review of records and examination revealed no evidence of spinal cord compression.

On cross-examination, Dr. Hsu acknowledged that he did not review cervical MRI images taken prior to Petitioner's surgery. He also acknowledged that he did not have the records of Dr. Drake or Core Orthopedics, or the surgical report, at his disposal when he rendered his opinions.

Respondent re-called Dr. Hsu as a witness and he gave testimony at a second evidence deposition on June 27, 2018. Dr. Hsu testified consistent with his reports that Petitioner's cervical condition was related to her accident at work, but her back and lower extremity conditions were not related to her accident at work. Dr. Hsu also opined that Petitioner's falls were unrelated to her accident at work. He agreed with Dr. Ghanayem's assessment that Petitioner required work restrictions, but he opined that those restrictions were necessitated by her unrelated lower extremity condition. Dr. Hsu reiterated that Petitioner's symptoms began well after her injury was successfully treated with a C5-6 anterior cervical discectomy and fusion.

Ultimately, Dr. Hsu opined that Petitioner's lower extremity complaints were unrelated to her original injury or cervical surgery because her original injury was cervical in nature and successfully treated with an ACDF. He explained that he reviewed Petitioner's post-operative MRI, which showed no evidence of stenosis. Without any objective evidence of compression on the spinal cord causing dysfunction, Dr. Hsu testified that it would be very difficult for him to conclude that Petitioner's cervical spine was the reason for her neurologic problems. He testified that it was in the realm of possibility that a cervical problem could be related to lower extremity issues, but not probable where there was no evidence of cervical cord compression.

On cross-examination, Dr. Hsu acknowledged that he did not review Petitioner's lumbar MRI films. He was also asked on cross-examination whether he had an opinion regarding the cause of Petitioner's lower extremity symptoms, and Dr. Hsu testified that he did not have such an opinion.

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F. Deposition Testimony – Dr. Wehner

Respondent called Dr. Julie Wehner as a witness and she gave testimony at an evidence deposition on July 23, 2014. Dr. Wehner is a board-certified orthopedic surgeon and has been for approximately 25 years. She testified about both of the examinations that she performed, her reports, and the opinions that she rendered related to Petitioner's condition and its relatedness, if any, to her accident at work.

Dr. Wehner testified about her Section 12 examination of Petitioner at Respondent's request on February 20, 2012. She reviewed various medical records, including records from the occupational health clinic, Sherman Hospital, and Dr. Drake. Dr. Wehner also took a history from Petitioner. On physical examination, Dr. Wehner noted positive Phalen's and Tinel's signs right greater than left. She diagnosed Petitioner with cervicalgia after a motor vehicle accident on May 24, 2010. Dr. Wehner testified that Petitioner's treatment had been reasonable and necessary. She agreed with the recommendations for an EMG and an updated MRI. Dr. Wehner further testified about the second Section 12 examination of Petitioner on June 25, 2012. She maintained the opinions contained in her report.

On cross-examination, Dr. Wehner testified that she was not provided with a job description for Petitioner's work as a bus driver. She also testified that she was not surprised that Petitioner was currently driving a bus although she did not know how many hours per day.

G. Deposition Testimony – Dr. Ghanayem

Petitioner called Dr. Ghanayem as a witness and he gave testimony at an evidence deposition on November 11, 2015. Dr. Ghanayem is an orthopedic surgeon with a practice confined to spine surgery. He testified about his treatment of Petitioner on consultation, and the opinions that he rendered related to Petitioner's condition and its relatedness, if any, to her accident at work.

Dr. Ghanayem testified that he had occasion to examine and treat Petitioner on consultation. Petitioner initially presented on October 13, 2014. He reviewed some MRI scans that pre-dated her surgery and noted that Petitioner had been diagnosed with cervical disc problems and had a fusion/discectomy in 2011 (ACDF). He noted she had ongoing neck pain with referral to the shoulder blades and right arm weakness. Dr. Ghanayem also noted she reported having some difficulty walking and driving a bus.

Dr. Ghanayem also reviewed Petitioner's post-operative MRI performed approximately one year after her surgery and it "showed that the decompression was gone, technically fine. There were some degenerative changes that were early at C4-5 adjacent to her fusion." He planned to obtain an updated MRI as Petitioner reported progressive difficulties. Dr. Ghanayem opined that Petitioner's symptoms were caused by the C5-6 disc herniation and compression that had been treated surgically. He testified that the surgeon did a good job.

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Dr. Ghanayem testified that Petitioner also underwent the updated MRI and it showed some degeneration around the fusion that did not cause compression. He testified that Petitioner had a mechanical type of neck pain problem that did not require surgery. Dr. Ghanayem opined that Petitioner had some transition problems at adjacent level, which was not compressive, but would be related to the surgery and tie back to the original injury. He explained that a transition problem is where the disc is overloaded because the fusion causes a transfer of stress causing neck pain. He further testified that her lower extremity neurologic exam was normal.

Dr. Ghanayem also opined that Petitioner should not continue work as a school bus driver given the nature of her residual symptoms and subjective complaints. He testified that, as a physician, her spine was causing the residual problems and he would not clear her for occupational driving. Dr. Ghanayem also testified that there were objective findings relative to her neck that prevented her from returning to work as a bus driver. Specifically, he testified that Petitioner's hyperreflexia was "indicative of some degree of cord damage absent any ongoing compression. If she had ongoing compression, you can say well, maybe there's something else that needs to be done to take care of that. But the hyperreflexia that I documented is indicative of perhaps some cord damage. And then the presence of the positive Hoffman sign can be indicative of prior compression or residuals of compression. And those are things that raise red flags in my mind." Dr. Ghanayem also testified with regard to Petitioner's reported weakness and his examination findings. Specifically, the following exchange occurred:

> Q When you say that she has a sense of weakness, did you find in your examination that she had actual weakness, or was it just her own sense of weakness?
>
> A Well, I couldn't find a particular motor distribution. So if it was radicular type problems, you can identify a motor problem. If it's cord dysfunction, you get this sense of weakness. So the condition of cervical myelopathy where someone says, you know, I feel like I'm weak and I'm clumsy, when you exam them, each muscle group works fine. But when it tries to work together, it's cord dysfunction. And so --
>
> Q Let me just interrupt.
>
> A Sure.
>
> Q Did you find in your examination actual weakness?
>
> A No. I found the sense of weakness in the entire right arm.

On cross-examination, Dr. Ghanayem testified that he would disagree with another doctor who cleared Petitioner to drive. He also testified that Petitioner's hyperreflexia prevents her from performing her job. Dr. Ghanayem explained that it was indicative of cord damage and a poor surgical result. However, Dr. Ghanayem acknowledged that he did not note weakness in Petitioner's arm; rather, Petitioner reported right arm weakness to him and, when he examined her, he could not isolate it to one particular nerve root. Dr. Ghanayem again testified that Petitioner's

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MRI showed no compression, but he testified that it did show disc abnormalities adjacent to her fusion.

Petitioner re-called Dr. Ghanayem as a witness and he gave testimony at a second evidence deposition on May 9, 2018. Dr. Ghanayem noted his examination of Petitioner on November 6, 2017 and her report of more difficulty walking and standing as well as her use of a walker. He also noted Petitioner's report of bladder dysfunction, that her legs and right arm were feeling worse as well as right arm numbness. Dr. Ghanayem testified that Petitioner still had a positive Hoffman's sign, which was in both hands, and bilateral hyperreflexia as well as general bilateral arm weakness. Dr. Ghanayem testified that Petitioner had decreased sensation in the right arm in C5, C6 and C7 and no hyperreflexia in the legs. The following exchange then occurred:

> Q Do you have an opinion based upon a reasonable degree of medical and surgical certainty as to the cause for the findings in the right upper extremity?
>
> A What I dictated was, quote, I am curious as to why she has progressed over the last year or so. There may be some underlying neurologic dysfunction that is occurring that is not readily apparent on the MRI scans, closed quote.
>
> Q Do you have an opinion based upon a reasonable degree of medical and surgical certainty as to whether or not it could be a progression of the myelopathy to which you testified at the last deposition?
>
> MR. VICTOR: I'm going to object based on Ghere and outside the four corners of the current report.
>
> THE WITNESS: The progression of myelopathy is an underlying neurologic dysfunction that would not be readily apparent on the MRI scans, and it is consistent with my curiosity.
>
> BY MR. SIMARD:
>
> Q Do you have an opinion based upon a reasonable degree of medical and surgical certainty as to the etiology of the left arm symptoms?
>
> A I mean, progressive myelopathy is - -
>
> MR. VICTOR: I'm going to make the same objection. Go ahead.
>
> [After an inquiry, the court reporter read back the question, answer and objection.]
>
> THE WITNESS: Progressive myelopathy, as I stated in my report, is an underlying neurologic dysfunction. It can cause the left arm to become symptomatic.
>
> BY MR. SIMARD:

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Q Going back to the legs. What did your examination of the legs reveal?

A Just some generalized weakness, but no hyperreflexia.

Q Do you have an opinion based upon a reasonable degree of medical and surgical certainty as to the cause of this weakness?

MR. VICTOR: I'm going to object once again based on Ghere. There's no indication of an opinion in the report regarding the lower extremities as to causation. Go ahead.

THE WITNESS: The lower extremity issues are not a lower extremity problem. It's a cord dysfunction problem which is emanating from the neck.

On cross-examination, Dr. Ghanayem testified that Petitioner's underlying neurologic dysfunction could not, in his opinion, be another disease process other than progressive myelopathy.

H. Additional Information

Petitioner testified that she has not worked anywhere since December of 2014. She applied for work at Wal-Mart as a greeter but was not hired. She also applied at B&R Accounting, but she testified that she was not hired because she had to sit, she could not type, and she had no keyboarding skills. Petitioner explained that she typed with one finger until her hand cramped up. Petitioner testified that she would work if she found a job.

Regarding her current condition of ill-being, Petitioner testified that she does drive but only 10-15 minutes at a time. She does drive to Wal-Mart and uses a scooter to shop there for groceries. Petitioner has a walker on every level of her home, uses it to ambulate, and sits on her walker to do the dishes at home.

Petitioner testified that her husband or daughter assist her putting things away in the cabinets as she cannot reach high or low. She testified that she cannot vacuum and has help from neighbor kids. Petitioner also gets help to bring groceries inside her home, had to hire people for housework, and cannot carry a laundry basket as she is weak.

Petitioner testified that it is hard to walk in the morning and she needs to get up and relax first and sit. She goes to the bathroom many times per night. Petitioner explained that there are five steps to the bathroom and she holds onto the railing and cannot lift her right leg. It is also hard using her left leg. Petitioner has breakfast in the morning and tries to get motivated, does dishes, and then sits on the couch and watches a lot of TV. On a good day she may go for a walk with her walker, as she was to sit down if she needs, and she tries to keep her legs moving as she does not want to fall. Petitioner explained that she cannot physically do the things she used to do.

Petitioner testified that she always has neck pain, every day. She testified that there is no position into which she can get herself that is comfortable for a long time. Sitting up causes

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pressure on her bladder and leg, and she gets wobbly and falls. Petitioner testified that she has bruises on her elbows and knees from banging them up. Her back also hurts all the time.

Petitioner further explained that she can hardly push the walker with her hands as it hurts badly and the walker is heavy. She testified that she cannot lift much, and her rib still hurts sometimes when she bends. Petitioner testified that she feels a knife-like pain in her back all the time and she cannot wear a heavy coat in the winter as it is too heavy and weighs her down. She also cannot wear jeans, as they are too heavy even if loose, just regular pants or Spandex shorts.

Petitioner also testified that she experiences a lot of right leg spasms and it affects her left leg now such that she gets wobbly and gives out. Petitioner testified that she experiences more pain more often, and she still takes anti-depressant medication prescribed by Dr. Joshi as well as the bladder medication.

II. ANALYSIS

A. Evidentiary Rulings

The Commission notes that there were no express rulings made on either parties' objections at the depositions, with the exception that the Arbitrator specifically addressed Respondent's *Ghere* objections related to Dr. Ghanayem's causal connection opinion relating Petitioner's upper and lower extremity complaints to the accident. See *Ghere v. Industrial Comm'n*, 278 Ill. App. 3d 840, 663 N.E.2d 1046 (4th Dist. 1996). The Commission finds that Respondent's *Ghere* objection in Dr. Ghanayem's second evidence deposition related to Petitioner's lower extremity complaints was properly sustained.

Petitioner saw Dr. Ghanayem for a second opinion regarding her complaints on two occasions in 2014. On October 13, 2014, Dr. Ghanayem examined Petitioner and noted she had hyperactive reflexes in the biceps and brachioradialis, but normal in the triceps. She also had positive Hoffman's sign in her hands. Her lower extremity neurologic exam was normal. Dr. Ghanayem's findings were similar at Petitioner's December 22, 2014 visit.

Dr. Ghanayem appeared for an evidence deposition on November 11, 2015. He testified that Petitioner reported to him that she had ongoing neck pain into her shoulders and a sense of weakness in her right arm. He noted she did have some difficulty walking and was having some trouble driving a bus. Dr. Ghanayem testified at length about Petitioner's upper extremity exam findings and stated they were related to cord compression or cord compression in the past from her accident and subsequent surgery. As mentioned, Dr. Ghanayem noted Petitioner had some difficulty walking. The only other mention of Petitioner's lower extremities in the deposition was that the neurologic exam was normal.

On November 6, 2017, Dr. Ghanayem issued a narrative report after evaluating Petitioner. He maintained his general causal connection opinions stating that Petitioner had "residual dysfunction" and "residuals" after her cervical disk injury and subsequent decompression and fusion surgery that were causally related. Dr. Ghanayem further stated that "[t]here may be some

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underlying neurologic dysfunction that is occurring that is not readily apparent on the MRI scans." However, he stated that in reviewing her medical records, MS has been ruled out and evaluation of her brain MRI was beyond his area of expertise, but there did not appear to be any significant abnormalities explaining her current neurologic dysfunction based on that MRI and her neurologist, Dr. Katsamakis.

At his second deposition, Dr. Ghanayem maintained the general causal connection opinions relating Petitioner's residuals and residual symptoms to her cervical injury or surgery. However, in response to questions drawing *Ghere* objections, Dr. Ghanayem explicitly concluded for the first time that Petitioner's lower extremity complaints were causally related to her cervical injury and surgery. The medical records reflect that Petitioner underwent treatment with Dr. Drake for a disc herniation and right upper extremity radicular symptoms that required a C5-6 fusion surgery with bone graft and plate.

While Dr. Ghanayem evaluated Petitioner's cervical spine in rendering his generalized opinion relating her residual symptoms to her cervical injury, his new, specific opinions at the time of his second deposition that Petitioner's lower extremity complaints were somehow causally related were not previously contained in any of his treatment records, his narrative report, or even rendered at the time of his first deposition. We cannot conclude that Respondent had reasonable notice that Dr. Ghanayem would provide causation testimony relating Petitioner's lower extremity symptoms to her cervical injury.

Thus, the Commission finds that the Arbitrator's exclusion of Dr. Ghanayem's causal connection opinions relating Petitioner's lower extremity complaints to her cervical injury or subsequent surgery pursuant to *Ghere* was proper.

With regard to the remaining objections made during the evidence depositions, the Commission makes the following rulings[1]:

PX15 – Dr. Ghanayem Deposition November 11, 2015
12:8-24 Objection Foundation – Overruled; Objection Area of Expertise – Overruled
13:1-9 Objection Foundation – Overruled; Objection Area of Expertise – Overruled
13:19-22 Objection Area of Expertise – Overruled
20:3-8 Objection – Overruled; Motion to Strike – Denied

PX16 – Dr. Ghanayem Deposition May 9, 2018
7:24-8:15 Objection *Ghere* – Overruled; Objection Outside Four Corners of Current Report – Overruled
8:21-9:21 Objection *Ghere* – Overruled; Objection Outside Four Corners of Current Report – Overruled

[1] The Commission refers to the deposition pages and line numbers as "Page:Line(s)" or "Page:Line-Page:Line" as appropriate.

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9:22-10:21 Objection *Ghere* – Sustained; Objection Outside Four Corners of Current Report – Sustained
11:7-12 Objection Foundation – Overruled
11:18-24 Objection Leading – Overruled
12:2-14 Objection Leading – Overruled
14:9-16 Objection Not a Vocational Expert – Overruled
15:8-20 Objection Asked and Answered – Overruled
17:20-18:23 Objection – Overruled
21:8-20 Objection Leading – Sustained
21:21-22:9 Objection Leading – Sustained

RX1 – Dr. Wehner Deposition July 23, 2014
27:17-22 Objection Calls for Speculation – Overruled
33:6-13 Objection Beyond her Examinations – Overruled; Objection *Ghere* - Overruled
34:6-11 Objection Beyond Cross – Overruled

RX2 – Dr. Hsu Deposition December 15, 2015
11:4-11 Objection Counsel Testifying – Sustained
13:6- 8-15 Objection *Ghere* – Overruled
17:12-22 Objection Doctor testified specifically on records he reviewed on direct and cross previously and no mention of Dr. Drake or Core Orthopedics, and not indicated in report – Sustained
18: 5-12 Objection *Ghere* – Sustained; Motion to Strike – Granted

RX3 – Dr. Hsu Deposition June 27, 2018
11:1-7 Objection Leading – Sustained
12:9-22 Objection *Ghere* – Overruled
13:11, 14:1 Objection *Ghere* – Overruled; Motion to Strike – Denied
23:4-10 Objection Outside of Scope – Overruled
31:24-32:8 Objection Asked and Answered – Overruled

B. Causal Connection

The Commission finds that the evidence submitted fails to establish that Petitioner's ongoing condition of ill-being is related to her accident at work.

Petitioner sustained an undisputed accident at work involving her cervical spine. She underwent conservative treatment to no avail and, eventually, an anterior cervical discectomy and fusion to correct a disc herniation at C5-6 with Dr. Drake. After post-operative care, Dr. Drake released Petitioner to full duty work on July 6, 2012. Of note, both Dr. Drake and Respondent's Section 12 examiner, Dr. Wehner, agreed that Petitioner's herniation was caused by the accident at work and that her medical care had been reasonable and necessary to this point. They also agreed that Petitioner could return to work without any restrictions.

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Petitioner lost her employment with Respondent while recovering from her cervical condition. However, after her release by Dr. Drake, Petitioner took and passed the CDL test and obtained other employment. She then resumed medical treatment in earnest in 2014 reporting new generalized complaints throughout her body. Her primary care physician referred her to a neurologist for evaluation and treatment, and she eventually saw three neurologists to attempt to diagnose her condition. After regular MRI's of the cervical spine and brain, in addition to other diagnostic tests and clinical exams, Petitioner's neurologists could not agree whether Petitioner suffered from MS.

While her neurologists attempted to diagnose a neurological condition, Petitioner also saw Dr. Ghanayem for a second opinion. In his narrative report dated November 6, 2017, Dr. Ghanayem noted Petitioner's complaints including symptoms in the lower extremities, falls, generalized weakness, and difficulty ambulating. Despite diagnostic test results that continued to reveal normal processes and a well-maintained cervical fusion with no significant cord compression or pathology, Dr. Ghanayem opined during his second deposition that all of Petitioner's complaints, including but not limited to her upper and lower extremities, were causally related to her accident at work or the subsequent cervical spine surgery. In so concluding, he also stated that "[t]here may be some underlying neurologic dysfunction that is occurring that is not readily apparent on the MRI scans." However, Dr. Ghanayem deferred any opinion regarding Petitioner's neurological deficits to her neurologist[2], Dr. Katsamakis, given that such matters were not within his field of expertise. Dr. Ghanayem's opinions are unpersuasive given the totality of this record.

Petitioner seems to suggest that she had a complex presentation which bridges gaps in treatment and covers a host of symptoms that onset long after she was released from care by her surgeon. She relies on the opinions of Dr. Ghanayem rendered in late 2014 and in 2017 to establish that she developed a myelopathy or some objectively unverifiable residual neurological condition that is casually related to her cervical injury or subsequent surgery. However, Petitioner's changing symptomatology, and the unidentifiable objective medical source of her subjectively reported symptoms, began to emerge years after Dr. Drake released her from care following a successful C5-6 fusion surgery to address a disc herniation and radiculitis in the right upper extremity.

"'Expert opinions must be supported by facts and are only as valid as the facts underlying them.'" *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC, ¶ 24, 960 N.E.2d 587, 594 (quoting *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87 (1st Dist. 2003)). Dr. Ghanayem is admittedly unable to pinpoint the source of Petitioner's complaints against objective medical evidence. He maintained a generalized causal connection opinion between Petitioner's residuals or her residual neurological symptoms and injury at work or subsequent surgery while simultaneously admitting that neurology was outside of his area of expertise. He also notes the unverifiable nature of myelopathy in the course of rendering that diagnosis, which is noticeably absent from his records or narrative report. In the end, Dr. Ghanayem's myelopathy diagnosis and causal connection opinions regarding Petitioner's subjectively reported residual complaints after July 6, 2012 are speculative and made against normal or minimal generalized

[2] It does not appear that Dr. Ghanayem reviewed any records from any of Petitioner's other neurologists.

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findings on physical examination and negative diagnostic tests that do not confirm clear spinal cord compression, cord pathology, or radicular symptoms. Dr. Ghanayem's opinions are not persuasive given the totality of the evidence in this case.

There is no dispute among the physicians that Petitioner's cervical disc herniation with right-sided radiculopathy requiring medical treatment including surgery was causally related to her accident at work. However, there are no diagnostic, objective findings to support any causal connection regarding Petitioner's myriad complaints after July 6, 2012 as claimed. The evidence in this case supports the opinions of Respondent's Section 12 examiner, Dr. Hsu.

Dr. Hsu explained that Petitioner's low back and leg complaints, as well as her falls long after her release from care by Dr. Drake, were unrelated to her accident at work. In so concluding, Dr. Hsu noted that Petitioner's expansive symptoms began well after her injury was successfully treated with a C5-6 anterior cervical discectomy and fusion and his first examination of her in 2015. He also noted that Petitioner's lower extremity complaints were unrelated to her original injury or subsequent medical treatment because her original injury was cervical in nature and successfully treated with an ACDF surgery. Dr. Hsu further pointed to the lack of objective medical evidence to support Petitioner's subjectively reported complaints, including her post-operative MRI showing no evidence of stenosis or compression.

Thus, the Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection relating Petitioner's cervical condition to her accident at work through July 6, 2012. The Commission further affirms and adopts the decision of the Arbitrator finding no causal connection relating any other conditions in any other body parts to the accident as not contrary to the weight of the evidence.

C. *Medical Bills*

The Commission, with the above finding on causal connection through July 6, 2012, further finds the decision of the Arbitrator relative to medical benefits through that date as not contrary to the weight of the evidence. However, the Commission modifies the award to include payment of any medical bills in evidence for care rendered prior to July 6, 2012 when Petitioner was released from care by Dr. Drake. Respondent is entitled to a credit for any of those bills that were paid as agreed by the parties.

D. Temporary Total Disability Benefits

The Commission, with the above finding on causal connection through July 6, 2012, further finds the decision of the Arbitrator relative to temporary total disability benefits as not contrary to the weight of the evidence. However, the Commission modifies the award to include payment of the stipulated periods of temporary total disability benefits from October 4, 2010 through October 31, 2010 and from May 17, 2011 through July 2, 2012 as claimed.

The Commission affirms all else.

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IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $538.99 per week for a period of 63 weeks (October 4, 2010 through October 31, 2010 and May 17, 2011 through July 2, 2012), 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 the Decision of the Arbitrator filed September 18, 2018 is, otherwise, hereby affirmed and adopted.

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

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

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

DATED: AUG 19 2019

Barbara N. Flores

BNF/jsf
6/20/19
045

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

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

STRINGER, DEBRA
Employee/Petitioner

Case# **10WC028640**

SCHOOL DISTRICT U-46
Employer/Respondent

19IWCC0442

On 9/18/2018, 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 2.29% shall accrue from the date listed above to the day before the 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

2461 NYHAN BAMBRICK KINZIE & LOWRY
DAVID A VICTOR
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
19(b)

Debra Stringer
Employee/Petitioner

v.

School District U-46
Employer/Respondent

Case # **10** WC **28640**

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 **Paul Seal**, Arbitrator of the Commission, in the city of **Chicago IL**, on **July 18, 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. ☒ 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 **Is Petitioner entitled to an initial vocational rehabilitation assessment? Chain of medical providers.**

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FINDINGS

On the date of accident, **May 24, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**42,040.96**; the average weekly wage was $**808.48**.

On the date of accident, Petitioner was **45** 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 $**32,530.59** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**32,530.59**.

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

ORDER

THE ARBITRATOR FINDS THAT THE PETITIONER'S CONDITION OF ILL BEING WAS CAUSALLY RELATED TO THE ALLEGED WORK INJURY UP TO DR. DRAKE'S RELEASE OF THE PETITIONER TO RETURN TO WORK ON JULY 6, 2012, ONLY.

Respondent shall pay Petitioner temporary total disability benefits of $538.99/week for 249 3/7 weeks commencing October 4, 2010, through October 31, 2010 (4), commencing May 17, 2011, through June 25, 2012 (59).

Respondent shall be given a credit of $32,530.59 for TTD benefits that have been paid.

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

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

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

Signature of Arbitrator

September 18, 2018
Date

ICArbDec19(b)

SEP 18 2018

FINDINGS OF FACT

The petitioner testified that on May 24, 2010, she was employed by District U-46 as a school bus driver. She had been driving a school bus for 12 years. She drove 42 hours a week. When she was hired, she had to pass a driving test. The petitioner testified that she had no restrictions on her ability to work and she was not under the care of any doctor for her spine.

She testified that she was driving her school bus on May 24, 2010, when a car ran a red light and struck the bus. After impact, the petitioner checked on the preschoolers in the bus. She noticed that her back was hurting. She hit her ribs on the steering wheel on the right side. She indicated that her lower neck and down her spine where she hit her ribs hurt her. She was taken by ambulance to Advocate Sherman Hospital in Elgin.

The petitioner was examined and x-rays were taken and she followed up with the Provena St. Joseph Occupational Health Clinic where she was taken off work. She returned to Provena St. Joseph the next day and was returned to work with no restrictions. She returned to work that next day. The petitioner indicated that she was still in pain following her return to work and sought treatment with a chiropractor, Randall Greener, on June 1, 2010. He performed manipulation and she was seen 37 times between June 1, 2010, and October 4, 2010. She continued working.

The petitioner testified that she noticed she was falling a little bit, and that her hands were getting numb and she was getting weaker in her arms and she was dropping things and could not carry a gallon of milk. She indicated that she was

wobbly and she was falling many times that year and was getting scared because she didn't know what was going on with her body.

On October 4, 2010, she began treatment with Dr. Gregory Drake at Core Orthopedics. She was referred to Dr. Drake from her family doctor, Dr. Tanna. Dr. Drake ordered MRI of the cervical spine and EMG for the neck and arms. She underwent EMG on October 6, 2010, at St. Joseph Hospital. Thereafter, she underwent MRI on October 7, 2010, at Sherman Hospital.

On October 26, 2010, Dr. Drake returned the petitioner to work. She returned to work November 1, 2010. The petitioner testified that on November 22, 2010, she told Dr. Drake that she was not getting any better. Dr. Drake ordered physical therapy at Midwest Physical Therapy on November 26, 2010. The petitioner testified that she was seen 59 times between November 26, 2010, and February 6, 2012.

On January 18, 2011, she saw Dr. Drake and he referred her to Dr. Cherala at Fox Valley Pain Center. Dr. Cherala examined her on February 28, 2011. Dr. Cherala administered three cervical spine injections. The petitioner testified that she returned to Dr. Drake on May 11, 2011, and she told him that she was not feeling better. Dr. Drake took her off work and on June 30, 2011, and he scheduled her for surgery.

On July 22, 2011, Dr. Drake performed a fusion at C5-6 with a bone graft and plate at Sherman Hospital. The petitioner followed up with Dr. Drake on August 11th and September 30, 2011. The petitioner testified that she treated with Dr. Drake through January 6, 2012, and that she continued to receive therapy.

The petitioner testified that on January 20, 2012, she received a termination letter from the respondent. She testified that she was terminated because her permit lapsed. This was a permit to drive a school bus and she testified that it lapsed because she was physically unable to drive and required a doctor's clearance to get the permit. She continued to treat with Dr. Drake. On February 20, 2012, Dr. Julie Wehner examined the petitioner at the respondent's request under section 12 of the Act.

The petitioner testified that she continued to treat with Dr. Drake and that he ordered more physical therapy followed by a functional capacity evaluation. She underwent the functional capacity evaluation on March 30, 2012, which was valid and indicated that she could only work at a sedentary level. She was sent for work hardening. She testified that she had 24 sessions through May 23, 2012. She continued to treat with Dr. Drake through May 25, 2012. He ordered another MRI on May 15, 2012, and he recommended another month of work hardening.

Dr. Wehner examined the petitioner again on June 25, 2012. The petitioner testified that her weekly TTD compensation ceased on July 2, 2012. She saw Dr. Drake again on July 6, 2012, and he placed her at maximum medical improvement with no restrictions as far as lifting or motion. The petitioner testified that at her time of discharge from care on July 6, 2012, the school year had ended, and she reapplied for a driver's job. She testified that there were four openings for a bus driver at the time that she applied online. She also testified that the respondent employs 350 drivers or more. She was not offered a job driving.

The petitioner testified that she began looking for work elsewhere and applied for a job at Illinois Central Bus Company. She started driving for Illinois Central Bus Company in late August, early September of the beginning of the 2012-2013 school year. She was driving 28 hours per week. She testified that she was earning $14.69 per hour. The next school year she began work driving for St. Charles School District which paid more but gave fewer hours. She was working 21 hours for St. Charles School District. She was earning $18.69 hourly.

The petitioner testified that, while working for Illinois Central Bus Company, she barely could walk and her right side would give out. She testified that the right side of her whole body including her legs bothered her and that she fell in the parking lot a couple of times. She was hurting every day because of her spine and her lower back and all the pressure. She testified that her neck, upper arms, hands, legs, all were in pain along with spasms in her back.

The petitioner testified that, while she was driving for St. Charles, the problem was getting worse. She barely could sit for long periods of time. She needed to get up and walk around. She could not push the roof hatches open to do her bus checks. She had to get a mechanic to check the bus to make sure it was working because that is part of DOT requirements. She also indicated that she fell a couple of times in the parking lot because her legs just gave out on her.

The petitioner testified that she drove for St. Charles School District for the 2013-2014 school year which ended in June 2014. She started up again with the start of the 2014-2015 school year driving for Illinois Central Bus. She testified that she returned to

see Dr. Greener in May and June 2013. She saw Dr. Greener eight times in those two months. She began seeing Dr. Drake again on April 3, 2014. The petitioner testified that Dr. Drake recommended another EMG but workers' compensation did not authorize it and she did not have health insurance in 2014. She paid for Dr. Drake out of her own pocket. The petitioner testified that she continued working in 2014, but her symptoms were getting worse.

She testified that she asked her attorney for a referral to an orthopedic surgeon. The petitioner testified that her attorney recommended Dr. Alexander Ghanayem at Loyola. She was examined by Dr. Ghanayem on October 3, 2014. He recommended an updated MRI. The petitioner testified that she followed up on December 22, 2014, and she indicated that Dr. Ghanayem thought she should not be driving a bus and that perhaps she should do office work. She testified that she then left her employment at St. Charles School District. She did not feel safe driving a school bus.

The petitioner testified that in 2015 she began getting health insurance from Medicare. She testified that she was approved for Social Security Disability on March 28, 2016, retroactive to June 2015. She testified that in 2015 she had Blue Cross Blue Shield insurance through her husband. The petitioner testified that she did receive medical treatment in 2015. She indicated that she began treating with Dr. Joshi on March 7, 2016.

She also received acupuncture treatments with Dr. Hanna 30 times. The petitioner testified that Dr. Hanna left the area with no means of getting her records. She saw Dr. Hanna in 2014 while she still was working at the St. Charles School District. The petitioner testified that she saw him again after seeing Dr. Ghanayem for the second time.

The petitioner saw Dr. Joshi on March 7, 2016. Dr. Joshi is her family doctor since Dr. Tanna did not accept Medicare and Dr. Tanna did not accept Blue Cross Blue Shield - according to her testimony. She reported right leg numbness to Dr. Joshi. She complained of depression and was given medication and a referral to a neurologist, Nicholas Schlageter.

The petitioner testified that she saw Dr. Schlageter on March 24, 2016. He examined her and sent her for MRI of the thoracic spine and lumbar spine and the brain. She testified that she underwent MRI of the spine on March 23, 2016, and returned on April 30, 2016, for MRI of the brain. The petitioner testified that she followed up with Dr. Schlageter on May 5, 2016. He reviewed testing and indicated that he suspected she had multiple sclerosis.

Dr. Schlageter prescribed Ditropan and over the next six months she continued taking this medication for depression. On December 7, 2016, the petitioner sought treatment at Northwest Neurology with Dr. George Katsamakis. Dr. Katsmakis reviewed the MRI study of her neck and brain and told her to continue medication and blood tests and have another MRI in six months.

The petitioner testified that on January 4, 2017, she underwent EMG and MRI prior to seeing Dr. Katsmakis again on February 3, 2017. She testified that Dr. Katsmakis reviewed testing and advised another MRI of the brain. She underwent MRI of the brain on March 6, 2017, and testified that on March 13, 2017, Dr. Katsmakis reviewed the updated MRI and told her that he doubted that she had multiple sclerosis. She saw Dr. Katsmakis again on March 29, 2017, and she was sent for MRI of the cervical spine on April 3, 2017.

The petitioner testified that on March 29, 2017, she was seen by Dr. Katsmakis' associate, Dr. McGonigle. On May 2, 2017, Dr. McGonigle went over the MRI of the cervical spine with her. The petitioner testified that Dr. McGonigle noted right leg atrophy. The petitioner testified that she underwent physical therapy for a month at Athletico which was prescribed by Dr. Katsmakis. She testified that on May 2nd, Dr. McGonigle recommended a psychologist for chronic pain issue but she has not seen a psychologist.

On April 12, 2017, Dr. McGonigle prescribed Baclofen, which the petitioner still takes. The petitioner testified that she returned to see Dr. McGonigle on April 25, 2017. Dr. McGonigle reviewed the MRI. The petitioner testified that she was told to put a walker on every level of her house and use a power wheelchair and continue on Baclofen and have another MRI in March with a return to Dr. Katsmakis.

She underwent another MRI of the brain on March 13, 2018, and she saw Dr. Katsmakis on March 19, 2018. Dr. Katsmakis prescribed Baclofen and some medication for a neurogenic bladder problem. The petitioner testified that she wet her pants which

started in 2013. She testified that she started wearing diapers and has to wear one every day. The petitioner testified that she never had any bladder problems prior to May 24, 2010. She testified that Dr. Katsmakis prescribed medical cannabis and that she was going through the state licensing procedure and her application is pending. On the date of hearing, the petitioner testified she had a future appointment with Dr. Katsmakis on August 11th.

The petitioner testified that she has not worked anywhere since December 2014, after seeing Dr. Ghanayem. She testified that she had looked for work. She went to Walmart to be a greeter but they did not hire her. She testified that she was going to work in an office at B&R Accounting - but, they did not hire her because she would have to sit and type and she cannot type. Her keyboard skills are limited to one finger typing with her index finger until it starts cramping.

The petitioner testified that she would be willing to work if someone found her a job that she could perform and that she could get to. She testified that she drives about an hour in a typical week with 10-15 minutes of driving at a time. She typically drives to Walmart and uses a scooter. She grocery shops in a scooter as well. She uses a walker to ambulate. She testified that she tries to perform household chores seated and uses a walker on every level of her home. She testified that she did not vacuum and neighbor boys help her bring in groceries.

She has had to hire people to do housework. She testified that on a daily basis she gets up in the morning and sits for a while and then goes to the bathroom up five stairs. She indicates that she has to hang on to the steps as she cannot lift her right leg to

get up – she has to use her left leg only. She testified that she eats breakfast and does the dishes in her walker and sits on the couch and watches television.

On a good day she might go for a little walk as long as she can sit down "every five seconds" if she needs to. The petitioner testified that her neck is always in pain. She struggles with pain and hurts every day. She has pain in her lower spine. She has pressure on her bladder and in her leg. She feels wobbly and she falls. She indicates that she has pain in her neck. The petitioner testified that when she puts pressure on her spine it is hurting when she sits down. Her hands hurt when she uses her walker. She testified that she cannot lift and it hurts when she lifts and her rib hurts when she bends down.

The petitioner testified that her back and spine feels as if someone is sticking a knife in it. She wears thin coats in the winter time as a heavier coat will bring her pain. She has to wear loose pants rather than jeans as they are too heavy. The jeans will weigh her down too much. The petitioner testified that her right leg spasms a lot and it is starting to affect her left leg as well. Her left leg is starting to wobble and give out and her lower spine on her left side is now giving her pain.

On cross examination the petitioner testified that while working for Illinois Central Bus she had to obtain a bus permit. She testified that she needed to pass a physical in order to obtain that permit. She was able to pass that physical and obtain her bus permit. The petitioner testified that the permit remains in effect for four years. She testified that she never reapplied for her bus permit license. It expired in 2014. She testified that she worked with St. Charles Bus Company through the end of 2014 until

she saw Dr. Ghanayem in December. 19IWCC0442

The petitioner testified that she saw Dr. Drake in May of 2012, and she did not see any orthopedic doctor again until April 3, 2014. She testified that she could not remember when she applied for work at Walmart or at B&R Accounting. She testified that she applied for those jobs after she saw Dr. Ghanayem and closer to 2014. The petitioner testified that she has not applied to any jobs within the last year.

Dr. Ghanayem and the other doctors indicated that her MRIs were normal. The petitioner testified that she never hurt herself or reported injuries from falling in the parking lots with either Illinois Central Bus or St. Charles School District. She indicated that she reported them but did not injure herself because she has to report. She testified that she did not have any medical treatment.

She still has a valid driver's license and does not have any Illinois restrictions. The petitioner testified that Dr. McGonigle, Dr. Ghanayem, and Dr. Katsamakis all told her that she should not drive over 15 to 20 minutes at most and pull over if she gets tired. She indicated that this was only continuous driving and she could pull over to the side.

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

The Arbitrator notes that accident is not in issue. The respondent paid the petitioner's medical as well as weekly TTD compensation benefits from October 4th through October 31st, 2010, and thereafter from May 17, 2011, through July 2, 2012. (AX1) This is an undisputed period of 63 weeks.

Following the petitioner's accident, she was released to return to work for four weeks and then took off again when she required surgery. On July 22, 2011, she underwent an anterior cervical discectomy and fusion at C5-6. The petitioner continued following surgery with physical therapy and a functional capacity evaluation. On February 20, 2012, she attended an examination under section 12 of the Act with Dr. Julie Wehner at the respondent's request. Dr. Wehner suggested continued treatment. She also agreed with the surgery.

On June 25, 2012, Dr. Wehner again examined the petitioner. Dr. Wehner reviewed MRI films and additional records. Dr. Wehner noted that at the petitioner's last visit with Dr. Drake May 25, 2012, he recommended one more month of work conditioning, and that she then would be at maximum medical improvement. At that time, Dr. Drake noted excellent strength and suggested that the petitioner would be back to work with minimal restrictions.

Dr. Wehner indicated that the petitioner already completed physical therapy and work hardening and the MRI and EMG did not show any ongoing pathology that would require any further intervention. She opined that the petitioner had plateaued in work conditioning; and, therefore, she had reached maximum medical intervention.

Dr. Wehner opined that the petitioner could return to work full duty. Following Dr. Wehner's examinations under section 12, the respondent terminated the petitioner's benefits. On July 6, 2012, Dr. Drake released the petitioner to return to work.

The school year already had ended - but, the petitioner obtained full duty work with Illinois Central Bus Company for the school year 2012-2013 driving a bus. In January 2012, her bus permit had lapsed as she physically could not drive and she could not get doctor's clearance - as a physical is required. Thereafter, when she did apply for Illinois Central Bus Company, she did take a physical and did pass in order to continue driving 2012 to 2013 and then again for St. Charles School District in 2013 through June 2014, when the school year ended. The Petitioner indicated that she again started the 2014-2105 school year with St. Charles School District until she stopped working after she saw Dr. Ghanayem at her request for a referral by her attorney an additional opinion. On December 22, 2014, Dr. Ghanayem indicated that she should not drive a bus.

The petitioner returned to her former job as a bus driver for over two years and four months from August 2012 through December 21, 2014. While she testified of various continued physical problems during that period of time, the petitioner did not seek any sustained treatment for her physical conditions other than her undocumented testimony that she underwent some acupuncture, a visit to Dr. Drake on April 3, 2014, and eight chiropractic treatments between May 24th and June 29th, 2013. It does not appear that the petitioner underwent any treatment between April 4, 2014, and her referral to Dr. Ghanayem on October 13, 2015.

Thereafter, per the petitioner's testimony, she was seen by Dr. Alexander Ghanayem in consultation. Dr. Ghanayem testified at his deposition that he examined her in consultation for the first time on October 13, 2014. He testified that he reviewed some MRI scans that predated surgery - but, he did not remember if he reviewed any medical records. Dr. Ghanayem stated that the petitioner complained of ongoing symptoms of neck pain with referral into the shoulder blades and also a sense of weakness in the right arm. She related some difficulty walking. He noted that her postoperative x-rays which he reviewed and her MRI scan about a year after surgery were all technically fine.

Dr. Ghanayem recommended an updated MRI scan. He testified "it appears that the surgeon did a good job" as it relates to the fusion. Dr. Ghanayem noted that some people who have fusions do not get better afterwards. He admitted that cervical surgeries have a higher success rate - but, they are not all perfect. He testified that the petitioner underwent an updated MRI and returned to see him on December 22, 2014. He noted degenerative changes in the discs around the fusion but nothing causing any neurologic compression.

Dr. Ghanayem suggested that there was mechanical-type neck pain but nothing that required surgery. He testified, "I think she just had not a great outcome as a result of her disc herniation and subsequent treatment for that disc herniation." He indicated that there were transition type problems at the adjacent level which can contribute to neck pain.

He told the petitioner that she should not drive a bus due to her sense of weakness and neck pain. He testified that he thought that the she should transition to more of an office type environment. Dr. Ghanayem admitted that he did not know whether the petitioner had other skills or could work in an unrelated field and indicated that he would defer to a vocational expert. He testified that the petitioner could work in an office type environment. He recommended sedentary type work - standing and sitting and lifting no more than 10 pounds.

Dr. Ghanayem suggested that the petitioner suffered from hyperreflexia which is indicative of core damage and explains the weakness in her right arm. He admitted that with core dysfunction there is a sense of weakness but not actual weakness. Dr. Ghanayem admitted that this was based on examination but really based on what the petitioner told him. He testified that the MRI showed disc abnormalities adjacent to her fusion which is not compression and does not require surgery but is a competent cause of her ongoing pain. Finally, he admitted that there is a test for whether the operated disc was causing the hyperreflexia on another disc but that he did not perform that test.

Dr. Ghanayem testified again on May 9, 2018, following evaluation of the petitioner on November 6, 2017. At that time, he offered his opinion that the petitioner's lower extremity condition was diagnosed as myelopathy and that it was causally related to her work injury. Dr. Ghanayem admitted that he had no diagnostic evidence to support the diagnosis - but, since multiple sclerosis had been ruled out, this was his determination based upon a reasonable degree of medical certainty. He did admit that there could be other causes of her current lower extremity condition.

The Arbitrator finds that the opinions expressed as to causal connection by Dr. Ghanayem regarding the petitioner's alleged myelopathy in his second deposition are barred by ***Ghere v. Industrial Comm.,*** 278 Ill. App.3d 840, 663 N.E.2d 1046, 215 Ill.Dec. 532 (4th Dist. 1996). The petitioner's original evaluation by Dr. Ghanayem was primarily for her neck complaints and he offered opinions relative to those complaints. During Dr. Ghanayem's second deposition on May 9, 2018, which was following his November 6, 2017, evaluation of the petitioner, he opined regarding causal connection as to her lower extremity condition and her original work accident. Dr. Ghanayem's reports are silent as to this issue, and his first opinion regarding this was at this second deposition.

The respondent timely raised its ***Ghere*** objection relative to surprise as to this new opinion on a new body part. Dr. Ghanayem was a consulting doctor who did not provide any report or opinion prior to his second evidence deposition relative to either a diagnosis or opinion as to the petitioner's lower extremity issues. For this reason, Dr. Ghanayem's opinions as to causal connection to the petitioner's lower extremity are barred.

Dr. Wellington Hsu examined the petitioner on April 13, 2015, pursuant to section 12 of the Act at the request of the respondent. The petitioner complained of neck pain and numbness and tingling in the right arm. She had right lower extremity pain as well. Dr. Hsu diagnosed the petitioner with a C5-6 disk herniation that had undergone an ACDF procedure. He also diagnosed cervical and lumbar spondylosis which was pre-existing and unrelated to the accident. He determined that the

petitioner could drive a school bus without restrictions. He testified that the petitioner reached MMI on the date of Dr. Wehner's examination.

Dr. Hsu testified that hyperactive reflexes can indicate spinal cord compression or a neurological disorder and he did not believe that the petitioner had cord compression based upon his review of the MRI studies of November 2014. There was no active cord compression seen on the post-surgical MRI studies that he reviewed. Dr. Hsu opined that there was a causal connection between the accident and the need for the fusion in the cervical spine. Dr. Hsu did not find any ongoing cord compression on the post-operative MRI films that he reviewed. At that time, Dr. Hsu did not have an opinion as to the cause of Petitioner's abnormal and methodical gait and her inability to heel-and-toe walk.

Dr. Hsu testified on June 27, 2018, for a second time. He re-examined the petitioner on January 22, 2018, after reviewing the records of Dr. Katsamakis, his section 12 report of April 13, 2015, his previous deposition and the records of Dr. Joshi and Dr. Schlageter. He reviewed MRI studies of the thoracic and lumbar spine taken in 2017, chart notes from Drs. Fisher and McGonigle, as well as Dr. Ghanayem's note of November 2017. The petitioner complained to him of low back, upper back, neck and bilateral lower extremity pain. She reported many falls and having received a number of conservative treatments.

Dr. Hsu reviewed the cervical spine MRI from April 3, 2017, which revealed no issues. He diagnosed a C5-6 disk herniation, a status post C5-6 ACDF, cervical spondylosis and lumbar spondylosis.

Dr. Hsu opined that his diagnosis regarding the cervical spine remained unchanged. He opined that the low back pain or lower extremity pain were not related to the original work injury because she did not have low back and leg pain when he last saw the petitioner in 2015. He did not believe that any of the falls described by the petitioner were related to the accident. Dr. Hsu indicated that the neck pain at the time of his examination was unrelated to the work accident. However, Dr. Hsu agreed with Dr. Ghanayem that the petitioner should have a sedentary work restriction - but, this restriction was based on her lower and not upper extremity issues. Dr. Hsu opined that the decreased lower extremity function was not related to the accident because the petitioner underwent a successful C5-6 ACDF and that the lower extremity dysfunction developed well after he saw her in 2015. Dr. Hsu opined that the petitioner was at MMI and that her restrictions were unrelated to the original accident.

Dr. Hsu testified that the petitioner's lower extremity symptoms are not the result of any neurologic dysfunction or myelopathy. He indicated that he could not make an opinion in this regard because the post-surgical cervical spine MRI did not demonstrate any significant stenosis. For that reason, he believed that that there was no objective evidence that the cervical spine would be the cause of her lower extremity dysfunction. Dr. Hsu testified that the petitioner might have one of many possible central neurological processes which can affect one's ability to walk for which she has not yet been diagnosed.

Dr. Hsu opined that her lower extremity problems are unrelated to the cervical spine because the cervical spine was treated successfully with the discectomy and fusion. The post-surgical MRI studies do not show that the cervical spinal cord is being compressed in any way to cause any dysfunction. It would be possible, but not probable, that the lower extremity problems could be caused by the cervical problem but he could not state this to a reasonable degree of surgical certainty as there was no objective evidence of any kind to suggest this and there are other competent causes of her condition which may not yet be diagnosed. He testified that he does not have an opinion because the lumbar imaging reports do not demonstrate any significant stenosis and the cervical spine images do not demonstrate cord compression.

At issue at the present time is the petitioner's current physical condition which, according to the petitioner, began to deteriorate starting sometime in 2012 while working at Illinois Central Bus and continued to the present day. This includes neck pain, back pain, and bilateral hand and arm pain.

The Arbitrator notes that the petitioner was seen three times by Dr. Ghanayem. She saw him on December 22, 2014, and October 13, 2015, and again on November 6, 2017. The petitioner indicated that she was sent to Dr. Ghanayem by her attorney and Dr. Ghanayem, in his deposition, indicated that he saw her in consultation.

During the course of her consults with Dr. Ghanayem, she did have additional MRIs which were reviewed, and the petitioner admitted that her MRIs for her cervical, thoracic and lumbar spine were normal. Dr. Ghanayem in his first deposition indicated that the petitioner should find another job, as he thought that her cervical condition was

such that she could not drive a bus. He suggested that she was suitable for some sort of office work.

Thereafter, the petitioner began treating with several neurologists and specialists due to the fact that her lower extremities use was deteriorating. She was seen by Dr. Joshi, Dr. Katsamakis, Dr. Schlageter, and Dr. McGonigle. These doctors performed a battery of tests. The petitioner was seen initially by Dr. Schlageter, a neurologist, beginning March 24, 2016. He ordered MRI of the spine and a variety of other tests including MRIs of the brain. He suspected that the petitioner had multiple sclerosis based upon her symptomology. Ultimately, Dr. Schlageter determined that she did not have multiple sclerosis. She last saw Dr. Schlageter on May 5, 2016.

Thereafter, the petitioner sought treatment with Dr. Katsamakis on November 14, 2016. He obtained another MRI of her neck and brain and continued medications and ordered blood tests as well. Dr. Katsamakis concluded on March 13, 2017, that the petitioner did not have multiple sclerosis. The petitioner also had physical therapy during the course of this treatment. Dr. McGonigle suggested putting a walker in her house and using a wheelchair around the house or her scooter.

Dr. Ghanayem, at his second deposition on May 9, 2018, indicated that he had examined the petitioner at the request of her attorney on November 6, 2017, and that her deteriorating lower extremity function was causally related to the original work accident. He suggested that the myelopathy that he diagnosed was due to an injury to the spinal cord. He indicated that he believed this to a reasonable degree of medical and surgical certainty. However, he admitted that he could not find any evidence of

this in any diagnostics nor did he have any other evidence that the petitioner did have myelopathy or that it was related to the alleged work accident other than her symptomology.

Dr. Ghanayem admitted that there were other potential causes for the petitioner's lower extremity problems. However, he suggested that he could not find that any of these could possibly be related to a reasonable degree of medical and surgical certainty.

The petitioner was evaluated twice by the respondent's section 12 examiner, Dr. Wellington Hsu. Dr. Hsu initially examined the petitioner on April 13, 2015. Dr. Hsu indicated that the petitioner's current condition of ill-being as it relates to her cervical spine and indeed all of her conditions were unrelated to the original work accident. He opined that the petitioner had been released at maximum medical improvement and, while she did deteriorate later, he could not find any evidence on the diagnostics or testing to suggest that her neck pain or back pain or any other pain or numbness or tingling were in any way related to the original work accident. At that point in time, the doctor felt that the petitioner could work full duty.

Thereafter, Dr. Hsu re-examined the petitioner on January 22, 2018. At his deposition he was asked regarding Dr. Ghanayem's diagnosis of myelopathy as well as the causal relationship to the original work accident. Dr. Hsu indicated clearly that while myelopathy was a potential condition there was absolutely no diagnostic or other evidence to clearly diagnose a myelopathy nor was there enough evidence to suggest that it was related to the original work accident. Because there was no real evidence to

determine whether a myelopathy was the actual cause of the petitioner's lower extremity problems, Dr. Hsu testified that he could not relate to the myelopathy to the original work accident. He indicated that this would be speculation rather than to a reasonable degree of medical and surgical certainty.

The Arbitrator notes the absence of any diagnostic testing such as MRI that the petitioner's cervical, lumbar or thoracic spine are in any way abnormal. No doctor, no medical records in evidence, no report, no diagnostics indicate a myelopathy.

The alleged cause of the alleged myelopathy is a spinal cord injury. No doctor, no medical records, no report, no diagnostics indicate any spinal cord injury. Dr. Ghanayem surmises that there might be a spinal cord injury that does not appear on any diagnostics. However, his opinions regarding alleged myelopathy and causation were not offered in any of his reports prior to his second deposition. Therefore, although Dr. Ghanayem's opinions are tenuous, they are inadmissible under the holdings of ***Ghere.***

The Arbitrator finds the opinions of Dr. Hsu more persuasive relative to causal connection, or the lack thereof, as it relates to the petitioner's lower extremity condition. The record does not contain sufficient medical evidence to verify a diagnosis to a reasonable degree of medical certainty. Based upon this finding, the Arbitrator finds that the petitioner failed to meet her burden of proving by the preponderance or greater weight of the evidence that her current condition of ill-being relative to her lower extremity is causally related to the original work accident.

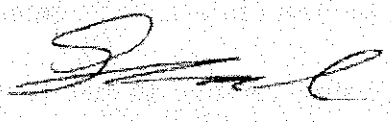
As it relates to the petitioner's other pain complaints regarding her neck, arms, hands and back, the Arbitrator agrees with the opinions of Dr. Hsu regarding causal connection. The petitioner passed her physical to return to work as a bus driver following her cervical fusion, and she worked for two and a half years with almost no treatment. She did not have any additional treatment at all for any condition for at least a year following surgery.

The Arbitrator finds causal connection limited to the original cervical injury and surgery. The Arbitrator finds that there is no causal connection to any of her conditions after her release by Dr. Drake on July 6, 2012.

For the above reasons all other issues are moot.

O. OTHER--CHAIN OF REFERRAL

The Arbitrator finds that based on all of the above regarding causal connection, the petitioner's medical bills after July 6, 2012, are not the responsibility of the respondent.



Arbitrator Paul-Eric Seal

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 correct PPD rate	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVEN SALERNO,

Petitioner,

vs. NO: 14 WC 02029

CITY OF CHICAGO,

Respondent.

19IWCC0443

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 average weekly wage/benefit rates, 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 parties stipulated to an average weekly wage in the amount of $1,944.16, which places Petitioner at the maximum permanent partial disability rate for his January 8, 2014 accident. The arbitration decision applied the incorrect maximum permanent partial disability rate. Respondent and Petitioner agree in their Statements of Exceptions that the correct maximum rate should be set at $721.66. The Commission agrees. Thus, the Commission herein modifies the arbitration decision to reflect the correct permanent partial disability rate of $721.66.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 129.95 (net total weeks) weeks, as provided in §8(d)(2) and 8(e)(9) and §8(e)(10) of the Act, for the reason that the injuries sustained caused the 2% loss of Petitioner's person as a whole (left shoulder, left ribs), 40% loss of Petitioner's left hand, and 40% loss of use of the left arm (left elbow adjusted to 15% loss of use of the left arm after application of a 25% credit - 37.95 net weeks).

19IWCC0443

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent to pay to Petitioner the outstanding and unpaid medical bills and charges from Midwest Orthopedics at Rush and Athletico, pursuant to the fee schedule and 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.

The party commencing 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 19 2019

BNF/jsf
7/17/19
045

Barbara N. Flores

Marc Parker

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SALERNO, STEVEN
Employee/Petitioner

Case# **14WC002029**

CITY OF CHICAGO
Employer/Respondent

19IWCC0443

On 7/10/2018, 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 2.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Salerno
Employee/Petitioner
v.

Case # **14 WC 2029**

City of Chicago
Employer/Respondent

19IWCC0443

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **1/25/2018**. 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 for 00 WC 18629?
O. ☐ Other:

FINDINGS

On **1/8/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$101,096.55**; the average weekly wage was **$1,944.16**.

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

Respondent shall be given a credit of **$167,020.76** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$167,020.76**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **2% of loss of a person-as-a-whole** for his left shoulder and left ribs (10 weeks), **40% loss of use of the left hand** for the TFCC tear with two surgeries and injections (82 weeks), and 40% loss of use of the left arm for the left elbow fracture, adjusted to **15% loss of the left arm** after application of a 25% credit (37.95) weeks, at a rate of **$735.37** per week.

Respondent shall pay outstanding and unpaid medical bills and charges from Midwest Orthopaedics at RUSH and Athletico, pursuant to the medical fee schedule.

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

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

Signature of Arbitrator

July 9, 2018
Date

JUL 10 2018

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?; ***N:*** Is Respondent due any credit for a prior left arm injury?

It was agreed that petitioner's Average Weekly Wage was $1,994.16. It was also agreed that Petitioner was entitled to Total Temporary Disability benefits commencing January 8, 2014 through June 27, 2016, 128 & 5/7 weeks.

STATEMENT OF FACTS

On January 8, 2014, Petitioner Steven Salerno was an employee of Respondent City of Chicago, Department of Fleet Management. On that date, Petitioner began his day at 7:00 a.m. at a building on 52nd and Western in Chicago. At approximately, 8:30 a.m., Petitioner was pumping windshield fluid from a drum into a vehicle. The drum of windshield fluid sat on top of a wooden skid, secured by shrink-wrap. As Petitioner stepped off the skid, his right foot caught the shrink-wrap and he fell over onto the concrete floor. Petitioner testified that as he fell forward, he extended his left arm to break his fall. Petitioner felt immediate pain in his left wrist, left elbow, ribs, and left knee.

Petitioner reported his injury to his supervisor and was referred to MercyWorks for medical care.

Thereafter, Petitioner consulted his own physician, Dr. Todd Simmons of Orthopedic Surgery Specialists on January 9, 2014 for his elbow and ribs. Dr. Simmons' records indicate Petitioner was referred by Dr. Bruce Bernheim.

Petitioner presented to Dr. Simmons with a history of his work accident the day before and complaints of pain and swelling in the left elbow and forearm. Petitioner reported that he had had x-rays of the left shoulder, left elbow and, and left wrist. He was diagnosed with a left radial head fracture. Dr. Simmons evaluated Petitioner's left shoulder, left elbow, and left wrist pain. Dr. Simmons reviewed the MercyWorks x-rays, noting the left shoulder showed signs of prior surgery, questionable fractures of left 11th

and 12th ribs, a nondisplaced radial head fracture in the left elbow, and no acute abnormality in the left wrist.

Dr. Simmons diagnosed a closed fracture of the head of the left radius. He recommended 10 to 14 days off work at which time Petitioner could return to light-duty one-handed work. He also recommended continued treatment for the radial head fracture and discussed physical therapy.

Petitioner returned to Dr. Simmons January 30, 2014. Examinations of the left shoulder, left elbow, and left wrist were essentially normal, except for reduced range of motion in the elbow. Dr. Simmons noted that the Petitioner's shoulder complaints were consistent with impingement syndrome and recommended range of motion exercises and occupational therapy. Petitioner was kept off work. On February 20, 2014 Dr. Simmons noted Petitioner's improvement with our occupational therapy. He still had occasional soreness in the elbow and the wrist. Petitioner was kept off work.

Petitioner returned to Dr. Simmons March 13, 2014. He reported improvement but still had pain and mild swelling in the distal forearm. Petitioner was to return in three weeks to discuss returned to work versus work hardening. Petitioner was to remain off work. On April 1, 2014 Petitioner reported that his elbow was feeling good but that he still had pain over the distal forearm and ulnar side of the left wrist. Dr. Simmons found excellent motion in the left elbow and forearm. He discussed the possibility of TFCC (triangular fibrocartilage complex) tear and recommended an MR are arthrogram of the wrist. He continued to keep Petitioner off work. Petitioner's condition was essentially unchanged April 10, 2014

The May 7, 2014 MRI arthrogram confirmed a TFCC tear, non-specific lunate edema, and a tiny cyst in the distal pole scaphoid. Petitioner testified that he did not remember who referred him for the MRI.

Petitioner was referred to Dr. Ho Min Lim of Orthopedic Surgery Specialists for his left wrist complaints. On May 16, 2014 Dr. Lim found signs and symptoms of adhesion of the flexor and extensor tendons secondary to a fall in January which caused a minimally displaced left radial fracture. Dr. Lim noted the MRI findings of TFCC tear although petitioner was totally asymptomatic in that area. Dr. Lim recommended Petitioner continue with occupational therapy and follow with Dr. Simmons.

Petitioner saw Dr. Simmons June 17, 2014. Petitioner's complaints were essentially the same. Petitioner reported improvement with therapy but still had a constant dull ache in the left wrist. Dr. Simmons noted that Dr. Lim did not feel that the TFCC tear was significant enough or surgical correction. Petitioner was to continue with

occupational therapy. He also noted that Petitioner was to seek another opinion. Dr. Simmons again kept Petitioner off work.

Petitioner sought a second opinion for his left wrist with Dr. John Fernandez of Midwest Orthopaedics at RUSH on July 8, 2014. Petitioner presented with complaints of left wrist and hand pain from a fall at work January 8, 2014. He also reported that he injured his left-sided ribs and left elbow. X-rays revealed ulnar-positive variance indicative of ulnocarpal impaction. Dr. Fernandez diagnosed left wrist ulnocarpal impaction with positive ulnar variance injury and left wrist injury post fall at work, 01/08/2014. Dr. Fernandez recommended physical therapy and performed a left wrist ulnar-sided pain injection. Dr. Fernandez kept petitioner off work.

Petitioner followed with Dr. Fernandez through August 2014. On August 28 Dr. Fernandez recommended arthroscopic debridement. Dr. Fernandez performed arthroscopic debridement of central triangular fibrocartilage, lunotriquetral ligament, and chondromalacia of lunate and triquetrum of Petitioner's left wrist on October 20, 2014. Petitioner went through post-operative physical therapy.

Petitioner continued to be symptomatic. Dr. Fernandez performed another left wrist TFCC injection July 8, 2015.Dr. Fernandez recommended and performed arthroscopic debridement of central triangular fibrocartilage, lunotriquetral ligament, and chondromalacia of lunate and triquetrum (ulnocarpal impaction) with ulnar shortening osteotomy December 2, 2015. Dr. Fernandez also applied a Wright plate and fixation screws. Dr. Fernandez fitted a wrist splint and ordered physical therapy.

Petitioner continued to follow with Dr. Fernandez and physical therapy. Petitioner reported continued improvement in his symptoms. On June 14, 2016, Dr. Fernandez noted Petitioner was at MMI and authorized return to work full duty without restrictions.

Petitioner testified that following Dr. Fernandez's release, he returned to full duty work in his usual and customary position as a Hoisting Engineer. Petitioner testified that since returning to work he earned the same or higher wages that he did at the time of the January 8, 2014 accident. Petitioner testified that since returning to work, he has not sought any additional treatment for his left arm or left hand. Petitioner further testified that since returning to work he has not missed any time from work for injuries from his January 8, 2014 work accident.

Petitioner offered no evidence regarding any current effects or symptoms relating to his injuries or any diminished capacity in either his work life or his home life.

On cross-examination, Petitioner acknowledged that he had sustained a prior work injury to his left shoulder in 1999 while employed by Respondent. He filed a

Workers' Compensation claim for that injury. Petitioner settled that claim for 25% loss of use of his left arm

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner proved that his current condition of ill-being is causally related to his work accident on January 8, 2014. The issue was not genuinely disputed.

Petitioner sustained an objective injury, a TFCC tear which required two arthroscopic surgeries with a plate and a displaced left radial head fracture. Petitioner underwent several courses of extensive therapy, both pre-operatively and post-operatively. Although Petitioner was noted to have signs of left shoulder impingement there was no indication that the prior left shoulder injury was neither aggravated by nor contributory to Petitioner's January 8, 2014 work accident. Petitioner received no therapy for his shoulder. Fractures of the left 11th and 12th ribs were suspected but Petitioner did not receive medical intervention for those related complaints.

Petitioner sought emergency care on the date of his accident, January 8, 2014. He followed up the next day with orthopedist Dr. Todd Simmons, who confirmed a radial head fracture the left elbow. Petitioner received extensive physical therapy to his elbow at Athletico on referral from Dr. Simmons. Persistent left wrist complaints led to a referral to Dr. Ho Min Lim. Petitioner sought care with Dr. John Fernandez for his unresolved symptomology in his left wrist. Dr. Fernandez gave Petitioner an injection in his left wrist which did not resolve his complaints. Dr. Fernandez performed arthroscopic debridement surgery in October 2014, which was followed by additional physical therapy. Unfortunately, Petitioner's symptoms continued post-operatively to where Dr. Fernandez injected Petitioner's left wrist a second time, then in July 2015. Petitioner's continuing complaints led to a second arthroscopic debridement but also a shortening of the distal ulnar at the wrist with plate and screws in December 2015. Dr. Fernandez found Petitioner at MMI in June 2016 and released him to full duty work.

The chain of events and the documented opinions of Drs. Lim and Fernandez clearly established the causal connection between Petitioner's injuries and necessary medical care and Petitioner's work accident January 8, 2014. No evidence to rebut this connection was offered by Respondent.

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

As noted above, there was clear evidence that Petitioner's injuries to his left elbow and left wrist, as well as his left-sided chest and left shoulder, were causally connected to his work accident. The Arbitrator finds that petitioner proved that the medical services provided to Petitioner for care and treatment of these injuries was reasonable and necessary. Likewise, the Arbitrator finds that Petitioner shall pay all reasonable and appropriate charges for those medical services, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

There was no apparent dispute regarding the immediate medical care provided to petitioner for his injuries. Records note that based on utilization reviews Petitioner's initial surgery and subsequent surgery were not authorized. However, both surgeries ultimately authorized, apparently based on successful peer-to-peer appeals. The utilization reviews were not independently offered in evidence. Nor was there medical opinion evidence offered to rebut the reasonableness and necessity of Petitioner's medical care.

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

Petitioner's permanent partial disability was evaluated in accord with §8.1b(b) of the Act:

(i) No AMA impairment rating was offered in evidence with regard to Petitioner's left shoulder injury, left elbow injury, left wrist injury, or left ribs injury. The Arbitrator can give no weight to this factor.

(ii) Petitioner was employed as a Hoisting Engineer by Respondent. Physical therapy notes documented this was a heavy labor occupation. Due to the nature of Petitioner's injuries is physicians kept him off work for nearly 2 years. Petitioner was released to full duty work without restrictions. The Arbitrator gives great weight to this factor.

(iii) Petitioner was 54 years old at the time of his accident. He had a statistical life expectancy of 26.5 years. The nature of Petitioner's injuries as well as the medical care he received suggest that it is likely he will continue to suffer from subjective complaints with his left elbow and left wrist for the remainder of his life. The Arbitrator gives great weight to this factor.

(iv) There was no evidence that Petitioner's earning capacity was adversely affected by his injuries. When he returned to full duty work he was earning wages at the same rate or higher than he was earning on the date he was injured. The Arbitrator gives no weight to this factor.

(v) The medical evidence documented that Petitioner sustained a left radial fracture in his elbow. That fracture was variously described as nondisplaced and minimally. The fracture did not require reduction

although Petitioner was fitted with a sling and referred for physical therapy.

The medical evidence also established that Petitioner sustained a TFCC tear in his left wrist which necessitated injections and two arthroscopic surgeries. The second surgery not only involved debridement by the included shortening of the ulnar at the wrist, requiring plate and fixation screws.

There were suspicious but unconfirmed fractures of the 11th and 12th ribs on the left. However, there was no apparent medical intervention for this finding. In fact, complaints about the left chest disappeared from medical notes rather quickly after the accident.

There were indications of signs of impingement in petitioner's left shoulder. There was evidence that petitioner had prior left shoulder surgery, the extent of which was not documented. Again, as with the ribs, complaints about the left shoulder disappeared from medical notes rather quickly after the accident.

Petitioner sustained clearly objective injuries to his left elbow and left wrist, both of which required physical therapy and, in the case of the wrist, injections and surgery.

In light of all the evidence, including the 5 factors above, the Arbitrator finds that Petitioner sustained permanent partial disability of 2% loss of a person-as-a-whole for his left shoulder and left ribs (10 weeks), 40% loss of use of the left hand for the TFCC tear with two surgeries and injections (82 weeks), and 40% loss of use of the left arm for the left elbow fracture, adjusted to 15% loss of the left arm after application of a 25% credit (37.95 weeks).

N: Is Respondent due any credit?

The Arbitrator finds that Respondent is entitled to a credit for a prior injury, 00 WC 18629, for which Petitioner received 47.29 weeks or 25% loss of use of the left arm, in accord with §8€17 of the Act. Application of the credit, as noted above, results in a net recoverable loss of 15% of the left arm.

Steven J. Fruth, Arbitrator

July 9, 2018
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 up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ARACELI GOMEZ,

Petitioner,

vs. NO: 09 WC 17551

TRU VUE, INC.,

Respondent.

19IWCC0444

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical treatment and expenses, 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.

Causation

Petitioner sustained an undisputed accident on April 6, 2009 when she fell injuring her right hand and lower back. T. 15. Petitioner immediately sought treatment at the LaGrange Hospital emergency room where to failed to voice any neck complaints. T. 32; RX6. Petitioner was referred by her primary care physician, Dr. Shukla for a lumbar spine MRI and to Dr. Harsoor for pain management and injections in her lumbar back. T. 16-20; PX4; PX5. Despite being seen by several providers, the Petitioner voiced no neck pain complaints until almost two months post-accident date when she saw Dr. Harsoor on June 2, 2009. Px5, Rx7.

The Commission agrees with the Arbitrator's finding that the Petitioner's cervical condition is unrelated to the work accident and affirms such finding based upon the lack of neck complaints in the initial medical histories and the interval of time between the accident and the first cervical or neck pain complaints. Petitioner failed to prove a causal relationship between her

accident and her condition of ill-being as it relates to her cervical spine.

On May 28, 2009, Dr. Shukla released Petitioner to return to work as June 8, 2009 with a continued recommendation for physical therapy and pain management. On June 1, 2009, Petitioner sought a second opinion with Dr. Loritz Chavez who authorized Petitioner off work from June 8, 2009 through June 29, 2009 and provided a continued referral for physical therapy at Advanced Rehab Center. Further, Dr. Chavez referred Petitioner to Dr. John Fernandez for right upper extremity pain complaints and Dr. Howard An for lumbar complaints. T. 20-25; PX7; PX8. On July 2, 2009, Dr. Fernandez evaluated Petitioner for a single consultation and referred Petitioner to a pain clinic for an evaluation regarding possible complex regional pain syndrome (CRPS). PX8. On July 17, 2009, Dr. An evaluated Petitioner and recommended continued conservative treatment with no surgical recommendation. PX8.

On August 12, 2009, Petitioner sought treatment from Dr. Goodman, a pain specialist who performed a series of injections to Petitioner's lumbar spine and authorized her off-work. T. 23-25; PX10. On September 8, 2009, Dr. An opined Petitioner suffered from discogenic back pain with radicular pain associated with L4-L5 stenosis which had warranted conservative treatment with noted improvement. Dr. An opined Petitioner could return to work as of October 8, 2009 with a gradual increase in work hours with a full-duty work release as of November 8, 2009. PX8.

Thereafter on October 2, 2009, Petitioner sought treatment with Dr. Scott Rubinstein at Illinois Bone and Joint regarding her right upper extremity. T. 23; Px9. After ordering an EMG/NCV and an MRI of her right forearm both tests which were unremarkable, Dr. Rubinstein agreed with Dr. Fernandez regarding proposed treatment. *Id.* The Commission finds Petitioner first choice of physician to be Dr. Shukla and her second choice to be Dr. Chavez. Therefore, the Commission finds Petitioner's choice to see Dr. Rubinstein was outside of the two referral chains established by Dr. Shukla and Dr. Chavez and denies the medical accordingly.

On November 12, 2009, Dr. Mather, an orthopedic spine specialist, examined Petitioner pursuant to Section 12 of the Act. Dr. Mather opined Petitioner's continued complaints of subjective pain were not supported by organic findings, and at most, Petitioner suffered from a lumbar and cervical strains which were resolved. Dr. Mather placed Petitioner at maximum medical improvement as of May 28, 2009 or 4-6 weeks after the accident with a full-duty return to work. RX1, pp. 23-24; RX1, DepX2.

On November 19, 2009, Dr. Noren, a pain specialist, examined Petitioner pursuant to Section 12 of the Act. Dr. Noren opined Petitioner exhibited multiple examples of symptom magnification involving the upper and lower extremities. Additionally, his examination revealed no evidence of complex regional pain syndrome or reflex sympathetic dystrophy. Dr. Noren found Petitioner to be at maximum medical improvement as well as no objective findings which would prevent her from returning to work. Rx2, pp. 21-31, 38; Rx2, DepX2, DepX3.

On September 29, 2010, Dr. Goodman placed Petitioner at maximum medical improvement and provided a lifting restriction of less than 15 pounds. T. 25; PX10.

The Commission as did the Arbitrator affords greater weight to the opinions of Dr. Mather

and Dr. Noren over those of Dr. Goodman. The Commission further finds that any finding of complex regional pain syndrome is unrelated to Petitioner's work accident based upon the similar findings of both Dr. Mather and Dr. Noren regarding Petitioner's non-organic pain complaints.

Temporary Total Disability

The Arbitrator awarded temporary total disability benefits for 8-6/7 weeks from April 6, 2009 through June 7, 2009. The Commission views the evidence slightly differently and finds Petitioner is entitled to temporary total disability benefits from April 7, 2009 through November 8, 2009 based upon Dr. Howard An's opinion that Petitioner could return to work without restrictions as of November 8, 2009.

Medical Benefits

The Arbitrator found the medical bills incurred by Petitioner through the last treatment with Dr. Harsoor on June 2, 2009 were reasonable and necessary. The Arbitrator also noted the medical payment log submitted by Respondent demonstrates that the provider charges through treatment of June 2, 2009 were reimbursed under the fee schedule and thus no additional disputed medical benefits were awarded. The Commission views the evidence differently and finds Petitioner did not exceed the limitations of Section 8(a) in seeking treatment from Dr. Goodman given Dr. Fernandez' referral for pain management. The Commission finds Petitioner only exceeded her choice of physicians with the treatment sought with Dr. Rubenstein. The Commission further finds Petitioner is entitled to medical benefits through November 19, 2009, the date Dr. Noren opined that Petitioner was at maximum medical improvement. All medical bills thereafter are denied.

The Commission finds that Respondent is not liable for Dr. Rubenstein's or IPN Medical Imaging expenses or any treatment related to Petitioner's neck, cervical spine or CRPS.

Based upon the above, the Commission strikes the phrase "and CRPS" from the Findings/Analysis section of the Arbitrator's Decision on page 19. The second sentence should read "She suffered a lumbar spine strain and a wrist strain for which she was treated by several physicians."

The Commission further finds the Arbitrator's Decision contains a scrivener's error on page three, paragraph four, under the Order section. The Order should read "Respondent shall pay Petitioner for her right wrist injury permanent partial disability benefits of $299.67/week for 12.3 weeks, because the injuries sustained caused the 6% loss of the right hand, as provided in Section 8(e) of the Act."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 5, 2017, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent pay to Petitioner the sum of $299.67 per week for a period of 30-6/7 weeks, from April 7, 2009 through November 8, 2009, that being the period of temporary total incapacity for work under §8(b) of the Act.

19IWCC0444

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $299.67 per week for a period of 12.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 6% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $299.67 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 4% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for reasonable and necessary medical expenses related to Petitioner's lumbar spine and right wrist/hand, except with respect to the diagnosis or treatment for complex regional pain syndrome, through November 19, 2009 under §8(a) and §8.2 of the Act.

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

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

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

DATED: AUG 19 2019
LEC/bsd
O061819
43

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

Maria Elena Portela
Maria E. Portela

D. Douglas McCarthy
Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOMEZ, ARACELI
Employee/Petitioner

Case# **09WC017551**

TRU VUE INC
Employer/Respondent

19IWCC0444

On 9/5/2017, 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 1.11% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 606030000

1120 BRADY CONNOLLY & MASUDA PC
DANIEL J CODY
ONE N LASALLE 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

Araceli Gomez
Employee/Petitioner

v.

Tru Vue, Inc.
Employer/Respondent

Case # **09** WC **17551**

Consolidated cases:

19IWCC0444

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **March 9, 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 **Choice of doctors**

FINDINGS

On **April 6, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**16709.16**; the average weekly wage was $**321.33**.

On the date of accident, Petitioner was **37** 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 and services provided by the petitioner's first two choices of providers.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $299.67/week for 8 6/7 weeks, commencing April 6, 2009 through June 7, 2009, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**10,469.72** for TTD, $**0** for TPD, $**0** for maintenance for a total credit of $**10469.72**.

Respondent is entitled to a credit of $**15,069.97** under Section 8(j) of the Act for non-occupational disability payments.

Respondent shall pay Petitioner for her right wrist injury permanent partial disability benefits of $299.67/week for 12.90 weeks, because the injuries sustained caused the 6% loss of the right arm, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $299.67/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before

the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Ketki S. Steffen August 30, 2017

Signature of Arbitrator Ketki Shroff Steffen Date

ICArbDec p. 2

SEP - 5 2017

Procedural History

This matter petition was tried before Arbitrator Gary Gale on March 9, 2016. 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

The petitioner, Araceli Gomez was 37 years old and had two dependent children at the time of her work accident of April 6, 2009. She testified that she worked as a packer for the respondent for approximately five years. Petitioner testified at he was stuck and fell, hurting her right hand and her low back. She could not catch herself and she bent her right hand and fell on her right hip onto concrete. She felt a strong pain on her tailbone and the right arm up to the neck from when she twisted it. She testified that she had pain in her whole arm, from the hand up to the shoulder, on both the inner and outer sides of her hand.

The petitioner testified that paramedics were called because the pain was too strong for her to sustain her footing. She was taken to the Emergency Room where x-rays were taken and medications given. She testified that the next day she saw her family doctor, Dr. Shukla. She also testified that she saw Work Rite at her employer's request. She testified that Dr. Shukla referred her to Dr. Harsoor, who is a female doctor. She had an MRI and low back injections.

The petitioner testified that she sought a second opinion from Dr. Chavez. She stated that she thought Dr. Shukla was fine but she was desperate due to the pain that she was experiencing. She noted that Dr. Chavez referred her to Dr. Fernandez and

Dr. An. Additionally, Dr. Fernandez suggested she follow up with a pain doctor. She couldn't remember to whom Dr. Chavez had referred her for the pain management.

The petitioner further testified that she saw Dr. Scott Rubinstein at the request of her attorney. She also saw Dr. Goodman but provided no testimony regarding how she was referred there.

She testified that Dr. Goodman performed injections but couldn't recall if any therapy was obtained at Advanced Rehabilitation Centers but remembered going to a center on Wells, which is consistent with the address for that facility. She also received blocks and radiofrequency ablation. Eventually, Dr. Goodman referred her for a functional capacity evaluation which she had at ATI. She was discharged from care on September 29, 2010 and testified she has not followed up with any doctor since that time for her injuries.

The petitioner testified that after the work injury, she contacted the employer about going back on light duty, but that was refused. She first testified that she never returned to work but then later testified that after she was released from Dr. Goodman's care, she did go back working at Primary Staffing boxing chocolates. She stated that some weeks she would work 40 hours and some less, and would stay home sometimes if she was not feeling well. She testified that there was no obligation for her to be there daily. She initially testified that she hadn't worked there lately, but when her attorney followed up she indicated she had worked there the prior Thursday and Saturday, four days before the hearing.

With respect to her current condition, the petitioner testified that she had tenderness in her right hand to her shoulder, pain in her tailbone and her low back. This was increased when she was sitting or standing too long. For treatment, she

would use lotions or take ibuprofen and again testified that she had had no additional treatment since seeing Dr. Goodman in 2010.

On cross exam, the petitioner testified that she told all her providers about the pain in her neck and would disagree with the medical records if they failed to indicate any neck pain. She later said that the pain was primarily in the arm and the back and later developed into her neck.

She denied that she stopped seeing a doctor once the doctor suggested she return to work. She further denied multiple other symptoms that were reported to her doctor and would disagree with records that would suggest she had reported those.

The petitioner further denied having an episode where she felt paralyzed for three or four days after receiving a steroid shot. She further denied telling her doctor this. Additionally, she denied an episode where she had electric shock down her leg and was unable to move her leg for a day. She further denied telling her doctor that. Additionally, she denied telling her doctor that the pain with cold exposure was as bad as having labor.

On April 6, 2009, the petitioner was taken by ambulance to LaGrange Memorial Hospital. She complained of pain to the right wrist, elbow and lower back. X-rays of the lumbar spine and right wrist were negative and the x-ray of the elbow revealed a faint lucency which was not strongly suggestive of a fracture. No evidence of degeneration was noted on the lumbar spine and it was noted that the petitioner landed on her right side because of the fall. The diagnoses at the time of the Emergency Room visit were right wrist pain and low back pain and the petitioner was authorized off work for two days to follow up with her primary doctor. The handwritten notes in the ER record indicate no loss of consciousness, head or neck pain. (RE 6)

The following day the petitioner saw her family doctor, Dr. Shukla at St. Jude Medical Clinic. She reported pain in her right wrist, elbow, back and pelvis after falling at work. Dr. Shukla diagnosed a wrist sprain, lateral epicondylitis and a back injury and pelvic pain. An MRI, x-rays and an EMG were recommended and physical therapy was prescribed. At the next visit, he referred the petitioner to Dr. Harsoor for pain management and the petitioner was now reporting left elbow and wrist pain and low back pain. (RE 4).

The petitioner also was seen at Work Rite at the request of her employer. This also included complaints of low back, right hip, elbow and wrist pain. She was prescribed medication and a back brace and wrist splint and was to begin physical therapy and was authorized off work. She continued to treat through April 29, 2009 when the records note that the petitioner was going to follow up with her own physician. At no point do the records reflect any complaints of pain other than to her low back, right wrist, elbow or hip. The therapy notes there indicate that the petitioner was treated for a lumbosacral spine and elbow and had complaints of right hip, lumbar spine, right elbow and wrist pain. No mention was made of any cervical involvement. (RE 7)

The petitioner did undergo an MRI of her right wrist on April 10, 2009 which was interpreted as being normal. The lumbar MRI showed only mild degenerative changes and disc disease. An MRI of her pelvis showed a cystic structure which represented a possible pelvic congestion syndrome but nothing related to a fall. On April 30, 2009, she had an EMG of her right lower extremity which was interpreted to show a few positive waves compatible with a mild right L4-L5-S1 radiculopathy. (PE 6)

The petitioner continued to treat with Dr. Shukla through May 28, 2009. At that time the petitioner was to continue to follow up with Dr. Harsoor and was allowed full duty as of June 8, 2009, by her primary care doctor. (RE 4)

While treating with Dr. Harsoor on April 21, 2009, the petitioner reported pain in her right elbow and wrist as well as her low back radiating down both legs with the right more than the left. The petitioner reported that she would lose her balance and could fall and the diagnosis was lumbar degenerative disc disease and disc bulge as well as facet arthropathy, lumbar myofascial pain, right lumbar radiculopathy and right wrist pain. A lumbar epidural injection was provided at four levels and on June 2, 2009 the petitioner reported significant improvement. On the June 2, 2009 visit the petitioner reported pain in her neck and down her shoulder, right elbow and right wrist. This was the first mention of any neck pain to a medical doctor. At that point Dr. Harsoor allowed sedentary work with frequent breaks as well as a cervical MRI which was negative. The petitioner failed to follow up with Dr. Harsoor after being released to light duty work. (PE 5)

On June 1, 2009 the petitioner began seeing Dr. Loritz Chavez at Infinite Health & Wellness. She reported that therapy had not been helpful and reported that she had a heavy menses following the fall and again at the time of that visit. She also alleged she would wake up with yellow-tinged eyes and that her face felt numb. She further reported that her head felt heavy and that her right thumb was numb. She also alleged occasional constipation which she felt occurred with the fall and Dr. Chavez reported positive cervical spine tenderness on examination. The assessment was menometrorrhagia, hemorrhagic cyst with abdominal pain, low back pain with sciatica and right extensor tendon tendonitis or lateral epicondylitis. The petitioner was referred

to Dr. Fernandez for an evaluation of her hand. She was also referred to Dr. Fakhouri. Dr. Chavez also diagnosed neck and upper back pain secondary to a muscular strain and spasm. At the second visit Dr. Chavez related all of the pain complaints of the petitioner to her injuries at work and continued her off of work. She again referred the petitioner to Dr. Fernandez for her hand and wrist and Dr. An for her spine. (RE 8)

On June 13, 2009 Dr. Chavez noted the referral to the pain specialist, Dr. Harrison, and felt she should have reviewed the work status. Referrals were provided to Dr. Fernandez, Dr. An and the Rush University Pain Center. By June 22, 2009, Dr. Chavez noted that the petitioner was reporting with a limp and that the back was in spasm. The petitioner followed up again on June 29, 2009 and was reporting a lot of cramps in her right thigh and groin which she claimed paralyzed her right leg. She did report that her arm and shoulder were better but also reported chest wall pain and that she couldn't grip with her right hand or hold anything because of forearm pain. Dr. Chavez noted that Dr. "Harrison" had called the petitioner at home on June 5, 2009 and was asking how the petitioner felt about returning to light duty. Dr. Chavez noted that the petitioner told Dr. Harrison (sic Harsoor) that she could not go back to work. (RE 8) Dr. Harsoor' s records confirm the petitioner did not seek care from her after that date. (PE 5) Dr. Chavez noted that the therapy had addressed her right shoulder and neck pain well and she had only had minimal pain. Right forearm pain continued as did low back pain. Dr. Chavez again referred the petitioner to Dr. Amin at Rush Pain Center. (RE 8)

On July 27, 2009, the petitioner reported to Dr. Chavez that petitioner was now reporting hemorrhoids because she had increased stooling. On September 9, 2009, the petitioner reported that after her first steroid injection she couldn't move her legs for

three to four days. The records further reflect on September 21, 2009 that the petitioner reported that during therapy she received an electric-type shock down her leg and she couldn't move the leg on her own for a day. (RE 8)

The records reflect that the petitioner continued to see Dr. Chavez through December 21, 2009 when she reported that the pain with cold exposure was as bad as having labor. By then the petitioner had begun treating with Dr. Rubenstein. On November 23, 2009 Dr. Chavez noted that the petitioner continued to report ulnar neuropathy despite negative MRI's and EMG's which she suggested was diagnosed clinically. (RE 8)

The medical records also indicate that the petitioner began treatment at Midwest Orthopedics at Rush on July 2, 2009 when she saw Dr. Fernandez. She reported burning pain in the arm in a stocking glove distribution which she claimed radiated to the neck and shoulder. Dr. Fernandez noted some subtle discoloration and cyanosis to the skin which he felt was relatively mild as well as very mild dystrophic findings that he said were "very subtle and mild." He noted no atrophy or paralysis in the hand and no significant examination findings for compression or neuropathy. He felt there was nothing orthopedically he could do for her and thought she might have complex regional pain syndrome and she was referred to the pain clinic. (PE 8)

The petitioner saw Dr. An on July 17, 2009 for her spine. He felt the petitioner had axial back pain with some right-sided radicular pain possibly associated with an L4-L5 stenosis. He thought there may have been a lumbar strain causing the back pain and he ruled out any surgery and recommended additional epidural injections. He did allow the petitioner to be off work and saw her again on September 8, 2009. At that point she was still reporting low back pain and he recommended continued physical therapy but also felt that the petitioner could return to work in three weeks' full duty.

The records reflect that the petitioner failed to follow up with Dr. An after that visit. (RE 8)

On August 12, 2009, the evidence reflects that the petitioner began treatment at Pain Specialists of Greater Chicago with Dr. Goodman. There was no evidence of how the petitioner was referred there either in testimony or in the medical records themselves. She was reporting low back pain and right buttock and leg pain with a gradual onset following a fall at work. Dr. Goodman's exam specifically found no change in hair growth or in her skin complexion or hypersensitivity to light touch. He further did not find any spinal spasms. His examination did report allodynia and dysesthesia of the dorsum of the hand with range of motion limited by pain reports. He again noted no hyperhidrosis, loss of skin folds, contractures, loss of hair, exuberant hair growth or atrophy or ridging of the nails. Despite that, the assessment was complex regional pain syndrome, myofascial pain syndrome, facet syndrome without myelopathy and lumbar sacroiliitis and lumbar radiculopathy. He provided a lumbar epidural steroid injection and allowed the petitioner off work. The petitioner reported an excellent response to the epidural steroid injection and he began treating the wrist and indicated he would come back to the back later. By January 2010, the petitioner was reporting some improvement and indicating she was still getting prescriptions from Dr. Chavez. He had assessed lumbar radiculopathy and CRPS of the upper limb with sacroiliitis that had improved and facet syndrome. He then provided stellate ganglion blocks to the upper extremity. By April 2010, Dr. Goodman was noting that the right shoulder pain had resolved and the low back and right buttock and leg pain had decreased but she continued with right elbow and wrist pain. The records reflect that Dr. Goodman continued to treat her through September 29, 2010 and the diagnosis

remained CRPS of the upper limb, lumbar radiculopathy and sacroiliitis and facet syndrome along with myofascial pain syndrome. An FCE was completed that showed the petitioner was capable of lifting up to 15 lbs. and he put permanent restrictions of sedentary to light physical demand level and placed the petitioner at maximum medical improvement. The records reflect and the petitioner testified that she followed up with no doctors after that time. (PE 10)

Medical evidence was submitted regarding the petitioner's physical therapy at ATI which began on June 29, 2010 for a wrist/hand evaluation. The therapist found no deformities, skin color changes or other deficits except tenderness reported to palpation on the right. The records reflect that the petitioner continued to treat through September 10, 2010 when she was then discharged. On her sixth visit the petitioner reported that she had complaints of pain everywhere and the therapist noted that the petitioner was able to grip a ball despite her low grip testing on the cynanmeter. (PE 11)

The admitted evidence records also show that the petitioner began seeing Dr. Scott Rubinstein on October 2, 2009. It was stipulated that the petitioner was referred to Dr. Rubenstein by her attorney. Dr. Rubenstein noted the normal MRI of the cervical spine and the degenerative changes on the lumbar spine and referenced the L4-S1 radiculopathy on the EMG. He noted the right arm and back complaints and noted the main unresolved issue was the right upper extremity. He felt there was irritation to the radial nerve and recommended a new MRI and EMG and authorized her off work. The EMG was completed on October 23, 2009 and was normal. Additionally, the MRI of the right upper extremity on November 3, 2009 was also normal. Dr. Rubenstein acknowledged this during the return visit on November 18, 2009 and gave the petitioner

another injection. The petitioner had a final follow up on December 7, 2009 and the possible diagnosis was mild sympathetic symptoms and a form of type I complex regional pain syndrome. Sympathetic blocks were recommended but the records reflect the petitioner failed to follow up for any additional care with Dr. Rubenstein. (PE 9)

The respondent offered the testimony and report of Dr. Stephen Mather. Dr. Mather performed an exam of the petitioner on November 12, 2009 at the request of the respondent. Dr. Mather testified that he is a board-certified orthopedic surgeon and 99% of his practice is treating adult spinal disorders. He testified that he does approximately 5 to 6 spinal surgeries every week (RE 1, pg 6-7). Dr. Mather testified that the petitioner provided a history of falling onto her right hand injuring her back, neck and right hand. The petitioner reported that the back pain went down her right leg and caused cramping in the leg which was not a typical symptom for a back injury. The petitioner denied any prior back treatment despite an MRI from 2004 (pg 9-10). Dr. Mather noted that the petitioner was very tearful during the examination which would not be consistent with her complaints and that when her reflexes were tested she would complain of severe low back pain. She specifically complained, when the elbow was tapped, of low back pain which was highly unusual. (pg 11-12) Dr. Mather noted that there was no anatomical explanation for that type of reaction. He further noted overreaction and struggling to get out of her chair and only extending 5° and flexing forward 20° due to reports of pain. He found no spasm but even to light touch the petitioner would complain. He noted reports of a lot of pain with lateral bending which generally shouldn't cause much back pain. Dr. Mather noted that these complaints were inconsistent with anything found on the petitioner's MRI. He noted that they were highly

suspicious and almost diagnostic of some sort of emotional problems or secondary gain. (pg 12-13) He further noted that the lack of spasm would be unusual in someone having that much difficulty getting up from a chair. Dr. Mather noted that most back disc problems would cause significant problems either in flexion or extension but usually not both that would be major as she demonstrated. He noted that she had normal muscle testing but refused a heel and toe walk which suggested secondary gain. He further noted the markedly different complaints by the patient for sitting and supine straight leg raising. They should yield similar complaints. (pg 15-16) He further noted that the petitioner reported severe pain and cramping with simultaneous flexing of the hip and knee which should create no significant symptoms in the back and further she complained of severe back pain when checking range of motion of the hips which is inconsistent with organic disease. (pg 16-17)

Dr. Mather reviewed an MRI from April 10, 2009 and May 29, 2004 and felt that they were both 100% completely normal. He additionally reviewed records from LaGrange Hospital, St. Jude's Medical Center, Dr. Chavez, an MRI of the cervical spine from Lincoln Imaging, Rush Pain Center, Work Right Occupational Center, Dr. Harsoor, an EMG and physical therapy records as well as records from Dr. An and Dr. Fernandez, Dr. Rubenstein and Dr. Goodman. (pg 18) Dr. Mather felt that the two MRIs that were done at the same facility for Araceli Gomez were completely normal and showed no serial change. Additionally, the cervical MRI revealed only a developmental finding which would not be traumatic in nature. (pg 20). He further noted that the records he reviewed revealed that the objective testing was essentially normal and that many of the physicians found complaints that they could not explain. He felt that the epidural steroid injection in May 2009 was not recommended because of the normal

anatomy and the potential risk-benefit ratio. The purpose of the injection is to reduce inflammation associated with nerve root compression but no nerve root compression was noted on the MRI. (pg 21) He further stated that after little relief to the first injection and with normal anatomy there really shouldn't be a second injection. Dr. Mather felt that the EMG showed nonspecific findings in the back of the hamstring but nothing below the knee and therefore no radiculopathy. Dr. Mather agreed with Dr. An's MRI interpretation noting no disc problems at any level. He further noted the diffuse issues that Dr. Rubenstein could not explain which were consistent with his own examination and report of symptoms of the petitioner. (pg 23)

Based upon his review of records and films, the history obtained and his examination Dr. Mather felt that the petitioner's diagnosis was non-organic pain behavior and he could not explain her symptoms.. He felt that at most, she had a neck and back strain on April 6, 2009. Dr. Mather noted six examples where the petitioner seemed to be exaggerating her symptoms. (pg. 24) If she did sustain a cervical and lumbar strain then she would have recovered within 4 to 6 weeks and should have been able to go back to regular work when released by St. Jude on May 28. Dr. Mather felt that most the petitioner would have missed for six weeks with stretching, exercises and over-the-counter pain medication and then should have been able to return to regular work. (pg. 25-26)

On cross-examination, Dr. Mather indicated that the diagnosis was nonorganic pain syndrome and a lumbar strain. He disagreed with the diagnosis of stenosis. He did agree that therapy until May 28 would've been appropriate and some nonnarcotic pain medication as well. (PE 12, pg. 31) He did not believe that Lyrica was appropriate at all for back pain and that Vicodin should only have been used in the first 7 to 10 days. He

did believe that the MRI was reasonable and necessary as well as the EMG but did not believe that a referral to a pain specialist was reasonable. Dr. Mather indicated he did approximately three or four independent medical exams per week mostly for insurance companies. (pg. 34-36)

The respondent also offered the testimony and report of Dr. Richard Noren who performed an examination of the petitioner on November 19, 2009 on behalf of the respondent. Dr. Noren testified that he is board certified in anesthesia with a subspecialty in pain management since 1993 and 1996. He specializes in treatment of chronic pain. (RE 2, pg. 5) Dr. Noren testified that the petitioner completed the pain diagram and reported having fallen. She reported low back pain that was constant, leg numbness and stiffness in her toes which she said had resolved. (pg. 11-12) Dr. Noren noted that doctors Rubenstein had injected the petitioner's elbow the day before the examination but the petitioner did not mention if it helped or hurt. The petitioner reported color changes of redness and darkness but no nail changes. (pg. 14) He noted that the petitioner brought a brace to her office but was not wearing it. The petitioner reported being unable to wear sleeves and indicated the brace hurt her. Dr. Noren noted that the petitioner's husband had to help the petitioner get out of the chair and step up on the exam table and she moved with a very slow gait with her right foot turned outward. He felt that this was an unusual presentation and that even his extreme elderly patients generally can get out of the chair by themselves or can get on the exam table. He could not think of any other patient in the prior year or two that had been unable to do so. (pg. 16-17) The petitioner reported diffuse allodynia from her upper extremity to the elbow and from the elbow to the hand. Despite this, Dr. Noren noted that the petitioner would frequently rub her arm to demonstrate where she had the

allodynia which is pain to light touch. (pg. 17) Dr. Noren noted that the brain would not be able to distinguish from when she was touching it or he was touching it and it would be very unusual for a patient to rub their own skin while complaining of severe pain to light touch. Undistracted testing, however, the petitioner failed to report any pain at touching. (pg. 19) Dr. Noren felt that this was therefore a fictitious complaint. He further noted that the petitioner had equally week handgrip it would facially grimace and on the movement against resistance it was if her arm was paralyzed. (pg. 21-22) He further noted that the petitioner complained of back pain while moving her toes which would have no physiological basis. The petitioner also had a positive Waddell finding of symptom magnification with light touch to her back and noted the inconsistent use of the biceps during different testing. Dr. Noren also noted the petitioner reported red and purple discoloration involving the upper extremity which he said was almost a first for him. He was unable to see any discoloration and the petitioner's husband and interpreter both were asked and were unable to see any discoloration despite the petitioner telling him that it existed at the time. (pg. 25-26) Dr. Noren also noted that there were no changes in the skin folds between the petitioner's two hands and that the hair pattern was equal on both sides. Further, Dr. Noren noted positive Waddell findings which could be indicative of narcotic seeking or secondary gain. He noted that those are non-physiologic findings. (pg. 28-30)

Dr. Noren testified that based upon his examination, the history given in the records reviewed the petitioner had a such a high degree of symptom magnification that it was difficult to make a formal diagnosis. He noted no exam findings to suggest complex regional pain and noted the changes you would typically see. (pg. 31-32) Dr. Noren noted that treatment for tendinitis by Dr. Rubenstein would be inconsistent with

the diagnosis of CRPS. If someone really had CRPS you would not inject the extremity which would inflame or aggravate it. Dr. Noren did not think that Dr. Rubenstein felt the petitioner had CRPS or he would not have provided the injection. (pg. 33-34) Dr. Noren testified that he would not disagree that the petitioner might have had a tendinitis of the upper extremity but that she did not have complex regional pain. (pg. 34-35) Based on presentation, the petitioner would not have been able to work but there was no objective support found for that presentation. (pg. 36-37) He further testified that there were no objective findings that would prevent her from returning to work and further that she did not require additional treatment. He further noted that the petitioner had not been taking medication as prescribed previously which usually was a result of side effects or that the petitioner was not having pain and the petitioner failed to report any side effects. (pg. 38-39)

On cross-examination, Dr. Noren noted that the MRI and EMG reports were consistent and there were no findings that would explain an S1 radiculopathy. He noted that the petitioner might have tendinitis but that he wouldn't think you would get that from falling off a skid. He did think it likely that the petitioner suffered a back strain because of the fall and some therapy would have been reasonable as well as some medication and the transforaminal injections but not for diagnostic purposes. (pg. 42-44)

Findings/Analysis

With respect to issue (F), whether the Petitioner's current condition of ill-being is causally related to the accident, the Arbitrator finds as follows:

The Petitioner did suffer a work accident on April 6, 2009. She fell and injured her right hand and fell on her right side. She suffered a lumbar spine and CRPS for which she was treated by several physicians. Petitioner claims that she currently suffers

great pain and discomfort caused by her work accident and that she suffers from complex regional pain syndrome. The Respondent's position is that the Petitioner has long healed from the sprain injuries and that her current condition is not related to her accident.

Initially the Arbitrator notes that the Petitioner's cervical condition is not related to the accident. Although Petitioner claims that she hurt her neck there is no documentation of said injury until over six weeks after the accident. Although the Petitioner disagrees with the medical reports, the Arbitrator notes that the records of LaGrange Hospital, Work Right, St. Jude Medical Center and Dr. Harsoor all failed to reveal any neck complaints.

As to her claims relating to the hand and lumbar spine, the record shows Petitioner treating with several different physicians for this ailment (some outside of the chain of referrals). The Arbitrator notes that the medical history shows that Petitioner stopped treating with her physicians when they suggested that she can return to work. The Arbitrator finds this aspect of Petitioner's medical history to be troubling. Specifically, both Drs. An and Fernandez felt the petitioner did not have any surgical problems and Dr. Fernandez felt that there was nothing orthopedically to be done for the hand sprain. Her family physican, Dr. Shukla, noted that many of her symptoms could not be explained. they could not explain some of her symptoms. The petitioner presented with strong Waddell findings and other non-physiologic symptoms when seen by both Dr. Mather and Dr. Noren. Both Drs. An and Fernandez felt the petitioner did not have any surgical problems and Dr. Fernandez felt that there was nothing orthopedically to be done for the hand at all.

Upon these diagnosis and findings, the petitioner admitted seeking a second opinion with Dr. Chavez. The medical reports show unusual and unrelated medical complaints by the Petitioner. (Petitioner reported being paralyzed for three to four days after an injection but denied the same during court testimony). Dr. Noren found her extreme pain complaints to be inconsistent with the medical evidence. There is no objective test or MRI findings to support Petitioner's contentions that her injury was beyond a sprain. (No fracture to hand, negative results on the MRI and EMG of the upper extremity).

The Arbitrator also notes the testimony of Dr. Mather who indicated that petitioner, at best, suffered a lumbar strain and would have been at maximum medical improvement and able to work full duty within six weeks of the accident. This is consistent and supported by the findings of Dr. Shukla at St. Jude's Medical Center who released Petitioner to full duty work as of June 8, 2009, Dr. Shukla's findings are supported by the testimony of Dr. Noren who noted that there are no objective findings to support a diagnosis of complex regional pain syndrome. The arbitrator notes the Dr. Rubenstein treatment which consisted of an injection to the arm also discounts a diagnosis of regional pain syndrome.

Lastly the Arbitrator notes that the Petitioner had a negative MRI and negative EMG of her upper extremity and positive Waddell findings and other non-physiological symptoms. Although the Petitioner continued to voice a myriad of complaints to her subsequent physicians, there is no medical test or findings that can collaborate Petitioner's subjective complaints. Therefore, the arbitrator finds that the current condition of ill-being of the petitioner is not causally connected to the April 6, 2009 incident.

With respect to issue (J) whether Respondent is liable to Petitioner for medical expenses, the Arbitrator finds as follows:

Petitioner is seeking the following medical bills, subject to the medical fee schedule: $3,284.37 to Dr. Chavez, $609.00 to Midwest Orthopedics, $2,225.00 to Dr. Shukla, $460.00 to Preferred Open MRI, $14,500.00 to ATI Physical Therapy, $2562.00 to Dr. Harsoor, $8456.23 to Fullerton Surgery Center, $20,097.00 to Pain Specialists of Greater Chicago, $16,291.26 to Hinsdale Surgical Centers, $57,565.19 to Advanced Rehabilitation Centers as provided in Sections 8(a) and 8.2 of the Act.

The arbitrator hereby incorporates his findings with respect to Issues F above as if more fully set out herein. The arbitrator finds that the medical incurred by the petitioner through the last treatment by Dr. Harsoor on June 2, 2009 was reasonable and necessary. The Arbitrator finds that any medical incurred by the petitioner after that date was based upon unsupported subjective complaints that were non-physiologic and non-anatomic and the medical was not reasonable and necessary to alleviate the effects of the work incident of April 6, 2009.

The arbitrator notes that the submitted medical payment log demonstrates that the provider charges through treatment of June 2 have all been reimbursed under the fee schedule. The arbitrator therefore, finds that the respondent is not responsible for any further payment on medical services. The Arbitrator denies awarding medical bill after the June 2nd treatment date based on her findings as to causal connection, that Petitioner was released to full duty work on June 8, 2009 and based on her findings that the cervical issues are not related and based on her findings that Petitioner exceeded her choice of physicians.

With respect to issue (K) whether Petitioner is entitled to temporary total disability, the Arbitrator finds as follows:

The Petitioner was off work from April 7, 2009 through September 29, 2010 and is seeking 77-2/7 weeks of TTD payments. The Respondent had paid TTD from April 7, 2009 through Dr. Mather's full duty release date of June 7, 2009. Based on above findings as to causal connection, the Arbitrator finds that Petitioner was treated, healed and released to full duty by her physicians. The Arbitrator awards petitioner temporary total disability from April 7, 2009 through June 7, 2009 at the rate of $299.67/week for 8 6/7 weeks as provided in section 8(b) of the Act.

With respect to issue (L), what is the nature and extent of Petitioner's condition, the Arbitrator finds as follows;

The arbitrator finds that the petitioner suffered a strain of her lumbar spine and of her right arm. The Arbitrator rejects Petitioner's claim that her current condition of ill-being is related to her accident. The Arbitrator also finds that the cervical complaints are unrelated. The petitioner suffered a permanent disability of 4% of the person as a whole for her lumbar strain. The arbitrator further finds the petitioner suffered a permanent disability of her right arm in the amount of 6%.

With respect to Issue N, Is Respondent due any credit, the Arbitrator finds as follows:

The Arbitrator hereby incorporates his findings with respect to Issue F, J, K and L above as if more fully set out herein. The Arbitrator notes that the petitioner stipulated to temporary total disability benefits paid in the amount of $10,469.72 and non-occupational indemnity disability benefits for which a credit is allowed under Sec 8(j) of the Act of $15,069.97.

With respect to issue (O), whether Petitioner exceed her choice of doctor, the Arbitrator finds as follows:

An employer's liability to pay for medical services selected by the employee is governed by section 8(a) of the Act (820 ILCS 305/8(a) (West 2008)). That provision states in relevant part:

> "[T]he employer's liability to pay for * * * medical services selected by the employee shall be limited to:
> (1) all first aid and emergency treatment; plus
> (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent service provider of medical services in the chain of referrals from said initial service provider; plus
> (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second [**13] service provider." 820 ILCS 305/8(a) (West 2008).
> Thus, pursuant to the plain language of section 8(a) of the Act, an employer is liable to pay for two chains of medical services selected by the employee. However, doctors chosen by the employer as well as first aid and emergency treatment do not count as an employee's physician choice.

The Arbitrator notes that the petitioner's emergency room treatment is not considered a choice of doctors. The petitioner was also seen at Work Right at the request of her employer and this also would not be considered a choice of petitioner. The petitioner's first choice of doctors was her primary care doctor, Dr. Shukla at St. Jude Medical Center. He referred the petitioner to Dr. Harsoor who would then still be part of the first choice of doctors. The petitioner then made her second choice when she began seeing Dr. Chavez at Infinite Health and Wellness. Dr. Chavez referred the petitioner Drs. An and Fernandez and the Rush Pain Center. These are all part of the petitioner's second choice of doctors and within the provisions of Section 8 of the Act.

The arbitrator notes that the petitioner chose not to seek pain management with Rush Pain Center but instead went to see her third choice, Dr. Goodman at the Pain

Specialists of Greater Chicago. The arbitrator notes that this is not a case where the second choice of doctors gave her a general referral to a pain doctor but instead to a specific provider whom the petitioner chose not to see. No evidence was presented as to how the petitioner came to be seen by Dr. Goodman and therefore this would be the petitioner's third choice of doctors. The petitioner admitted that she was sent to Dr. Rubenstein by her attorney and therefore this would be considered as the petitioner's fourth choice of doctors. Based on the facts, the petitioner's request for reimbursement for medical incurred by Dr. Goodman, Dr. Rubenstein or for any medical prescribed by them including Advanced Rehabilitation Centers after June 2, 2009 and ATI is denied.

Ketki S. Steffen — *August 30, 2017*

Arbitrator Ketki Shroff Steffen — Date

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rodney Buckley,

Petitioner,

vs. NO: 16 WC 6581

Grayslake Fire Protection District,

19IWCC0445

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, prospective medical expenses and temporary total disability, reverses the Decision of the Arbitrator and denies Petitioner's claim for compensation, for the reasons stated below.

Findings of Fact

Petitioner testified that he had previously injured his right knee in high school, and that he had arthroscopic surgery to remove loose pieces right after he graduated. (T.11). He indicated that he did not undergo physical therapy following surgery and subsequently resumed physical activities, including running a mile, within a week. (T.11-12). He denied receiving any treatment for or experiencing any difficulties with his right knee from that time until 8/31/15. (T.12-13). Petitioner noted that he began working part-time for the Grayslake Fire Protection District on 5/1/91, and that he went full time on 1/1/96. (T.13). He indicated that he was part-time status from May of '91 until January of '96 during which time he worked as a firefighter/EMT and then a paramedic. (T.13-14). He stated that he also worked full time for two years for the Sheridan Fire Department, and that after he became a paramedic he left there to work for the Gurnee Fire Department. (T.14). He indicated that he was then offered a full-time position on 1/1/96. (T.14). He noted that he is currently a lieutenant with the Grayslake Fire Protection District, a Station 1 officer, and acting battalion chief when the battalion chief is off for the day. (T.14).

Petitioner testified that on 8/31/15 he was "... a station officer assigned to an engine or ladder depending on the day." (T.14). He noted that he worked a 24-hour shift on, 48 hours off. (T.14). He indicated that prior to that day he did not have any difficulty doing his job with respect to his right knee, and that he did not miss any time from work because of same. (T.15). Petitioner testified that on the day of the alleged accident (8/31/15) he started work at his scheduled time of 7:00 a.m., and that he arrived at the station at 6:00 a.m. (T.16). He noted between his arrival time and the start of his shift he "[w]alk[ed] on the treadmills, coffee. At shift change would change information. Showering and cleaning up." (T.16).

Petitioner testified that on the morning of the alleged accident he responded to a motor vehicle accident on Rollins Road west of Route 45. (T.16-17). He noted that "[o]n that particular call, I assisted medical personnel from the ambulance evaluating patients. Also, it's my responsibility for seeing management, controlling where the engine goes, equipment that comes off the engine, and seeing safety." (T.17). He indicated that when he got to the scene he "... instructed the driver where to park the vehicle in order to protect the scene, got out and met up with several individuals that were already out of their vehicle and ascertained the status of medical needs." (T.17). He stated that "[t]he truck parks on an angle to deflect any potential vehicles not stopping" and that he was seated in the front right seat. (T.17). He did not recall how long he was at the scene. (T.18).

Petitioner noted that "[w]hen our vehicle and my crew [were] no longer needed, we went to go leave the scene. In order to do so, we had to back the truck up and around to go from eastbound to westbound on a 4-lane highway... Per our policy, we require a backer. So I backed him up. Once the engine was out of the eastbound lanes, I ran around the front and jumped up into the engine to hurry up and get out of the way of traffic." (T.18). When asked to describe these movements, Petitioner noted that "[g]oing around the front of the engine requires a right hand pivot on the driver's side corner and then another right hand pivot on what we call the officer side of the apparatus or the engine. I grabbed the door latch, pivoted again, and jumped up into the step from the seat and then got in the vehicle all in – I guess it appears as a fluid motion. There is no separation of steps." (T.18-19). The engine then returned to the station. (T.19).

When asked to describe the space in the front right passenger section of the engine, Petitioner noted that "[t]he front seat for where I have to sit is barely larger than I am. So I am unable to move my feet around or legs around at all while I'm sitting in there. So my legs did not move once I was seated." (T.19). He indicated that his legs were kept at a 90-degree angle, similar to how he was sitting at arbitration, with his feet on the ground. (T.19-20). He noted that when they returned to the station he got out of the engine but was unable to straighten his leg. (T.20). When asked to describe the movement involved in getting out of the engine, Petitioner testified that "I pivoted down. One step goes – one leg goes on the step, the other leg goes down to the ground. The right leg went to the ground, but I wasn't able to straighten it." (T.20). He indicated that he did not have any difficulty straightening his leg prior to responding to the MVA, and that his knee felt "[u]ncomfortable" as he was trying to exit the engine. (T.20). He noted that he had not felt this sensation prior to responding to the MVA. (T.21).

Petitioner testified that after he exited the engine he went to a meeting inside the fire station. (T.22). He indicated that as he walked from the engine to the meeting he noticed that he "... was

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not able to extend my right knee all the way, and I had to walk into the meeting with a limp." (T.22). He stated that when he left the meeting he was still unable to straighten his knee and that "[t]he discomfort was getting more extensive." (T.22-23). He noted that he then went to another location [presumably in the fire station] where he sat down to conduct verbal training. (T.23).

Petitioner testified that following this training he "... went to go inform the deputy chief that my crew was leaving to go on an errand" when he attempted to straighten his leg, it gave out, and he fell to the ground. (T.23). He noted that prior to falling to the ground he noticed that "[t]he discomfort was continuing. It was not going away. Despite the fact I kept trying to straighten it when it finally gave way, there was a popping sound when I went to the ground. I got up on one leg and hobbled to my office, and that's when the deputy chief came into my office because he had seen through his window that I had fallen." (T.23-24). He noted that he had to hobble to his office "[b]ecause I could not put any weight on my leg." (T.24). Petitioner indicated that the deputy chief "... asked what was going on, what happened, if I was all right. Through the course of the conversation, I informed him that I was not able to put any weight on it. We had a conversation about going to the hospital. I actually contacted the department doctor, and his recommendation was going to the ER." (T.24).

Dan Pierre testified that he is a deputy fire chief with the Grayslake Fire Patrol District, a rank he has held for a little less than two years. (T.72). Before that he was a division chief for five years, and has worked for Respondent for 23 years. (T.73). He noted that he is a supervisor, but that he is not Petitioner's immediate supervisor; instead, he indicated that he is Petitioner's supervisor's supervisor. (T.73).

Mr. Pierre noted Respondent's accident reporting policy is "[t]hat when an injury occurs, the person reports the accident to his immediate supervisor and fills out an incident report." (T.73). He noted that this is to occur "[a]s soon as possible", including if they are in the station. (T.74).

Mr. Pierre testified that on 8/31/15 "I was at my desk, and Lieutenant Buckley had walked in the hallway outside of my office. There is a door and a window; and when he passed by the window, I could see that he went down. I called to him and asked him if he was all right. I left my chair to go investigate. When I got into the hallway, I noticed that Lieutenant Buckley had made it through the door to his office and so I proceeded to his office to speak with him." (T.74-75). Mr. Pierre noted that Petitioner reported that "... he had pain in his knee and that it gave out. He had positioned himself in his chair in his office. So at that point, I could see that he was in discomfort, pain. He was a little pale, a little diaphoretic. So we basically at that point initiated care as paramedics." (T.75). He also indicated that Petitioner "... did state that he wasn't able to bear any weight on his leg... I recall that he stated that prior to the incident, he was – there was a stiffness in his knee." (T.75).

Mr. Pierre testified that Petitioner did not report to him any incident of jumping in and out of the engine that morning. (T.76). He indicated he was at the station all morning, but that he could not recall whether he saw Petitioner before the buckling incident. (T.76). Mr. Pierre stated that he was aware Petitioner went on a fire run that morning for a motor vehicle accident. (T.76-77). He testified that Petitioner did not report a work injury to him when he returned from that fire run. (T.77). Further, Mr. Pierre indicated that after the buckling incident Petitioner did not report

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an incident at the fire run that morning to him. (T.77). However, he noted that they had spoken in the car on the way to see the doctor and that "[h]e had discussed that he had some soreness previous to that, that he had been running on the treadmill at home a lot lately and that he had some stiffness earlier during his shift." (T.77-78). He also stated that when Petitioner went by his office at the time of the buckling incident he appeared to be walking. (T.78). Mr. Pierre further recounted that "[w]hen I left my office, I looked on the ground obviously because I thought he was on the ground. There didn't appear to be anything on the ground that caused him to fall." (T.78).

Mr. Pierre indicated that they keep an accounting of all fire runs, and that they are required by the State to report to a national fire reporting system. (T.78). He noted that these records are kept in the normal course of business. (T.79). Mr. Pierre was shown RX7, a copy of a National Institute Fire Incident report ("NIFIR"). (T.79). He stated that it appears this exhibit contains all of the reports that were prepared for 8/31/15. (T.79). He noted that these reports are a way to identify if there was an injury to someone in the department on a particular run, and that the incident report for the Rollins Road MVA was "... vacant meaning nobody did." (T.80).

Mr. Pierre testified that between 8:00 a.m. and 2:30 p.m. on 8/31/15 Petitioner never reported an injury to him. (T.83). He agreed that Petitioner currently works full duty for the Grayslake Fire Patrol District as a firefighter/paramedic. (T.83). He indicated that he is not aware of any issues with Petitioner being able to complete his job activities as a firefighter. (T.84). He also noted that Petitioner has been involved in fire suppression activities during that time. (T.84).

On cross examination, Mr. Pierre agreed none of the aforementioned reports were signed by Petitioner. (T.85). Mr. Pierre also agreed that the front passenger or officer's seat provides very little room for mobility, and that someone sitting there is basically confined to one particular position. (T.86).

Petitioner indicated that following the injury he went to the Grayslake Emergency Center, which is part of Northwestern Lake Forest Hospital where x-rays were taken and he was told to follow-up with a physician at Illinois Bone and Joint. (T.25).

In a Northwestern Lake Forest Hospital emergency department note dated 8/31/15 it was noted that the patient "... reports feeling right knee stiffness after returning from call today that did not involve crawling, lifting, or climbing. When he stepped down from engine, he noted right knee stiffness followed by audible 'pop' with acute posterolateral right knee pain and diffuse swelling. He is unable to bear weight on right leg. Denies locking or instability. Denies direct contusion. Denies radicular pain from back or buttocks, numbness or weakness." (PX1). It was noted that "[e]xam limited due to pain and swelling but MOI and McMurray's test support lateral meniscus injury. He has h/o previous surgery right knee for 'cartilage' problem ten years ago. Discussed need for ortho referral given his physically demanding job." (PX1).

Petitioner testified that he was unable to finish his shift and ultimately went home. (T.25). He indicated that he also did not work his next shift and that he did not return to work until 2/17/16. (T.25-26). He stated that he had cortisone shots and physical therapy thereafter. (T.26).

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Petitioner testified that he visited Dr. Pavlatos at Illinois Bone and Joint three days after the alleged accident. (T.26).

In a progress note dated 9/2/15, Dr. Christ J. Pavlatos recorded that Petitioner was a 45-year-old firefighter who presented "... for evaluation of right knee without any previous right knee problems. He was jumping off an engine, he did not hear any pop or any pain at that time. This happened about 3-4 days ago. Since then, he has been having stiffness with progressive pain that requires the use of crutches for ambulation... Pain is anterior and medical in nature." (PX3). Dr. Pavlatos' impression was "[s]ome chondromalacia of the right knee with a possible meniscal tear." (PX3). Dr. Pavlatos recommended an MRI to rule out a meniscus tear. (PX3).

An MRI of the right knee performed on 9/14/15 was interpreted as revealing the following: 1) Medial femoral condylar changes consistent with a remote, healed/bone without focus of osteochondritis dissecans. Morphology suggests that it at one time represented a high-grade or late stage lesion. Limited ability to evaluate articular congruence but no articular cartilage is seen associated with the lesion. No unequivocal loose body seen. No evidence of an active process; 2) Unstable radial tear of the root insertion of the posterior horn of the medial meniscus along extrusion of the body causing mass effect on the MCL. Superimposed horizontal cleavage tear of the posterior horn and body; 3) Large Baker cyst causing significant mass effect on surrounding structures; 4) Moderate tricompartmental osteoarthritis; 5) Moderate joint effusion; and 6) Mild superficial prepatellar bursitis. (PX3).

In a progress note dated 9/16/15, Dr. Pavlatos recorded that "[t]he patient had a workman's comp-related right knee injury, works as a fireman, here for follow up, still complaining of significant pain in his knee with swelling." (PX3). Dr. Pavlatos noted that the MRI showed "... some moderate arthritic changes but clear evidence of the medial meniscus tear... I am also suspicious of an associated lateral meniscal tear." (PX3). Dr. Pavlatos recommended right knee arthroscopy and an intraarticular surgery for a partial meniscectomy, noting that "[w]e will proceed to schedule his surgery once he has obtained workman's comp approval." (PX3).

In a progress note dated 10/21/15, Dr. Pavlatos recorded that Petitioner "... had an IME recently. Now, he is here for evaluation. He is still complaining of significant pain and swelling in his knee." (PX3). He noted "[w]e discussed the results of his MRI showing evidence of degenerative arthritis of his knee in addition to a root tear and horizontal cleavage tear. At this point, we decided to proceed with conservative approach for management of this problem. He was given a cortisone shot... I will have him go through a formal rehab program. Reevaluate in four weeks. If we do not see improvement, possible arthroscopy may be indicated at that point." (PX3).

In an Accelerated/Athletico Physical Therapy progress note dated 11/5/15 it was recorded that the patient had attended 6 appointments and that he reported on 8/31/15 "... he was responding to an auto accident when he was walking across the pavement and felt a snap in his R knee. He was able to complete the call but the pain never went away so his division chief took him to the emergency room in [G]rayslake." (Emphasis added)(PX3).

In a progress note dated 11/25/15, Dr. Pavlatos recorded that the patient "... has failed to respond to conservative treatment with a cortisone shot and therapy. I do feel that at this point this

patient will require a right knee arthroscopy, partial meniscectomy, and chondroplasty… He will proceed to schedule this at his convenience once we have obtained work comp approval." (PX3).

Petitioner indicated that he did not have the surgery in 2015 because workers' compensation would not approve it. (T.27). However, he stated that he did have physical therapy at Athletico in Third Lake in 2015, but that it did not resolve his issue. (T.27-28). He testified that after physical therapy he noticed he still could not straighten his knee all the way and that "[i]t was still not right." (T.28).

In a Northwestern Lake Forest Hospital history and physical dated 1/26/16 it was recorded that Petitioner was being admitted for arthroscopy and intra-articular surgery. (PX2). It was noted that the patient presented with "… moderately advanced arthritis in his knee with evidence of a meniscal tear, treated conservatively with cortisone injections, physical therapy, and anti-inflammatory medication without resolution of his symptoms, having persistent pain in his knee with moderate tricompartmental arthritis…" (PX2).

On 1/27/16 Petitioner underwent a right knee arthroscopy, partial medial meniscectomy, partial lateral meniscectomy and chondroplasty by Dr. Pavlatos. (PX2). The postoperative diagnosis was right knee medial and lateral meniscus tear with degenerative arthritis. (PX2).

In a progress note dated 2/3/16, Dr. Pavlatos recorded that the patient was one week post knee arthroscopy and was "doing great… He is having no complaints. He is quite happy with his progress." (PX3). Dr. Pavlatos noted that "[w]e discussed in detail the results of surgery indicating he does have also significant arthritic changes. He understands at some point, he may require knee replacement in the future, currently obviously not indicated at this time." (PX3).

In a "Generic Rx Form" dated 2/3/16, Dr. Pavlatos noted that "[a]s a result of 8/31/15 work injury to his right knee, necessitating the January 27, 2016 surgical repair, Rodney Buckley remains under my care. May return to desk work duties on 2/4/16 for 2 weeks, then full duty." (PX3).

Petitioner indicated that following surgery he underwent physical therapy at Athletico through February of 2016. (T.28-29). He noted that once he completed physical therapy he noticed that he was able to straighten his knee, but that now he had limited stability and chronic pain. (T.29). He stated that "[a]ny repetitive motion would hurt. Any sharp impacts would hurt. I would not be able to have a normal gait while walking because of the discomfort." (T.29). He indicated that he "… was able to function in my job. It was very uncomfortable to do so. I had to work through a lot of pain to the point that people watching me work could tell I was in a lot of discomfort." (T.29).

In a progress note dated 3/9/16, Dr. Pavlatos recorded that the patient was five weeks post knee arthroscopy with degenerative changes in his knee and that "[h]e is still having discomfort with increased activity… He has been able to return back to work." (PX3). Dr. Pavlatos noted that "[a]t this point, because of persistent synovitis in his knee, he was given a cortisone shot in his right knee." (PX3).

In a progress note dated 4/21/16, Dr. Pavlatos recorded that Petitioner presented with complaints of recurrent right knee pain, noting that "[h]e states he did a significant amount of activity recently at home that seemed to aggravate his knee. He is here for evaluation. No falls or injuries." (PX3). Dr. Pavlatos administered another cortisone shot and noted "I have informed him the degree of arthritis that he had, it is most likely flaring up his knee. I have recommended that he maintain his exercise program and ice on a regular basis and a weight loss program because of the arthritic process in his knee, where he is at risk for a possible knee replacement at some point in the future... If no improvement, possible Monovisc injection." (PX3).

Petitioner noted that following physical therapy he did exercises and iced his knee at home, and that he continued to treat with Dr. Pavlatos. (T.30). He also stated that his activities of daily living were "reduced" and that he could not do the things he could do before like "[g]o on long trips with the family, whether going to Six Flags Great America. Prior to that, we did a trip of Yellowstone with a lot of walking, hiking, biking. I could not do some of the yard work, things I would do. I could not do some of the projects around the house. Going up and down the stairs was uncomfortable." (T.30). He noted that this is true to this day. (T.30).

In a progress note dated 5/18/16, Dr. Pavlatos recorded that Petitioner was "... still having some discomfort with increased activity, although he has been active in biking in order to keep his strength up." (PX3). Dr. Pavlatos administered a Monovisc injection and instructed Petitioner to return in three months for evaluation. (PX3).

Petitioner agreed that Dr. Pavlatos administered a Monovisc injection, which he was able to get every six months. (T.31). He noted that the first injection lasted "[l]ess than 6 months" and that by the third injection on 5/10/17 it lasted approximately four months. (T.31-32). He indicated that at some point Dr. Pavlatos discussed further surgery, namely a knee replacement. (T.32). He indicated that he would like to have this procedure, but that it has not been approved by workers' compensation. (T.32-33). He noted that since the third Monovisc injection has worn off he feels instability and increased pain in his knee. (T.33).

X-rays of the right knee performed on 8/31/16 revealed Grade IV changes in the medial compartment of the knee with some moderately advanced patellofemoral arthritis. (PX3).

In a progress note dated 8/31/16, Dr. Pavlatos recorded that Petitioner was seven months post knee arthroscopy and presented with complaints of "... persistent pain and swelling. He has had several cortisone shots. He has gone through Monovisc injections. He has done his therapy with persistent pain and swelling that is affecting the quality of his life." (PX3). Dr. Pavlatos' impression was that "... the patient is a 46-year-old active individual with significant degenerative arthritis... He is certainly at risk of needing a knee replacement. We discussed the possibility of an unloading brace, although I cannot guarantee it would provide him any significant relief. Ultimately, he will require knee replacement. It is my opinion at this point that this patient did have some preexisting arthritis prior to his surgery, but his Workmen's Compensation related injury has resulted in aggravation of his arthritic process as well as tearing of the meniscus which has accelerated his arthritic process to the point where he has grade IV changes currently. It is my opinion that this is a Workmen's Compensation related injury and ultimately at some point this patient will require a total knee arthroplasty to relieve his symptoms." (PX3).

In a progress note dated 11/29/16, Dr. Pavlatos recorded that Petitioner had "... degenerative arthritis of the right knee mainly as a result of his work-related injury." (PX3). Petitioner was administered another Monovisc injection in his right knee and instructed to return in 4 to 6 weeks. (PX3).

In a "Generic Rx Form" dated 11/29/16, Dr. Pavlatos noted that "[r]ight [t]otal [k]nee [r]eplacement is recommended." (PX3).

In a progress note dated 5/10/17, Dr. Pavlatos noted that Petitioner had lost over 50 to 60 pounds and "[h]is knee is feeling better. He had Monovisc injection given in the past and has done well." (PX3). Dr. Pavlatos noted that "[a]t this point, [Petitioner] understands that as some point he may require a knee replacement; however, he is trying to avoid knee replacement and since the Monovisc injections have worked, I do feel it is clearly indicating in this patient where I feel this can significantly improve his symptoms along with his weight reduction and possibly avoid a knee replacement, which we would like to do at his age." (PX3).

In a progress note dated 10/23/17, Dr. Pavlatos recorded that "[t]he patient is here for followup for his Workmen's Compensation related right knee injury. This is a patient with preexisting arthritis who injured his knee at work suffering meniscal tears in his right knee that resulted on 01/27/2018, him having a partial medial lateral meniscectomy and followup. The patient has been noted to develop progressive arthritic changes in his knee and having pain with ADLs, activities of daily living as well as pain at night. He has had limited relief with anti-inflammatories, physical therapy, and cortisone injections." (PX3). Dr. Pavlatos noted that "[i]t is my feeling at this point that this patient has significant arthritis in his knee and has the symptoms that warrant a knee replacement... A right total knee arthroplasty is the only method I would recommend for this patient to relieve his pain, and I do feel that this arthritis has clearly been accelerated as a result of his work related injury which led to the removal of significant portions of his meniscus which led to progressive arthritis that led to the symptoms this patient is currently suffering from. The patient will discuss knee replacement with his family and once Workmen's Compensation approval, he is planning on proceeding with a knee replacement." (PX3).

X-rays of the right knee performed on 10/23/17 revealed "... grade IV bone-on-bone arthritic changes noted in the medial compartment of his right knee with moderate patellofemoral arthritis. Evidence of some lateral compartment arthritis is also noted to be developing. He currently is in a slight varus alignment indicating progressive disease." (PX3).

Currently, Petitioner notices "[t]hat it continues to hurt" and that his "... gait is not normal." (T.36). He indicated that it is his desire to have the knee replacement. (T.36).

Petitioner testified that prior to the accident in question he had undergone back surgery at the hands of Dr. Citow sometime in 2014. (T.33). He stated that following that surgery he was restricted from physical activity and was able to return to work with no restrictions within two and a half months. (T.34). He noted that he "... was not allowed to do repetitive motion such as walking and jogging for the rods and screws to finish adhering to my back." (T.34). He agreed that at some point he was allowed to begin doing those activities, noting that he was able to start

working out on the treadmill again in the beginning of August 2015. (T.34). He noted that when he began to work out again he was sore and that he "... had gotten a little out of shape, so my body was sore after each of the workouts, but I had to get better. I had to get stronger." (T.35).

Petitioner agreed that prior to August of 2015 he had an x-ray of his right leg performed at Northwestern Lake Forest after a tree limb hit him on the top of his thigh. (T.35). He noted that he "... just had some swelling, so I wanted to make sure I didn't break anything." (T.35). He also noted that he saw Dr. Citow again in 2016 when he "... hit my head in April hard enough to create a bump; and then shortly after, I started having nerve issues" down both arms. (T.35-36). He stated that Dr. Citow did not provide any treatment for his right knee at that time, and that Dr. Pavlatos did not provide any treatment for his head, neck or right arm. (T.36).

On cross examination, Petitioner indicated he is not entering any of the records from his prior knee treatment 20 years earlier, and that he did not recall the name of the doctor that he treated with back then. (T.37). He agreed the right leg injury he suffered in 2013 was a quadriceps rupture. (T.38). He also indicated he stands 6'5" tall and weighs 300 pounds. (T.38). However, he agreed that at the time of the injury (presumably the current one) he was 350 pounds. (T.38).

Petitioner agreed on the morning of 8/31/15 he was on the treadmill for approximately one hour. (T.38-39). When asked whether his knee felt stiff after that, Petitioner responded: "[m]y entire body was stiff." (T.39). He then agreed that his knee felt stiff after he was on the treadmill that morning. (T.39).

Petitioner agreed that he could not recall how long he was on the scene of the MVA; however, he indicated that he would not dispute the records if they show he was there for 30 minutes. (T.40). When asked what happened to his knee when he jumped into the truck after he assisted in backing it up, Petitioner responded: "I did not feel any pain, but I wasn't able to move it." (T.41). He denied that there was a popping or snapping or anything when he jumped in. (T.41). He agreed that he did not seek treatment immediately after jumping into the truck. (T.41). He also noted that he would not dispute the records if they show they arrived at the scene of the MVA around 8:15 a.m. and that they did not leave until after 2:00 p.m. that afternoon, or about six hours. (T.41-42). He agreed that he did not report an injury when he returned to the station that day. (T.42). He also agreed that there is a reporting procedure at the Grayslake Fire Protection District, and that as a lieutenant he is familiar with that reporting procedure – which he believed was to report it within 24 hours. (T.42-43).

Petitioner indicated he went into a meeting with Ford Fire Board Insurance when he returned to the station. (T.43). He noted that the current fire chief, John Christian, was there. (T.44). He also agreed that he went into verbal training after that. (T.44). Petitioner noted that he did not recall having lunch that day, and that he took no breaks between the MVA and when he left to go to the ER. (T.44-45). He noted that the morning meeting took approximately an hour and a half, two hours, and that the verbal training took about as long. (T.44). He could not recall what the verbal training was about. (T.45).

Petitioner indicated that he was walking past the office of Assistant Deputy Chief Pierre's office at a normal pace when his knee gave out. (T.45). He noted that the floor was carpeted and

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that there was no issue with the carpeting as far as he was aware of. (T.45). He agreed that his testimony was that his knee gave way. (T.46).

Petitioner recalled seeing Dr. Alpert and would not disagree with his records if they show he was seen on 10/9/15. (T.46). When asked if he would disagree with Dr. Alpert's records if they show he reported running at the scene and his knee felt stiff, Petitioner responded: "Well, at the scene, correct. It was no problem other than general soreness from working out in the morning." (T.46). He agreed he reported jumping into the engine and jumping back out. (T.47).

Petitioner agreed that he has consistently treated with Dr. Pavlatos, his treating physician, since 9/2/15. (T.47). He also agreed that he has no reason to dispute the accuracy of Dr. Pavlatos' records. (T.48). Similarly, he agreed that when he got off the engine back in the station he did not hear a popping at that time and that he felt no pain, just stiffness. (T.48-49). However, he denied that it was the same stiffness that he had after the treadmill. (T.49).

Petitioner recalled giving a recorded statement to Kathy Johnson on 9/2/15. (T.49). The statement was admitted at RX10. Petitioner recalled giving the statement recorded therein, including his claim that he felt no specific injury whatsoever. (T.51). He also recalled telling Ms. Johnson that he went through the rest of the day with a stiff knee that kept getting stiffer until he was "... just walking and ... heard and felt a snap and then ... could no longer put any weight on [his] right leg." (T.52). He likewise agreed that he was able to walk until he felt the snap in his leg while simply walking. (T.52).

Petitioner agreed he was released to return to work by Dr. Pavlatos on 2/3/16, or a few weeks after surgery, and that he began working full duty for Respondent on 2/18/16 as a firefighter/ paramedic. (T.53). Petitioner could not recall being discharged from physical therapy on 2/26/16 but recalled telling his therapist he was feeling great and pain free, and that he was performing all activities of daily living. (T.54). He has not undergone physical therapy since 2/26/16. (T.54).

Petitioner did not recall returning to Dr. Pavlatos on 4/21/16 and reporting that he had an injury at home and aggravated his knee. (T.55). However, he would not disagree with the records if they state he "... did a significant amount of activity recently at home that seemed to aggravate his knee..." (T.55-56). When asked whether his knee was aggravated due to activities he performed at home sometime in April of 2016, Petitioner responded: "Correct." (T.56). He also agreed that he reported the same thing to Dr. Alpert on 2/23/17. (T.56).

Petitioner agreed that he has been working full duty since February of 2016 as a paramedic/firefighter, performing all the elements of his job. (T.56). He also agreed that he suffered a new injury to his neck in April of 2017, and that he saw Dr. Citow who examined him and ordered an MRI. (T.56-57).

When asked whether he showed Dr. Alpert's report to Dr. Pavlatos, Petitioner responded: "I do not recall." (T.59). He also could not recall ever having Dr. Alpert's records sent to Dr. Pavlatos, although he then conceded that "[m]aybe I did ask him to get the records or I provided a copy. I don't recall." (T.59). However, he acknowledged that "[o]n some items, my memory may not be clear." (T.60). When questioned as to whether he may have asked Dr. Pavlatos to review

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Dr. Alpert's reports, Petitioner replied: "I may have, yes." (T.60). When asked why he would have done that, Petitioner responded: "I'm not going to speculate if I asked him to review those [*sic*] information. I would want him to have the most information available to treat me the best way." (T.60). He agreed this also included providing opinions. (T.60).

Petitioner indicated that he and Deputy Chief Dan Pierre had worked together for over 20 years. (T.60). He agreed that they have a good rapport and that there is no ill-will between the two of them. (T.60-61). He also agreed that he has not lost any time from work since February of 2016 due to his right knee. (T.61). Likewise, he agreed that Dr. Pavlatos told him the Monovisc injections created a gel to act as a shock absorber for the arthritis in his knee. (T.61).

On re-direct, Petitioner agreed that he was having difficulties or symptoms with his right knee before April of 2016. (T.62). He indicated that the physical therapy helped his right knee "[v]ery minimally." (T.63). He also noted that when he was done with physical therapy his symptoms increased. (T.63). He agreed with the records (presumably physical therapy) dated 3/9/16, or before the home activities, if they show he was having knee pain and had an injection. (T.63). Petitioner also noted that there was a "[b]ig difference" between the stiffness he felt getting out of the truck when he got back to the station and the stiffness he had that morning while exercising in that "[o]ne was just general soreness from a workout. The other one was so stiff I could not straighten the leg out that would force me to have to limp when I walked." (T.63). He also indicated that he had been able to run while he was at the scene of the MVA that morning, and that when he was done guiding the truck back he ran around the front to get inside. (T.64). In describing how he got into the truck, Petitioner testified that "[m]y motions were to run around the driver's side, pivot around the front, and pivot around the front right side, what we call the officer side, and then pivot again up into the seat. The seat is elevated, so you have to step up or jump up to get up there." (T.65). He noted that he was pivoting on his right leg. (T.65). He also agreed that at the time of his statement he told Ms. Johnson he did notice a change from jumping in and out of the truck and that it was very stiff. (T.66). He also recalled saying that he did not say anything to anybody but that it was quite obvious because he was walking around with a limp, and he thought it was just getting stiff from sitting inside the small cab. (T.66).

Petitioner agreed that his weight increased following back surgery in 2014 due to inactivity. (T.67). He also indicated that when he walked into that first meeting, and when he went to his second meeting, he just thought it was very stiff, but it got stiffer and the pain started to increase as the day went on. (T.67-68).

On re-cross, Petitioner denied that his testimony at trial was the first time he gave a history of pivoting. (T.69). He agreed that it was his testimony that he did not feel any pain until the buckling incident when the knee gave out, noting that "... greater discomfort and pain is a very blurry line. But at the point it gave out, it was distinctively very painful." (T.69-70). He agreed that when he heard the popping sound he was simply walking down a hallway in the station, and that's when he sought immediate treatment. (T.70).

On further re-direct, Petitioner stated that just prior to the popping he noticed that he was not able to extend his knee. (T.70).

Board certified orthopedic surgeon Dr. Joshua Alpert testified that he examined Petitioner on 10/9/15 at the request of the Respondent. (RX1, p.7). He indicated that on that date he recorded the following history: "... on August 31st, 2015, while working as a paramedic and firefighter there was a car accident. He was running, and his right knee felt stiff. Several hours later he was running again during a scene and it snapped. He heard the snap. He felt the snap. He could not walk on it. It swelled up... He also told me he had a preexisting right knee surgery 25 years ago to remove some cartilage. He states that on the day of his injury his right knee was feeling stiff when he was on a treadmill but otherwise was feeling normal. He had not seen a doctor in 20 years regarding his right knee." (RX1, pp.7-8).

Following his examination and review of the record, Dr. Alpert issued a report dated 10/9/15 wherein he stated that he was of the opinion Petitioner "... had preexisting arthritis in his knee. He had a right knee injury at work and exacerbated the knee arthritis and aggravated the preexisting medial meniscus tear... At that time he had basically no conservative treatment. It was my opinion that he had exacerbated the arthritis and degenerative meniscus tear. I did not think a knee arthroscopy was necessary as he has had no conservative care." (RX1, pp.10-11). Dr. Alpert also felt that Petitioner would reach MMI in four to six weeks after conservative care and did not need any further diagnostic studies. (RX1, p.11). In addition, Dr. Alpert recommended only desk work activities at that point. (RX1, p.11).

Dr. Alpert subsequently authored an IME addendum report dated 12/28/15. (RX1, p.12). Following his review of Petitioner's updated records, Dr. Alpert was of the opinion that Petitioner's "... condition was consistent with preexisting right knee osteoarthritis and a degenerative medial meniscus tear... [and] [t]hat it was not causally related." (RX1, p.14).

Dr. Alpert noted Petitioner "... didn't have any kind of traumatic twisting injury to the knee, to the right knee. He was just running. He had been complaining of pain and stiffness in the knee prior to the accident. Symptoms that he was currently complaining of are consistent with degenerative arthritis in the knee and a medial meniscus tear which is not related to any work injury and it is preexisting. It was my opinion that running at work temporarily exacerbated his arthritic changes in the right knee. He got cortisone and therapy. And given his pain and swelling in the knee, it is a typical picture for arthritis. And the meniscus tear is degenerative in someone of his age, his height, his weight, and his x-ray findings that showed degenerative conditions in his knee." (RX1, p.15). Dr. Alpert also "... didn't believe any further treatment was warranted or necessary as it relates to his work injury from August 31st, 2015." (RX1, p.15). In addition, he did not think the surgery recommended by Dr. Pavlatos "... was related to the work injury and was solely due to the preexisting condition." (RX1, p.16). Finally, Dr. Alpert opined Petitioner "... was at MMI regarding any injury sustained in the work accident August 31st, 2015." (RX1, p.16).

Dr. Alpert agreed that he subsequently performed another examination of Petitioner on 2/17/17 and thereafter drafted a report dated 2/23/17. (RX1, p.16). Dr. Alpert noted that at that time Petitioner "... described the mechanism of his right knee injury exactly that on August 31st, 2015, he was running around the front of his engine. He jumped up into the truck. He states he is a big individual who is 6 foot 5 and 312 pounds. He cannot fully sit inside the truck. When he tried to get out of the truck, he felt right knee pain because he could not extend it. He ended up going and sitting in a meeting. He tried to walk after the meeting and the knee gave out on him

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and he fell." (RX1, pp.17-18). He also noted that following arthroscopic surgery Petitioner returned to full duty work without restriction in February of 2016 and that "[h]e says he took up some biking last [F]all but his knee would just swell up on him. He discharged himself from physical therapy on February 26th of 2016, and he noted that on April 21st, 2016, he engaged in a significant amount of activity at home that aggravated his knee." (RX1, p.18).

Following his examination on 2/17/17 and review of the records, Dr. Alpert opined that Petitioner's "... current conditions are not causally related to the accident August 31st, 2015, but due to his preexisting arthritis... His x-ray, MRI, and arthroscopic pictures of his knee all show moderate to severe arthritis in his knee. His mechanism of injury of running around the truck or getting in the truck wouldn't cause knee arthritis. It was all preexisting in my opinion." (RX1, p.22). He also thought that "... the first six weeks of treatment [was] reasonable and after that it was not reasonable or medically necessary." (RX1, p.22). In addition, he indicated that "[r]ight knee arthroscopy does not help a patient who has osteoarthritis of the right knee. He has not gotten better after the surgery due to continued pain in his knee. That's all due to his degenerative arthritis of his right knee." (RX1, p.23). Thus, he agreed that the surgery performed was not causally related to the alleged work accident. (RX1, p.23).

Furthermore, Dr. Alpert testified that "[i]t was my opinion that [Petitioner] did not require any further treatment as it relates to the August 31st, 2015, accident. Due to advanced arthritis in his knee and the fact that after the arthroscopy he had two cortisone injections and a lubricant injection and the fact he is 6 feet 5 [inches tall] and weighs 312 pounds that a knee replacement certainly would be reasonable for him, but it would be due to his preexisting arthritis and not his – not any work injury." (RX1, p.23). Dr. Alpert was also of the opinion that Petitioner was at MMI, and that "[h]e was currently working without restrictions and he can continue to work without restrictions." (RX1, p.24).

On cross examination, Dr. Alpert agreed that there was nothing in the medical records which showed that Petitioner had any treatment to his right knee within the past 10 to 15 years of the accident. (RX1, pp.27-28). He also indicated that he did not review any medical records of Petitioner for any kind of treatment that predated 8/31/15. (RX1, p.27). In addition, Dr. Alpert indicated that Petitioner told him that he had undergone arthroscopy 25 years earlier. (RX1, p.28). He agreed that he did not review any medical records which indicated he had any difficulty doing his job in the year before the accident, although he did note that Petitioner "... said he had some stiffness in his knee, but never said that he had an issue with his job." (RX1, p.28).

When asked about the histories that he recorded, Dr. Alpert noted that "[t]here is one record that says he was – he was just running and felt a snap. There is one record that says – not record, I mean when he had told me one time he said he was running, one time he was just getting into his truck and then getting out of his truck. So there is a couple different ways that he described it to me. But he did say he heard a snap... [a]nd felt a snap" in the right knee. (RX1, p.29). He agreed that Petitioner never told him that he heard and felt a snap in his right knee prior to 8/31/15. (RX1, p.29). He likewise agreed that there is no indication in any of the materials he reviewed that Petitioner was having medial patellofemoral or lateral joint pain for a significant period of time before 8/31/15. (RX1, p.33). He also agreed that a person can have an arthritic knee as shown on radiographs without having symptoms, and that such a person can become symptomatic after some

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event. (RX1, p.34).

With respect to the meniscal tear, Dr. Alpert testified that Petitioner "... had a meniscus surgery 25 years ago and then comes in at 45 years old with Grade 4 arthritis on the inside of his knee, that's probably because the meniscus was – I don't have that operative report, but that's probably because the meniscus was removed 25 years ago, he is 45 years old and now he has developed arthritis. So it is more likely without the meniscus over time for someone to develop worsening arthritis than someone who has their meniscus." (RX1, p.44). However, he agreed that he had not seen the operative report from 25 years ago and did not know which side of the meniscus had been repaired or trimmed. (RX1, p.44). With respect to the arthroscopic surgery performed by Dr. Pavlatos, Dr. Alpert agreed that "... any symptoms you are having from the meniscus tear will be cured from a partial meniscectomy procedure. Any pain you are having from arthritis it will not help at all." (RX1, p.46). He also agreed that Petitioner needs a right knee replacement – he just disagrees that it is because of the 8/31/15 accident. (RX1, pp.46-47).

Dr. Alpert agreed that the 8/31/15 work-related incident aggravated a preexisting arthritic condition. (RX1, p.47). He also agreed that feeling and hearing a pop in the knee could be an indication of an acute meniscal tear. (RX1, p.47). However, he did not agree that the 8/31/15 accident caused the meniscal tear, noting that he thought Petitioner "... irritated the preexisting arthritis and that the meniscus tear was there, that it was degenerative given the advanced arthritic nature of his knee and that he had preexisting meniscus tear and arthritis and that the injury he sustained was a temporary aggravation of the preexisting arthritis in his knee and that the meniscus tear was there and not contributing to his symptoms." (RX1, p.48).

Dr. Alpert also noted that "[p]eople's knees pop all the time. Very commonly with arthritis bone rubs on bone. You can hear a pop. You can strain or sprain a ligament. You can pop a Baker cyst. You could – there is a variety of things it could be. Based on what he was telling me from a mechanism standpoint, I didn't see any kind of twisting hyperflexion or any kind of mechanism that caused a meniscus to tear. So I think more likely the pop was just from the arthritis in his knee." (RX1, p.48).

Conclusions of Law

The burden is on the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d. 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977).

In the present case, Petitioner provided no less than three (3) different accounts of his injury to various caregivers, in addition to the version of events he provided at arbitration. Specifically, he informed Lake Forest Hospital emergency department personnel on the date of the alleged injury (8/31/15) that he had "... right knee stiffness after returning from call today that did not involve crawling, lifting, or climbing. ***When he stepped down from engine, he noted right knee stiffness followed by audible 'pop' with acute posterolateral right knee pain and diffuse swelling.***" (Emphasis added) (PX1). Later, when he first visited Dr. Pavlatos three days later on 9/2/15, it was recorded that Petitioner presented "... for evaluation of right knee without any

previous right knee problems. ***He was jumping off an engine, he did not hear any pop or any pain at that time. This happened about 3-4 days ago.*** Since then, he has been having stiffness with progressive pain that requires the use of crutches for ambulation…" (Emphasis added) (PX3). Later, when he reported to physical therapy, it was recorded that he "… ***was responding to an auto accident when he was walking across the pavement and felt a snap in his R knee.*** He was able to complete the call but the pain never went away so his division chief took him to the emergency room in [G]rayslake." (Emphasis added) (PX3).

At arbitration, Petitioner testified to nothing more than his knee feeling "uncomfortable" and that he was having difficulty straightening it after he responded to a motor vehicle accident on the morning of the incident and returned to the station. He did not testify to any twisting or turning incident involving his right knee, or his knee giving out on him at that time, much less experiencing a "popping" sensation. Nor did he claim that he felt pain while ambulating at the scene of the MVA or when he got back into the fire engine and returned to the station house. Instead, he testified that he continued to experience stiffness and an inability to straighten his knee while attending two subsequent meetings, each lasting an hour and a half to two hours. Indeed, it was not until he got up following the last meeting and started walking down the hall that his leg gave out and he fell to the floor.

Thus, the evidence fails to show that Petitioner sustained any kind of specific accident or injury while responding to the MVA or while returning to the firehouse while seated in the cramped quarters of the fire engine. In fact, Petitioner admitted as much when he told Kathy Johnson, as part of his recorded statement on 9/2/15, that he did not feel he had suffered any specific injury until he was walking down the hallway back at the firestation and his right knee snapped, after which he could no longer place any weight on it. Likewise, he admitted at arbitration to having no problem with his knee at the scene of the MVA "… other than general soreness from working out in the morning." (T.46).

Along those lines, the record shows that Petitioner admittedly complained of "stiffness" in his knee after working out on the treadmill prior to work that day, although he claims that the stiffness he experienced at that time was different from the stiffness he later felt following his response to the MVA.

Furthermore, the Commission finds that under a neutral risk analysis, Petitioner failed to show the incident at the stationhouse wherein his right knee gave out while he was walking down the hallway arose out of his employment. The Commission notes injuries resulting from a neutral risk – or risks that are neither personal nor related to the employment -- generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to a risk to a greater degree than the general public. *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 990 N.E.2d 284, 371 Ill.Dec. 384 (4th Dist. 2013). The increased risk may be either qualitative (i.e. 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 members of the general public by virtue of his employment). *Metropolitan Water Reclamation Dist. of Greater Chicago v. Ill. Workers' Comp. Comm'n*, 407 Ill.App.3d 1010, 1014, 944 N.E.2d 800, 348 Ill.Dec. 559 (2011).

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In the present case, there was absolutely no evidence to suggest that Petitioner's employment had anything to do with or somehow contributed to his knee giving out. Petitioner did not claim that he tripped or otherwise fell due to any defect or hazard on the premises, and in fact simply stated that his leg just gave out. There is also no evidence to show that from a quantitative standpoint Petitioner was exposed to a risk of injury to a greater extent than a member of the general public because of his employment due to the frequency with which he performed this activity.

As a result, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on 8/31/15.

Furthermore, the Commission finds that Petitioner failed to prove that his current condition of ill-being is causally related to the alleged accident in question based on the opinion of Dr. Alpert. The Commission notes that while Dr. Alpert conceded that "... running at work [may have] temporarily exacerbated his arthritic changes in the right knee...", he believed that Petitioner's "... condition was consistent with preexisting right knee osteoarthritis and a degenerative medial meniscus tear... [and] [t]hat it was not causally related." (RX1, pp.12,15). In addition, the record shows that Petitioner aggravated his knee following surgery and after performing "... a significant amount of activity recently at home..." per the office note of Dr. Pavlatos dated 4/21/16. (PX3). Whether such an event would be considered an intervening accident or a reflection of the significant degree of degenerative arthritis present in Petitioner's knee, as posited by Dr. Pavlatos (PX3), the fact remains that Petitioner failed to prove that his current condition of ill-being relative to his right knee is the result of any incident that may have occurred at work on 8/31/15.

Accordingly, Petitioner's claim for compensation is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award dated 1/30/18 is vacated and Petitioner's claim for compensation 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 19 2019
o: 6/18/19
DDM/pmo
52

D. Douglas McCarthy

Maria E. Portela

L. Elizabeth Coppoletti

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

ESEQUIEL IRACHETA

Petitioner,

19IWCC0446

vs.

NO: 09 WC 20467

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REMAND

This cause comes before the Illinois Worker's Compensation Commission ("Commission") pursuant to the Rule 23 Order of the Appellate Court, First District, Workers' Compensation Commission Division (Appellate Court), No. 1-18-0151 WC, entered November 30, 2018. The Appellate Court reversed the Circuit Court of Cook County, County Department, Tax and Miscellaneous Remedies Division's ("Circuit Court") decision, 17-L-50530, confirming a decision of the Commission which affirmed and adopted the Arbitrator's Decision, and further remanded the matter to the Commission for further proceedings.

Background

The Petitioner, a tree trimmer for the respondent, City of Chicago ("City"), filed two cases assigned case numbers 07 WC 50937 and 07 WC 50938, on November 14, 2007. The subject accident date, September 14, 2007, occurred two months before the earlier cases were filed, however, the Application for Adjustment of Claim was not filed until May 12, 2009. The subject case and the two earlier 2007 cases were consolidated on June 13, 2011. A fourth case, assigned number 14 WC 10550, was filed on March 31, 2014 and was consolidated with the three earlier filings before the Commission on November 21, 2014. The 2007 filings were settled on September 24, 2015 and only the subject case and case number 14 WC 10550 were adjudicated at a hearing

on February 29, 2016 before an Arbitrator at the Illinois Workers' Compensation Commission. After the hearing, the Arbitrator issued a decision and denied the request for benefits for case 09 WC 20467 and dismissed the claim.

The Arbitrator also awarded 1% loss of use of a person as a whole under §8(d)2 for case number 14 WC 10550 and medical benefits for his lumbar spine injury from November 23, 2012 through March 20, 2014. The Arbitrator found the medical care rendered the petitioner for his cervical spine and other conditions are not related to the November 23, 2012 work injury and those medical expenses were denied. The petitioner's request for penalties and fees was also denied.

The Petitioner appealed the Arbitrator's decisions to the Commission on the issues of accident, causal connection, temporary total disability, maintenance benefits, medical expenses, permanent partial disability, wage-differential entitlement under §8(d)1 and penalties and fees. The Commission unanimously affirmed and adopted the arbitrator's decisions. The Petitioner appealed, and the case was before the Circuit Court of Cook County, County Department, Tax and Miscellaneous Remedies Division ("Circuit Court") for administrative review of the decision of the Commission on May 25, 2017. The Circuit Court confirmed the decision of the Commission on December 22, 2017.

Petitioner then appealed solely case number 09 WC 20467 to the Appellate Court, rendering the Commission decision regarding case number 14 WC 10550 final. The Appellate Court, acknowledging that the exhibits in the case at bar did not contain a narrative report documenting the Petitioner's injuries, diagnosis and treatment from Mercy Hospital on September 14, 2007, held that a MercyWorks' invoice dated February 25, 2016, demonstrated that emergency services were rendered to the Petitioner on September 14, 2007. The Appellate Court noted:

> Specifically, the invoice stated that the Petitioner presented for a "[t]ear, medial cartilage/meniscus of rightknee [sic]/S/P [;] Right knee Anthroscopy/Left shoulder rotator cuff tear/S/P[;] Left Shoulder Anthroscopy and RTC Repair/L5-S1 HNP," and reflected the following "ICD diagnostic codes 924.8, 871.6 and 836.0." The invoice also reflected the following treatment dates: September 14, 2007, for Level III trauma treatment, fluorescein strips ophthalmology, Ibuprofen 400 mg, BSS Ophthalmic solution, Erythromycin 5 mg/gm and Proparacaine 0.5% Opthalmic solution;" September 17, 2007, for knee x-rays with four views, an extended office visit, and an elastic slip-on knee support; and October 1, 2007, for a head CT scan.

The Appellate Court also detailed the Petitioner's medical treatment thereafter and the histories the Petitioner relayed to multiple providers.

Findings of Fact and Conclusions of Law

The Commission finds that based on the evidence, the Petitioner's treatment on the date of accident on September 14, 2007 was limited; the Commission notes that BSS ophthalmic solution and fluorescein strips opthalmology and Proparacaine Ophthalmic solution were dispensed, however, no other Level III trauma treatment can be identified except for Ibuprofen and erythromycin. The February 25, 2016 invoice for the subject date of accident reflects the following charges indicating the treatment that day was limited: ER Profee - $209.00; Level III - $375.00; Fluorescein Strip Ophthalmic - $1.50, the Bss Ophthalmic solution - $33.59; Erythromycin - $10.56; Proparacaine Ophthalmic Solution - $47.64; Ibuprofen - $4.00.

In addition, the Petitioner testified, "the accident happened on a Friday and Monday I had to report to MercyWorks and they started treating me and going over the –how I felt and stuff." (T, p.15) The Petitioner was not kept for overnight treatment the day of the accident.

The Commission further finds that the MercyWorks records contain evidence of low back complaints that predate the accident. The MercyWorks' office notes document that prior to the subject incident, the Petitioner treated with Dr. Heller for bilateral hand injuries (the 2007 referenced cases). On February 2, 2007, Dr. Heller placed the Petitioner on limited duty for his left-hand injury and noted that the Petitioner should return to the clinic on June 4, 2007. On June 4, 2007, the MercyWorks' notes document that the Petitioner returned with a new lumbar back complaint. The Petitioner reported he "began having back pain in his left side to his heel (outer part) that is now constant. Today feels in back of knee to buttock." The diagnosis included: "…lumbar strain newly reported."

Thereafter, the Petitioner treated with occupational therapy for his left thumb and left hand for several more months all the while working light-duty. On September 12, 2007, two days before the subject incident date, the MercyWorks office notes document the Petitioner was released to regular work duties as a tree trimmer. (Px6)

Only two days after returning to full-duty work, the subject incident occurred. The Petitioner had knee x-rays on Monday, September 17, 2007.

The February 2016 invoice confirms that the Petitioner underwent a CT of his head on October 1, 2007 and an MR of his lower joint extremity on November 8, 2007. The Petitioner then had shoulder x-rays on November 16, 2007, however, there is no evidence of any additional left shoulder treatment until seven months later, when he underwent an MRI of his left shoulder at Mercy Hospital on June 10, 2008. The first lumbar spine treatment after the subject accident date was not until April 2009, and thereafter Petitioner filed the subject Application for Adjustment of Claim.

Pursuant to the Appellate Court remand order, the Commission finds the Petitioner's right knee and left shoulder conditions are causally related to the September 14, 2007 accident and the lumbar and cervical spine conditions are not related to the September 14, 2007 accident.

Following a November 8, 2007 MRI of his right knee, the Petitioner first presented to an orthopedic surgeon, Dr. Michael Maday on January 17, 2008. Dr. Maday performed a right knee arthroscopy and partial medial meniscectomy on March 1, 2008. Dr. Maday's operative report revealed the Petitioner presented with "increasing right knee pain. He injured his knee while cutting down a tree and a large portion struck him in the knee and he complained of pain. An MRI revealed an effusion, but no frank tear." The postoperative diagnosis was right knee medial meniscal tear and degenerative changes of the medial femoral condyle. (Px6) The Petitioner also had a cardiac stent placement in March 2008. (Rx5) According to the MercyWorks bill, the Petitioner underwent work hardening through June 2008.

The Petitioner underwent a section 12 independent medical evaluation (IME) regarding his right knee, with Dr. David Raab, a board-certified orthopedic surgeon, at Illinois Bone & Joint Institute on April 20, 2009 at Respondent's request. Dr. Raab opined that the Petitioner was at maximum medical improvement (MMI) for his right knee injury. In addressing the mechanism of injury, Dr. Raab noted "it appears based on the body of the operative report, most likely these findings were pre-existing the date of the injury but certainly a work-related injury can exacerbate pre-existing findings in a knee." Dr. Raab also opined that "any further treatment of the right knee is not related to the work-related injury of September 14, 2007 but more so to the natural progression of the degenerative arthritis in his right knee that was found at the time of the knee arthroscopy." Dr. Raab also opined that Petitioner could return to work full duty without restrictions as a tree trimmer with regard to his right knee. (Rx1)

At the request of his attorney, the Petitioner was further examined for his right knee condition by Dr. Rajeev Garapati from the Illinois Bone & Joint Institute on December 2, 2011. Dr. Garapati also opined that Petitioner was at MMI, however, assigned restrictions including light duty work, no lifting greater than 40 pounds from floor to waist or 20 pounds above that level, no climbing or stairs or getting in and out of his car more than 15-20 times during the course of an eight-hour shift. The Commission finds Dr. Garapati's report had inconsistencies, c.f. that the Petitioner "is currently still doing light duty work and has been doing this since October of 2010" (Px1, p. 11) and "My impression at this time is that the patient is a very pleasant 58-year-old male who was in his usual state of health until September 14, 2007, when he was involved in an accident at his job as a tree trimmer and he has been unable to return to work since then." (Px1, p. 13)

Further, the Commission notes that in the Fullerton Occupational Medicine & Urgent Care ("Fullerton") Health history on October 9, 2010, one year and two months prior to Dr. Garapati's visit, the Petitioner attributed his lumbar back pain to activities of climbing stairs and getting in and out of his car more than 15-20 times during an eight-hour shift, a condition that predated the subject accident, and those activities were not noted to aggravate his knee.

The Commission finds the right knee medial tear is causally related to the accident on September 14, 2007, however, neither Dr. Maday, the Petitioner's treating surgeon, nor Dr. Raab assigned work restrictions.

The Commission further finds Dr. Garapati's opinion, given 2 years and 9 months after the Petitioner's right knee surgery, is less credible than Dr. Raab's opinion, and further finds that based on Dr. Raab's credible opinion, that the Petitioner was at MMI as of April 20, 2009 with respect to his right knee and that he could return to work full-duty without restrictions as a tree trimmer with regard to his right knee at that time.

In regard to the Petitioner's left shoulder, medical bills establish that he had a shoulder x-ray two months after the subject accident date. The Petitioner underwent a left shoulder MRI at Mercy Hospital on June 10, 2008, nine months after the incident and upon conclusion of the Petitioner's right knee treatment. Following the MRI, the Petitioner presented to Dr. Gregory Nicholson of Midwest Orthopedics at Rush Hospital on July 9, 2008. Dr. Nicholson recommended surgery based upon the January (sic) MRI revealing a high signal throughout the subacromial bursa and a small full-thickness rotator cuff tear. Dr. Nicholson noted that an examination revealed a marked positive impingement, Yergason sign and speed test. (Px5)

On September 29, 2008, the Petitioner underwent a left shoulder arthroscopic rotator cuff repair and subacromial decompression. On February 17, 2009, Dr. Nicholson evaluated the Petitioner and noted he had full rotation and 5/5 strength in his left shoulder. Dr. Nicholson stated that the Petitioner could "return to full duty work on Thursday, March 19, 2009. I will follow him up in six weeks which will be two weeks after he returns to full duty work. Between then and now he cannot work; he needs to get into work conditioning." On March 18, 2009, Dr. Nicholson recommended the Petitioner undergo a functional capacity evaluation (FCE) and remain off work after the Petitioner reported that he had knee and low back problems. Dr. Nicholson noted that he would dictate an addendum after "we see the FCE." (Px5)

The Petitioner underwent a lumbar spine MRI on April 2, 2009, however, he did not undergo an FCE until 2014 and he did not follow up with Dr. Nicholson until 2015 when he complained about his right shoulder. Dr. Nicholson never offered any further opinion regarding the Petitioner's left shoulder.

The Petitioner presented to an orthopedic surgeon, Dr. Kevin Tu, on September 1, 2010 for a section 12 IME of his left shoulder, at Respondent's request. Dr. Tu diagnosed the Petitioner with a traumatic rotator cuff tear and in the history noted that the Petitioner completed a course of post-operative physical therapy and a work conditioning program and that an FCE was recommended. Dr. Tu noted that "He was unable to participate in the functional capacity evaluation *secondary to conditions unrelated to his left shoulder.*" (emphasis added). Dr. Tu opined that the Petitioner had reached MMI and recommended a functional capacity evaluation (FCE) to determine permanent work restrictions. In response to an interrogatory, Dr. Tu opined that the Petitioner could return to work and assigned reasonable work restrictions based on a work

hardening note and the fact that an FCE could not be performed at that time. Dr. Tu also opined that "If a functional capacity evaluation can be (per)formed, the above work restrictions may be changed based on the results of the FCE." (Rx2)

On December 2, 2011, the Petitioner was seen and examined at the request of his attorney, by Dr. Jeffrey Visotsky at Illinois Bone and Joint Institute, in regard to his left shoulder. Dr. Visotsky explained to the Petitioner that "this was an independent medical evaluation and no treating relationship was established." (Px1) The Commission notes that this was the same date that the Petitioner also saw Dr. Garapati at Illinois Bone & Joint Institute at his attorney's request. Dr. Garapati documented that the Petitioner reported "that the left shoulder is doing okay, that it does click but that it is not significantly causing him any pain and that he is able to use the left shoulder." (Px1) Dr. Visotsky opined:

> The patient has recovered from what appears to be a full-thickness rotator cuff tear. He has some residual muscle weakness in the overhead plane, but the balance of his motion in the frontal plane is normal. There are changes seen at the AC joint which may be age related or due to his overhead activities at work. The patient has reached maximum medical improvement from his injury sustained on September 14, 2007. No records were available for review. No work-hardening or functional capacity evaluation was available for review. (Px1)

Dr. Visotsky did not assign work restrictions for the left shoulder.

The Commission finds that with respect to his left shoulder, the Petitioner had no permanent restrictions. In so finding, the Commission relies upon Dr. Nicholson's February 17, 2009 office note, documenting that the Petitioner had already exhibited full rotation and 5/5 strength in his left shoulder, and in his opinion at that time, that the Petitioner could return to full-duty work on Thursday, March 19, 2009 after work conditioning, (Px5) At that time, when the Petitioner was approaching a release to return to work, the Petitioner returned on March 18, 2009, and told Dr. Nicholson he "has a problem with his right knee as well as his low back." (Px5) Although Dr. Nicholson's plan was to have him undergo an FCE and have the final evaluation faxed to him so he could issue an addendum with regard to his left shoulder only, the Petitioner did not submit to an FCE at that time; he did not have an FCE until 2014 after the intervening work accident.

The Commission thus rejects Dr. Tu's opinion regarding permanent restrictions because by the time the Petitioner saw Dr. Tu, the Petitioner had already returned to work months prior, with the same title, earning the same wages, albeit with some accommodations. Other unrelated conditions prevented him from undergoing an FCE at the time Dr. Nicholson or Dr. Tu recommended that he participate in an FCE. The Commission also relies upon Dr. Nicholson's July 15, 2015 office note wherein the history Petitioner confirmed that his left shoulder was "doing very well." (Px5) Therefore, the Commission finds there is no evidence that the Petitioner had left

shoulder restrictions prior to the intervening work accident in 2012. The Petitioner did ultimately undergo an FCE in 2014 after the work-related accident in 2012.

Regarding Petitioner's lumbar and cervical spine conditions, during cross-examination the Respondent's attorney questioned the Petitioner regarding two prior workers' compensation cases. The Petitioner testified he could not recall filing a workers' compensation claim for a low back injury in the past. When asked about a second case with injury to the neck and low back, the Petitioner testified that he filed the other case for an injury to the neck, admitting that he knew he got hit in the neck but did not remember "about a lower back." (T, pp. 38-40) The Petitioner did not, however, deny a prior low back injury.

On June 4, 2007, the MercyWorks' notes document that the Petitioner reported a new lumbar back complaint while treating for his 2007 bilateral hand injuries and working light-duty. The Petitioner reported he "began having back pain in his left side to his heel (outer part) that is now constant. Today feels in back of knee to buttock." The diagnosis included: "...lumbar strain newly reported." (Px6)

The Petitioner underwent a lumbar spine MRI in April 2009, 19 months after the subject accident, and very shortly thereafter Dr. Nicholson recommended the Petitioner undergo an FCE after his left shoulder treatment. The MRI history states only "low back pain."

The Petitioner first saw Dr. Kern Singh at Midwest Orthopedics at Rush on May 11, 2009 for a second opinion and reported the subject accident was a precipitating factor. The Petitioner had complaints of low back and left lower extremity dysesthesias he rated at 6/10. Dr. Singh reviewed the April 7, 2009 MRI of the lumbar spine and diagnosed:

1. Degenerative disc disease at L4-5, L5-S1;
2. L4-5, L5-S1 spinal stenosis. (Px5)

Dr. Singh saw the Petitioner again on June 8, 2009 and his complaints were the same as they were predating the accident on June 4, 2007, "left leg as well as left-sided buttock pain." On June 15, 2009, Dr. Singh referred him for a series of three epidural steroid injections and opined that the Petitioner could return to work light duty with less than ten pounds lifting, push/pull, minimal kneeling, bending, stooping and squatting. (Px5)

The Petitioner reported low back pain complaints at Fullerton Occupational Clinic on February 19, 2010. (Px7) The Petitioner testified that it was a City doctor that released him to return to work on June 4, 2010 with a 20-pound lifting restriction. (T, p. 20)

The Petitioner was evaluated by Dr. Carl Graf at Illinois Spine Institute at Respondent's request for a section 12 evaluation on August 27, 2010. Dr. Graf noted that the Petitioner's injury had occurred nearly three years prior, that the Petitioner had a normal neurologic examination and diagnosed age appropriate degenerative changes. Dr. Graf recommended an FCE, further opined that the Petitioner was at MMI and that some restrictions imposed as a result of an FCE would

likely be a result of his age and not the injury in question. He offered to review the FCE after completed. His opinion stated, "He denies any prior problems therefore (in) my opinion he treated for the original injury."

Given the Petitioner's June 4, 2007 left sided lumbar back, leg and buttocks complaints at MercyWorks, which were the same complaints he made to Dr. Graf, the Commission finds Dr. Graf's causal connection opinion is therefore not credible and 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.)

In August 2010, the Petitioner underwent an EMG for the cervical spine despite Dr. Graf's opinion that the EMG was not necessary.

The September 14, 2010 Fullerton office notes document results of a cervical spine EMG and MRI. His physical exam showed full range of motion (ROM) without pain on palpation of L4, 5-S1, and a negative straight leg raise (SLR). (Px7)

On October 9, 2010, the Fullerton notes document the Petitioner's chief complaint: "This is follow-up for injury sustained to the low back and cervical spine resulting in a multilevel disk herniation of the lower lumbar spine along with a herniated disk of the cervical spine." (Px7) However, the Petitioner's history attributes his lumbar back pain to an entirely new mechanism of injury. The History states:

> This is a 57-year-old male who presents today with primary complaints of recurrent low back pain, which he attributes to getting up and off the truck on multiple occasions throughout the day. The patient states he has to step approximately 18-20 inches and then grab a side rail to pull himself onto the vehicle and then step to another step. The patient does this maneuver anywhere from 30-40 times per day while doing runs checking job sites. The patient states that this recurrent maneuver causes pain primarily in the lower back, primarily on the right side with radicular pain noted in right and left lower extremities. (Px7)

On January 28, 2011, the Fullerton Progress note reflects the Petitioner requested a referral to see a neurosurgeon for a second opinion. He was referred to Dr. Sheldon Lazar and was "to bring (a) copy of all records for Dr. Lazar." His lawyer was also identified and the same note documents that he had requested a disability evaluation for the Petitioner's trigger thumb. (Px7)

On July 29, 2011, the Petitioner was evaluated by Dr. Lazar at North Suburban Neurosurgery. Dr. Lazar's history documents that since the subject incident, the Petitioner had pain in his neck and left upper extremity as well as pain in his lower back with left leg symptoms. Dr. Lazar reviewed the August 2010 EMG and cervical spine MRI and the April 2009 lumbar spine MRI. He opined that the lumbar MRI revealed mild degenerative changes at multiple levels

with a broad-based disc bulge/protrusion at L5-S1 and a mild disc bulge at L4-5. There was no significant central spinal stenosis at any level.

The cervical MRI revealed disc bulges at C3-4, C4-5, C5-6 and C6-7 with diffuse, mild degenerative changes. Dr. Lazar did "not believe that the injury caused the disc bulges at multiple levels in his neck nor the changes in his lumbar spine at L4-5 and L5-S1, however, at the time of the injury he began to complain of pain. I based this assumption on the patient's history of not having any neck or back symptoms prior to the injury like he had immediately following and which persist to date." (Px3)

Dr. Lazar assigned restrictions but did not believe the Petitioner was a surgical candidate at that time. Of note, Dr. Lazar's causation opinion was based upon the premise that the Petitioner "emphatically stated that he never had any pain in his neck or arms nor in his lower back or legs prior to his injury." (Px3)

The Commission finds the history relied upon by Dr. Lazar is not consistent with the June 4, 2007 MercyWorks office note documenting that he "began having back pain in his left side to his heel (outer part) that is now constant. Today feels in back of knee to buttock." (Px6) The Commission finds the Petitioner's misrepresentation to the medical providers tarnishes the Petitioner's credibility. The Commission further finds Dr. Lazar's opinion is thus 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.)

Dr. Graf authored a second opinion report dated November 18, 2011 and recommended an FCE, however, most notably still commented on the Petitioner's lack of objective findings, nonorganic pain signs, and remarked that the Petitioner had back pain "at least since 2009." (Rx4)

While the Petitioner testified that he could not recall a prior workers' compensation low back claim, he had documented low back complaints in June 2007, only three months before the subject accident. The Petitioner also conceded on cross-examination that he had a prior accident when he was hit in the neck. Nonetheless, the Petitioner did not seek lumbar back treatment until 19 months after the subject accident. The Commission find's the Petitioner's testimony and the medical histories relating the lumbar and cervical spine conditions to the subject accident to be of questionable veracity.

The Commission further questions the Petitioner's motivation to return to work. First, he treated solely for his right knee and he did not treat for his left shoulder until after he completed his right knee treatment and was released to work. Only after he was finished treating for his left shoulder and Dr. Nicholson released him to work in February 2009 did he voice lumbar back complaints and eventually commence lumbar back treatment. While the Committee on Finance approved an invoice nine years after the fact, the Commission finds no evidence of a causal

connection between the subject work incident and the Petitioner's lumbar back or cervical conditions.

On November 23, 2012, the Petitioner had a new accident, aggravating his pre-existing degenerative lumbar back and cervical conditions. Thereafter, the Petitioner treated for his lumbar spine and cervical spine conditions. On October 3, 2013, Dr. Bernstein opined that his cervical MRI scan dated July 1, 2013 shows some minor disc bulging. At C4-5, there is some impingement of the anterior cervical cord without spinal cord compression. Dr. Bernstein felt those findings were benign. On May 29, 2014 Dr. Avi Bernstein opined that the high-quality study from a 3T MRI demonstrated multilevel cervical disc osteophyte complexes with small central herniations which impinge the spinal cord without obvious cord impingement or compression. He did not recommend surgical intervention and opined that the Petitioner was at MMI.

Therefore, pursuant to the Appellate Court's remand order, the Commission finds that the Petitioner's right knee and left shoulder injuries are related to the subject accident.

Based upon the record as a whole, the medical evidence and the testimony, as a result of the Petitioner's right knee injury, the Commission finds the Petitioner suffered a 20% loss of use of the right leg under section 8(e).

Based upon the record as a whole, the medical evidence and the testimony, as a result of the Petitioner's left shoulder injury the Commission finds the Petitioner suffered a 15% loss of use of the person as a whole under section 8(d)2.

The Commission finds that the Petitioner's lumbar spine condition and treatment and the Petitioner's cervical spine condition and treatment are not causally related to the September 14, 2007 accident for the following reasons:

Cervical Spine:

1. It does not appear that the Petitioner sought any treatment for his cervical condition until the cervical MRI he had in August 2010, almost three years after the incident at bar. Dr. Lazar, the only physician that provided a causal connection opinion between the Petitioner's cervical issues and injuries sustained in the September 14, 2007 accident, based his opinion solely on the Petitioner's history that he had pain "immediately following and which persist to date." The medical records belie that history.
2. On June 24, 2013, Dr. Avi Bernstein opined the cervical spine findings to be benign.
3. The May 12, 2014 high resolution cervical MRI confirms degenerative changes at C4-6, and no abnormal cord signal.

Lumbar Spine:

1. There is no indication of treatment for the Petitioner's lumbar back condition until he had a lumbar spine MRI in April 2, 2009 and then consulted Dr. Kern Singh in May 2009, short of two years after the subject incident. Dr. Singh characterized the Petitioner's lumbar condition as degenerative based on the April 2, 2009 lumbar back MRI. This gap in treatment severs any causal connection between the incident and his later pain complaints.
2. On October 9, 2010 the Petitioner complained of injury to his low back and spine as a result of climbing up and down from his truck in the Fullerton Occupational Records. There is no mention of the September 14, 2007 accident at that time.
3. On February 4, 2013, after reviewing the lumbar spine MRI dated April 2, 2009, Dr. Fisher noted that the larger left paracentral disk herniation seen in more recent films was not there.
4. Dr. Levin's addendum report dated August 29, 2014 notes that the Petitioner had cervical/lumbar spine clinical symptoms referable to the September 14, 2007 accident. However, he does not specifically relate same to injuries sustained in the September 14, 2007 accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 28, 2016, is hereby reversed regarding accident and otherwise modified as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $112,431.44 representing $794.17 per week for a period of 141-4/7 weeks, commencing September 17, 2007 through June 3, 2010 that being the period of temporary total incapacity for work under Section 8(b) of the Act, less a credit for amounts paid in TTD.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the cost for reasonable related medical bills for the Petitioner's right knee and left shoulder conditions commencing September 14, 2007 through June 3, 2010 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 $636.15 per week for a period of 43 weeks, as provided in section 8(e) of the Act, for the reason that the injuries sustained caused the 20% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 75 weeks, as provided in section 8(d)2 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the person as a whole for the left shoulder injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for penalties and attorney's fees is hereby denied.

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 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: AUG 2 0 2019
DLS/bsd
O070919
46

Deborah L. Simpson

Deborah L. Simpson

Thomas J. Tyrrell

Thomas J. Tyrrell

Maria Elena Portela

Maria Portela

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Bays,

Petitioner,

19IWCC0447

vs.

NO: 18 WC 27050

State of Illinois/Menard Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

As indicated above, this matter was arbitrated under §19(b) of the Act. The Arbitrator found that Petitioner failed to meet his burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2015 is hereby affirmed and adopted with the changes noted above.

19IWCC0447

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

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

DATED: AUG 2 0 2019
o7/9/19
DLS/rm
46

Deborah L. Simpson
Deborah L. Simpson

Maria Elena Portela
Maria E. Portela

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Decision of the Arbitrator. After a careful review of the evidence, I believe Petitioner met his burden of proving he sustained injuries due to an accident arising out of and in the course of his employment. Thus, I would find that a compensable accident occurred and would award benefits accordingly.

Petitioner is a correctional officer in a state prison facility. On the date of accident, Petitioner was stationed in a tower and was charged with observing line movements and providing safety for prison staff stationed on the ground. Petitioner testified that after standing to observe inmates in various lines, he returned to his chair. He testified that as he sat in the chair it broke and he fell to the floor. The chair in the tower is not a normal office chair. Instead, the chair is elevated off the ground approximately five feet and swivels but does not recline. This special chair is only used in the towers and allows a guard to still observe what is happening on the ground while seated. The parties called several witnesses and Respondent denied this seemingly clear-cut claim solely due to the allegation made by another correctional officer that Petitioner was sleeping just before the chair broke. The majority found the testimony of Officer Martin, the alleged witness, more credible than Petitioner's testimony and the medical records. I view the evidence much differently than the majority.

After weighing the credible evidence, I believe Petitioner testified credibly regarding the work accident. Officer Martin's testimony regarding what he allegedly observed through binoculars just prior to Petitioner's accident, is simply not credible. I find it unbelievable that a guard would not report a fellow guard found sleeping while on duty. After all, the safety of the prisoners and the correctional officers depends on each guard being alert and diligently performing his duties. Regardless of Officer Martin's incredible testimony, I believe Petitioner sustained his injury due to a defect in the chair Respondent provided. Petitioner credibly testified regarding the unusual features of the chair and Respondent undeniably only provided a single chair in the tower

for an assigned guard's use. Petitioner credibly testified that the elongated stem of the chair broke and caused him to fall.

For the forgoing reasons, I would reverse the Arbitrator's Decision and find that Petitioner sustained an injury due to an accident arising out of and in the course of his employment. As such, Petitioner is entitled to all appropriate benefits including the requested prospective medical treatment.

Thomas J. Tyrrell

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

19IWCC0447

BAYS, MICHAEL
Employee/Petitioner

Case# **18WC027050**

STATE/ MENARD C C
Employer/Respondent

On 11/13/2018, 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 2.45% 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:

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PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

NOV 13 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
19(b)

Michael Bays
Employee/Petitioner

v.

State/Menard C.C.
Employer/Respondent

Case # 18 WC 27050

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on October 12, 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. ☒ 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, August 13, 2018, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $54,277.56; the average weekly wage was $1,043.79.

On the date of accident, Petitioner was 36 years of age, married with 1 dependent child(ren).

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

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

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

ORDER

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

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 3, 2018
Date

NOV 13 2018

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on August 13, 2018. According to the Application, Petitioner sustained an injury to his right arm, head, neck and body as a whole when a "Chair broke after sitting down" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical as well as prospective medical treatment. Respondent disputed liability on the basis of accident and medical causality (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Correctional Officer. At the time of the accident of August 13, 2018, Petitioner was in one of the observation towers. After observing lines of inmates for chow and the commissary, Petitioner sat in an elevated barstool type chair. At that time, one of the welds in the base of the chair broke which caused Petitioner to fall backward sustaining the injury.

Petitioner's counsel initially called Major Christopher Bradley to testify. Major Bradley stated he was the shift supervisor on August 13, 2018. He confirmed Petitioner was in Tower 10 and he received a call on the radio that an officer was down. Major Bradley did not have any first-hand knowledge of the circumstances of Petitioner's accident, but received a report prepared the following day by David Martin, a Correctional Officer. The report prepared by Officer Martin noted that Officer Martin (who was in another tower) observed Petitioner with his binoculars and Petitioner appeared to be asleep (Petitioner's Exhibit 6). When he testified, Bradley stated officers are reluctant to report misconduct by other officers for fear of being labeled as a snitch.

On cross-examination, Bradley testified Petitioner had been the subject of a number of disciplinary actions in regard to his job performance. Specifically, Petitioner was previously disciplined for permitting a homemade weapon to be taken into the visiting room and abandoning his assigned job.

Petitioner testified he was in Tower 10 on August 13, 2018, and watched the lines of inmates for chow and the commissary. At approximately 10:25 AM, the line movement ended and Petitioner got into the chair. At that time, Petitioner stated the metal base of the chair broke which caused Petitioner to fall backward. Petitioner recalled that he struck his right arm when he fell, and that he was unconscious for a period of time thereafter. Petitioner stated that there was no time when he was on duty on August 13, 2018, that he was sleeping or resting with his feet up on a desk or ledge. Petitioner stated he reviewed the report prepared by Officer Martin and disagreed with it.

Subsequent to the accident, Petitioner was taken to the ER of Chester Memorial Hospital. At that time, Petitioner advised he had sustained a fall when a chair broke, scraped his right forearm and hit his head. A CT scan of Petitioner's head was performed which was normal (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Dr. Alex Garrido, his family physician, who initially saw him on August 16, 2018. Petitioner informed Dr. Garrido of the accident of August 13, 2018, and complained of back/neck pain, lightheadedness and headaches. Dr. Garrido diagnosed Petitioner

with a concussion syndrome and has continued to provide treatment to Petitioner. Dr. Garrido has authorized Petitioner to remain off work (Petitioner's Exhibit 3).

On cross-examination, Petitioner again stated that he was not asleep at the time of the accident. Petitioner was questioned about the distance between the tower he was in and the tower Officer Martin was in and he stated it was approximately 100 yards. Petitioner was then handed an Incident Report dated October 9, 2018, which noted that on October 7, 2018, Petitioner had made a telephone call to Major D. Evelsizer, wherein he inquired about the distance between the two towers. Petitioner acknowledged that purpose of the telephone call was to make that determination (Petitioner's Exhibit 5).

On redirect, Petitioner stated that he doubted whether anyone in one tower could observe someone else in the other tower. However, on re-cross examination, Petitioner agreed binoculars were issued as part of tower duty.

The Witness Incident Report prepared by Officer Martin was received into evidence at trial. The report was prepared by Officer Martin the day following the accident, August 14, 2018. According to that report, Officer Martin observed Petitioner in Tower 10 with his binoculars and saw that Petitioner appeared to be asleep with his feet elevated before and during inmate line movement. When a radio call went out, Petitioner appeared to be startled, fell over and disappeared from Officer Martin's sight. The report also noted Officer Martin had previously observed Petitioner sleeping while on duty (Petitioner's Exhibit 6).

Petitioner's counsel called Officer Martin to testify. Officer Martin estimated the distance between the two towers to be approximately 100 yards. Officer Martin was also watching the inmate movement. Officer Martin was issued both a weapon and binoculars and stated that it was the job of the officers in the towers to "watch everything" which included the other tower officers. Officer Martin stated he had to put his weapon down and pick up the binoculars to observe Petitioner; however, it was totally appropriate for him to do so.

Officer Martin stated he could clearly observe Petitioner with the binoculars and the sun was behind him so Petitioner's image was illuminated. Officer Martin described the chair as having a rigid/straight back and while seated in one of them, one would sit straight up and look out. Officer Martin described Petitioner as being in an exaggerated slouched position with his hands on his chest and his feet up on the wooden ledge adjacent to the window. It was when the call went out over the radio that Petitioner moved suddenly and fell backward and out of Officer Martin's sight.

Petitioner testified in rebuttal. Petitioner stated that the tower Officer Martin was in was two stories shorter than the tower he was in. However, on cross-examination, Petitioner conceded Officer Martin would have been able to observe him with his binoculars.

Major Bradley testified in rebuttal on behalf of Respondent. He disagreed with Petitioner's testimony that the tower Petitioner was in and was two stories taller than the tower Officer Martin was in. He estimated the tower Petitioner was in was approximately 10 to 15 feet taller than the tower Officer Martin was in.

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

The Arbitrator concludes Petitioner did not sustain an accidental injury arising out of and in the course of his employment by Respondent on August 13, 2018.

In support of this conclusion the Arbitrator notes following:

The evidence clearly supports the conclusion Petitioner was asleep at the time he sustained the accident on August 13, 2018.

Petitioner's credibility is highly questionable and he was disciplined for poor job performance prior to the accident of August 13, 2018, specifically, permitting a homemade weapon to be taken into the visitor room and abandoning his assigned job.

In the Witness Incident Report completed by Officer Martin, it indicated that in addition to his observation of Petitioner appearing to be asleep on August 13, 2018, he noted he had previously observed Petitioner sleeping while on duty.

Officer Martin credibly testified he observed Petitioner by using binoculars issued to him and Petitioner was in a slouched position with his hands on his chest and appeared to be asleep with his feet on the ledge until a call went out over the radio which startled Petitioner and apparently caused him to fall.

The fact that Officer Martin did not make the report of what he observed until the following day does not significantly impact his credibility. The Arbitrator acknowledges the reality that there is a reluctance of an officer to report misconduct of a fellow officer.

The Arbitrator acknowledges that Officer Martin could not hold his weapon and binoculars at the same time. Obviously, an officer performing such observation duties would have to alternate the use of the weapon and binoculars. It appears that it was anticipated that officers on duty in the towers would possibly require both a weapon and binoculars or they would not have been issued.

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

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN BUMPHUS,

Petitioner,

19IWCC0448

vs. No: 17 WC 28585

UNIQUE PERSONNEL,

Respondent.

DECISION AND OPINION ON REVIEW

Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of *Res Judicata*, dismissal of the instant Application for Adjustment of Claim, and denial of Petitioner's Motion to Reinstate, and being advised in the facts and law affirms the Decisions of the Arbitrator dismissing the instant Application for Adjustment of Claim and the Arbitrator's denial of Petitioner's Motion to Reinstate.

Procedural background

Petitioner initially filed an Application for Adjustment of Claim under the Workers' Compensation Act in 15 WC 27577. There, he claimed he developed the psychological condition of anxiety, manifesting on July 17, 2015, and alleging it was caused by his employer's failure to accommodate his medical condition as well as "bullying and duplicity."

The matter was arbitrated before Arbitrator Rowe-Sullivan on March 23, 2016. On April 19, 2016, she issued a decision finding that Petitioner did not prove he sustained an accident causing a psychological injury and denied compensation. In her decision, the Arbitrator distinguished Appellate Court cases that allowed mental-mental claims *inter alia* on the fact that those claims were filed under the Occupational Diseases Act and that Petitioner's claim was filed under the Workers' Compensation Act. Petitioner filed a Petition for Review of the arbitration decision and on April 19, 2017 the Commission affirmed and adopted the Decision of the Arbitrator. Petitioner appealed to the Circuit Court of Madison County. On November 17, 2017, the court affirmed the Decision of the Commission affirming the Arbitrator's denial of compensation.

On September 29, 2017, Petitioner filed a new Application for Adjustment of Claim alleging the same set of facts and same accident date. However, he filed it under the Occupational Diseases Act rather than under the Workers' Compensation Act as he did previously. Respondent moved the application be dismissed based on the doctrine of *Res Judicata*. That Motion was granted by Arbitrator Lee on May 8, 2018. On June 19, 2018, Arbitrator Lee declined to rule on Petitioner's Motion to Reinstate for lack of jurisdiction.

Petitioner then sent a letter to the Commission critisizing the Decision of Arbitrator Lee not to reinstate his application. The Commission construed the letter to be a Petition for Review of the decision not to reinstate, sent the parties a briefing schedule, and the parties filed briefs. Petitioner then filed a mandamus action naming Arbitrator Lee and the Commission. The Circuit Court of Madison County dismissed Petitioner's action based on its lack of jurisdiction because the review was pending before the Commission and Petitioner had not exhausted his administrative remedies.

Statutory provision

Petitioner relies on the following paragraph from the Illinois Occupational Diseases Act to justify filing his second Application and in support of his Motion to Reinstate (820 ILCS 310/19(a)(1)):

> "Whenever any claimant misconceives his remedy and files an application for adjustment of claim under the Workers' Compensation Act and it is subsequently discovered, at any time before final disposition of such cause that the claim for injury or death which was the basis for such application should properly have been made under this Act, then the application so filed under the Workers' Compensation Act may be amended in form, substance or both to assert claim for such disability or death under this Act and it shall be deemed to have been so filed as amended on the date of the original filing thereof, and such compensation may be awarded as is warranted by the whole evidence pursuant to the provisions of this Act. When such amendment is submitted, further or additional evidence may be heard by the Arbitrator or Commission when deemed necessary; provided, that nothing in this Section contained shall be construed to be or permit a waiver of any provisions of this Act with reference to notice, but notice if given shall be deemed to be a notice under the provisions of this Act if given within the time required herein."

Conclusions of Law

The Commission finds that the Arbitrator correctly dismissed this cause, 17 WC 28585, on the basis of *Res Judicata*. The statute Petitioner cites is inapplicable because Petitioner did not move to AMEND the Application filed in cause 15 WC 27577. He filed a second Application alleging similar facts and the same accident date.

Furthermore, the Commission finds that the Arbitrator lacked jurisdiction over the subject matter when Petitioner filed his Motion to Reinstate and therefore he was correct in denying that motion. Initially, Petitioner did not file a Petition to Review the Arbitrator's dismissal of his claim. Instead, he filed a Motion to Reinstate the claim, which did not toll the running of the time in which he had to file a Petition for Review. Petitioner did not file a Petition for Review within 30 days of receipt of the Order of Dismissal. (*See*, 820 ILCS 305/19(b)). Therefore, the Commission lacks jurisdiction over this matter as well. Accordingly, Petitioner's Petition to Review the dismissal of the claim on the basis of *Res Judicata* is dismissed for lack of jurisdiction.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's dismissal of the instant Application for Adjustment of Claim on May 8, 2018 is affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION, that the Arbitrator's denial of Petitioner's Motion to Reinstate on June 19, 2018 is affirmed.

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

DATED: AUG 20 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-7/15/19
46

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

Carlon Madison,

Petitioner,

vs. NO: 12 WC 39159

State of Illinois Department of Rehabilitation Services,

19IWCC0449

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 notice, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 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 20 2019
TJT:yl
o 8/13/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MADISON, CARLON
Employee/Petitioner

Case# **12WC039159**

19IWCC0449

REHABILITATION SERVICES
Employer/Respondent

On 3/20/2018, 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 1.95% 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:

3181 BUTLER & KEMPER
ROBERT W BUTLER
2421 CORPORATE CENTRE DR #101
GRANITE CITY, IL 62040

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

6137 ASSISTANT ATTORNEY GENERAL
CORI STEWART
W POINTE DR SUITE 7
SWANSEA, IL 62226

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 20 2018

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

19IWCC0449

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Carlon Madison
Employee/Petitioner

v.

Rehabilitation Services
Employer/Respondent

Case # 12 WC 39159

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 William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on February 16, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] 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 _____

Document

19IWCC0449

FINDINGS

On February 1, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $36,636.60; the average weekly wage was $704.55.

On the date of accident, Petitioner was 54 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 4 as provided by Sections 8(a) and 8.2 of the Act subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $469.70 per week for 17 4/7 weeks commencing March 16, 2012, through July 16, 2012, , as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $422.73 per week for 38 weeks because the injury sustained caused the 10% loss of use of right hand and the 10% loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

March 16, 2018
Date

ICArbDec p. 2

MAR 20 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of February 1, 2012, and that Petitioner sustained a repetitive trauma injury to both hands (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident, notice and causal relationship in regard to arthritis (Arbitrator's Exhibit 1).

In regard to the notice dispute, the stipulation indicated that Petitioner gave notice on February 20, 2012, to Geraldine (no last name) and Carla Commander, both of whom were identified as "supervisor/client." In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits for a period of 17 4/7 weeks, commencing March 16, 2012, through July 16, 2012. Respondent stipulated that Petitioner was temporarily totally disabled for that period of time, but disputed liability for same (Arbitrator's Exhibit 1).

Petitioner has worked for Respondent for approximately 30 years as a caregiver for disabled people. Petitioner provided for services to the disabled people in their homes and her services included bathing/washing, dressing, providing assistance getting in/out of bed/wheelchairs, cooking, housework, laundry, etc.

Petitioner referred to the various individuals she provided services to as "clients." Petitioner testified about the hiring process of Respondent. When Petitioner first applied for her job with Respondent, she filled out an application. Upon been approved by Respondent, Petitioner's name was put on a list which was then submitted to various prospective clients. The prospective client would then interview and hire the caregiver if he/she chose to do so. If approved by the client, the caregiver would start performing services for the client. The client would set the hours and determine the caregiver's job duties. If the caregiver was ill or wanted time off, he/she would speak with the client who would either approve or deny the request. The client also had the authority to terminate the caregiver. The client would then review and sign a statement of the caregiver's hours which the caregiver would then drop off in a box for the Respondent. Petitioner did not have a contact person with Respondent.

Petitioner testified that in February, 2012, she was working with three clients. One was a double amputee (both legs), another had cerebral palsy and the third was partially paralyzed. None of the three clients were able to walk on their own. Petitioner testified that the duties she performed for each of the clients were physically demanding and she usually worked four to six hours with each client and worked approximately 11 hours a day, five days a week and sometimes worked four hours on Saturdays.

Petitioner stated she began to experience numbness/tingling in both of her hands which caused her to experience sleep disruption. Sometime in February, 2012, Petitioner sought medical treatment from her family physician, Dr. Krisna Kunche, who prescribed wrist splints. Dr. Kunche's records were not tendered into evidence at trial; however, she ordered nerve conduction studies which were performed on January 18, 2012, and subsequently referred Petitioner to Dr. Bruce Vest, an orthopedic surgeon.

Dr. Vest initially evaluated Petitioner on February 20, 2012, and reviewed the nerve conduction studies. Dr. Vest opined Petitioner had bilateral carpal tunnel syndrome and mild degenerative arthritis of the CMC joints of both thumbs. He recommended Petitioner undergo carpal tunnel release surgery on both wrists (Petitioner's Exhibit 1; Deposition Exhibit 2).

Subsequent to her appointment with Dr. Vest, Petitioner gave notice to two of her clients, Geraldine (could not recall her last name), the client who had cerebral palsy, and Carla Commander. At that time, Petitioner was providing services to those two clients.

Dr. Vest performed carpal tunnel release surgeries on Petitioner's left and right hands on March 16 and April 5, 2012, respectively. Subsequent to the surgeries, Dr. Vest ordered physical therapy. He later released Petitioner to return to work without restrictions on July 16, 2012 (Petitioner's Exhibit 1; Deposition Exhibit 2).

In response to a letter from Petitioner's counsel, Dr. Vest addressed the issue of whether Petitioner's bilateral carpal tunnel syndrome was related to her work activities. In a report dated July 3, 2014, Dr. Vest initially noted Petitioner did not have either diabetic or thyroid conditions or any other activities/risk factors that could cause carpal tunnel syndrome. Based upon Petitioner's work activities, as described in the letter from Petitioner's counsel, Dr. Vest opined the work activities could have caused or aggravated the bilateral carpal tunnel syndrome (Petitioner's Exhibit 1; Deposition Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on May 16, 2017. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records provided to him by Respondent. In regard to the causality of the bilateral carpal tunnel syndrome, Dr. Sudekum opined Petitioner's job activities could have aggravated the condition. In regard to Petitioner's bilateral hand/wrist arthritis, Dr. Sudekum opined that Petitioner's work activities did not cause or aggravate that condition (Petitioner's Exhibit 3).

Dr. Vest was deposed on December 6, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Vest's testimony was consistent with his medical records. He specifically noted that Petitioner did not have either diabetes or any thyroid conditions. When asked about whether Petitioner's bilateral carpal tunnel syndrome was caused or aggravated by her work activities, Dr. Vest reaffirmed his opinion that there was a causal relationship as he had previously noted in his report of July 3, 2014 (Petitioner's Exhibit 1; pp 6, 11-12).

On cross-examination, Dr. Vest agreed that he was not aware of how much time Petitioner spent performing each of her job duties, whether they were continuous or whether Petitioner was able to rest in between. He also agreed that Petitioner's job description was limited to what Petitioner's counsel advised him of in his letter when he requested the report regarding causality (Petitioner's Exhibit 1; pp 15-17).

At trial, Petitioner testified that the numbness/tingling symptoms in both hands had completely resolved. Petitioner stated she still experiences some pain in both hands, but not nearly as much as she did prior to undergoing the surgeries. Petitioner also stated that her grip strength in both hands is less than it what was prior to the surgeries, but that she is still able to perform all of her job duties. However, Petitioner also stated that she experiences stiffness in both hands if she attempts to do too much. Petitioner testified she stopped working full time about one year prior to the date of trial.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent and that her current condition of ill-being is, in part, causally related to her work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified in detail regarding her job duties as a caregiver for disabled people. This testimony was unrebutted.

Both Petitioner's treating physician, Dr. Vest, and Respondent's Section 12 examiner, Dr. Sudekum, opined that Petitioner's bilateral carpal tunnel syndrome could have been caused or aggravated by her work activities.

Respondent's Section 12 examiner, Dr. Sudekum, opined that there was not a causal relationship between Petitioner's work activities and her bilateral hand/wrist arthritis. Petitioner's treating physician, Dr. Vest, did not opine as to whether there was a causal relationship between Petitioner's work activities and her bilateral hand/wrist arthritis.

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

The Arbitrator concludes that Petitioner gave notice to Respondent within the time period required by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she informed her two clients shortly after her appointment with Dr. Vest of February 20, 2012. That testimony was unrebutted.

Petitioner testified that the clients had the right to interview/hire, set the hours, determine Petitioner's job duties, authorize time off and terminate Petitioner's services. That testimony was unrebutted.

Petitioner testified she would turn in her hours worked to Respondent by dropping off a statement of same in a box. Petitioner did not have a supervisor with Respondent who she reported to. That testimony was unrebutted.

Respondent's position was that Petitioner's informing the two clients did not constitute notice to Respondent; however, Respondent did not tender any evidence as to whom appropriate individual an accidental injury should have been reported to.

Section 6(c)(2) of the Act provides in part that "No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is *unduly prejudiced* in such proceedings by such defect or inaccuracy." (Emphasis added).

In this case, Respondent did not present any evidence that its rights were "unduly prejudiced" because Petitioner's notice to Respondent may have been defective. As aforestated, Petitioner's testimony regarding her job duties was unrebutted. Respondent had the opportunity to present evidence to the contrary, but did not do so. Further, Respondent had Petitioner examined by a physician of its choosing pursuant to Section 12 of the Act, who reviewed Petitioner's medical records and job duties and opined that her condition was, in part, related to her work activities.

The Illinois Supreme Court has held that a defect or inaccuracy in the notice is not a bar to the maintenance of proceedings on arbitration by the employee unless the employer proves it was unduly prejudiced by the defect or inaccuracy. Sohio Pipe Line Co. v. Industrial Commission, 345 N.E.2d 468, 470 (Ill. 1976).

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

The Arbitrator concludes that all the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 4 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 17 4/7 weeks commencing March 16, 2012, through July 16, 2012.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner was temporarily totally disabled during the aforestated period of time.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 10% loss of use of the right hand and 10% loss of use of the left hand.

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 caregiver who provided various services to disabled people. The job duties required the active and repetitive use of both of her hands. The Arbitrator gives this factor significant weight.

Petitioner was 54 years of age at the time of the accident. At the time the case was tried, Petitioner was 60 years of age and had stopped working full time approximately one year prior to trial. The Arbitrator gives this factor moderate weight.

As aforestated, Petitioner stopped working full time approximately one year prior to the time the case was tried and is earning less. However, there was no evidence that Petitioner's decision to reduce her work hours had anything to do with her bilateral carpal tunnel syndrome. The Arbitrator gives this factor no weight.

Petitioner was diagnosed with bilateral carpal tunnel syndrome and underwent carpal tunnel release surgeries on both hands. Petitioner's symptoms improved following the surgeries, but she still has complaints consistent with the injury she 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cedric Bean,

Petitioner,

vs.

NO: 16 WC 32769

Amsted Rail,

19IWCC0450

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 8, 2019, is hereby affirmed and adopted.

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

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

19IWCC0450

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

DATED: AUG 22 2019
TJT:yl
o 7/9/19
51

Maria Elena Portela
Maria E. Portela

Deborah L. Simpson
Deborah L. Simpson

DISSENT

I totally disagree with the Arbitrator's reliance on the opinion of Respondent's hired-gun, Dr. Katz, who is not an orthopedic surgeon, over that of treating board certified orthopedic surgeon Dr. Choi in denying compensation in this claim.

Petitioner credibly testified that he had worked for Respondent for 16 years and that he did not have any problems with his hands or arms before he began his employment. (T.12-13). Furthermore, the job analysis video (RX6), specifically with respect to the plate line operator position Petitioner has worked in for the past six years, clearly shows that his job demanded the gripping, grasping and manipulation of 9" square metal sheets weighing 5 to 7 pounds using both hands, and that he would perform this activity 1,000 a day. By any reasonable standard that's a substantial amount of repetition, and a job that Dr. Choi rightly concluded could have significantly contributed to the evolution of, at the very least, Petitioner's right carpal tunnel syndrome, if not bilateral carpal tunnel syndrome per Dr. Phillips' EMG/NCV performed on July 10, 2018, a study that Dr. Katz never even saw much less offered an opinion on.

As a result, I would reverse the Arbitrator's decision and find that Petitioner sustained repetitive trauma-type injuries arising out of and in the course of his employment on or about October 7, 2016, and that a causal relationship existed between said accident and Petitioner's current condition of ill-being with respect to his right and left hands/wrists.

And for that reason, I respectfully dissent.

Thomas J. Tyrrell
Thomas J. Tyrrell

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

BEAN, CEDRIC
Employee/Petitioner

Case# **16WC032769**

AMSTED RAIL
Employer/Respondent

19IWCC0450

On 1/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

0385 BOGG AVELLINO LACH & ET AL
STEVEN J McMAHON
2900 FRANK SCOTT PKWY W #988
BELLEVILLE, IL 62223

19IWCC0450

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)

Cedric Bean
Employee/Petitioner

v.

Amsted Rail
Employer/Respondent

Case # 16 WC 32769

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on November 28, 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. ☒ 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 (manifestation), October 7, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $52,591.10; the average weekly wage was $1,039.25.

On the date of accident, Petitioner was 40 years of age, single with 1 dependent child(ren).

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

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

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

ORDER

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

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

January 1, 2019
Date

JAN 8 – 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment by Respondent. The Application alleged a date of accident (manifestation) of October 7, 2016, and that Petitioner sustained repetitive trauma to both hands and arms (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner has been employed by Respondent for approximately 16 years. For the six years preceding the date of trial, Petitioner worked for Respondent as a plate line operator. Petitioner testified that while working as a plate line operator, he would grind and cut metal plates. Each plate weighed about five pounds and Petitioner would put the plate on a magnet, push it onto a grinder and hold it in place. The Petitioner operated a machine which would move and slide the plate inside another machine where the grinder was located. Petitioner used his right hand to push/pull a bar when performing this task. Petitioner estimated he would grind 1,000 plates every day.

At trial, Respondent tendered into evidence a video of Petitioner performing his job duties. The Arbitrator watched the video which was slightly less than four minutes long. Petitioner was observed placing metal plates on the magnet and rotating the machine to position the plate over the grinder. Petitioner holds the plate in position for a few seconds and the machine moves back on its own to its original position. There was no visible vibration (Respondent's Exhibit 6).

At trial, Respondent also tendered into evidence a vibration analysis of the plate grinder dated October 26, 2016. It was prepared by Timothy Knox, a physical therapy and ergonomic assessment specialist. Knox used a vibration analyzer to determine the amount of vibration exposure to the operator of the plate grinder. Knox determined an operator of the plate grinder would grind an average of 800 and 1,000 plates during an eight hour and ten hour shift, respectively. However, Knox also noted the study revealed the vibration exposure was considerably lower than what would cause repetitive motion disorders of the hands (Respondent's Exhibit 5).

Petitioner initially sought treatment at Respondent's plant dispensary on July 21, 2016, for left neck and right arm pain. At that time, Petitioner advised that when he put a plate on the magnet, he felt pain in the left side of his neck which went down his right shoulder and elbow. Petitioner was given medication and an application of heat. Petitioner's condition improved and he was able to return to work (Respondent's Exhibit 8).

It was not clear when Petitioner first sought medical treatment for hand symptoms; however, Petitioner underwent EMG/nerve conduction studies on September 8, 2016, administered by Dr. Riaz Naseer. According to his report of that date, the ordering physician was Dr. Jim Hong. Petitioner complained of numbness referable to the right hand. According to Dr. Naseer, Petitioner had "Evolving sensory Carpal Tunnel Syndrome" and a normal EMG exam (Petitioner's Exhibit 1).

Petitioner was seen by Dr. Hong on October 7, 2016 (the date of manifestation alleged in the Application) for right hand numbness, pain and weakness that had been present for three months. Dr. Hong opined Petitioner had right carpal tunnel syndrome and recommended Petitioner use a wrist splint (Petitioner's Exhibit 1).

Petitioner was subsequently evaluated by Dr. Luke Choi, an orthopedic surgeon, on October 28, 2016. At that time, Petitioner informed Dr. Choi he had right hand pain and had underwent EMG/nerve conduction studies which were consistent with carpal tunnel syndrome. In regard to his work activities, Petitioner advised Dr. Choi he used a grinding machine in which he would grind approximately 1,000 metal plates a day on a large grinding wheel. Petitioner described this as involving a very high level of vibration (Petitioner's Exhibit 2).

On examination, Dr. Choi observed Petitioner had a significant amount of callus formation in the palm of his right hand. He also noted Petitioner had positive Phalen's and Tinel's findings at the level of the carpal tunnel, but no muscular atrophy. Dr. Choi reviewed the report of the EMG/nerve conduction study and noted the findings were consistent with evolving sensory carpal tunnel syndrome. Dr. Choi opined Petitioner had right wrist carpal tunnel syndrome and he recommended Petitioner undergo corrective surgery (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Richard Katz, a physical medicine/rehabilitation specialist, on January 20, 2017. In connection with his examination of Petitioner, Dr. Katz reviewed medical records, a job description and the vibration analysis. On examination, Dr. Katz noted a positive Phalen's sign in the right hand. Dr. Katz ordered a nerve conduction study on the right upper extremity which was performed that same day. The diagnostic study was normal (Respondent's Exhibit 2).

Dr. Katz noted Petitioner had symptoms of right carpal tunnel syndrome, but a normal nerve conduction study, so he opined Petitioner had "possible" carpal tunnel syndrome. Dr. Katz noted Petitioner had advised he had vibratory exposure, but the information Dr. Katz reviewed from Respondent indicated he had no vibratory exposure. He also referenced the fact Petitioner had a brother who has been diagnosed with carpal tunnel syndrome and was obese, having a BMI of 38.6 (Respondent's Exhibit 2).

Dr. Katz subsequently re-reviewed the vibratory analysis and prepared a supplemental report dated January 30, 2017. Dr. Katz opined the work exposure did not support Petitioner having work-related carpal tunnel syndrome (Respondent's Exhibit 2).

Dr. Choi was deposed on July 19, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Choi's testimony was consistent with his medical report of October 28, 2016, and he reaffirmed the opinions contained therein. Dr. Choi testified Petitioner informed him that his job duties involved using a grinding machine that involved a very high level of vibration. He opined Petitioner's job duties could have contributed to Petitioner's right carpal tunnel syndrome (Petitioner's Exhibit 4; pp 5-6, 11-12).

In regard to his diagnosis of right carpal tunnel syndrome, Dr. Choi testified Petitioner had a positive examination for right carpal tunnel syndrome and an EMG/nerve conduction study which revealed evolving carpal tunnel syndrome (Petitioner's Exhibit 4; pp 6-7).

On cross-examination, Dr. Choi stated that he assumed Petitioner used both hands when operating the grinder, even though Petitioner only had right hand symptoms. In regard to the level of vibration Petitioner was exposed to, Dr. Choi reviewed Dr. Katz' report and its reference to the vibration analysis. He agreed he did not know the level of vibration Petitioner was exposed to at his job and his opinion was based upon what Petitioner had told him (Petitioner's Exhibit 4; pp 32- 35).

Dr. Katz again examined Petitioner on September 18, 2017. At that time, Dr. Katz' examination of Petitioner's right hand was essentially normal for carpal tunnel syndrome. Dr. Katz ordered another nerve conduction study which was performed that same day. It was normal. Dr. Katz was provided with the video of Petitioner working on the plate grinder which both he and the Petitioner watched. Petitioner informed Dr. Katz that the video was not complete because he also ran a press and a shearer (Respondent's Exhibit 2).

Dr. Katz opined Petitioner was not subject to any work-related risk factors for carpal tunnel syndrome. Rather than carpal tunnel syndrome, Dr. Katz indicated another alternative diagnosis might be indicated, namely, either palmar fasciitis or palmar nerve irritation (Respondent's Exhibit 2).

At the direction of Dr. Choi, Petitioner was subsequently evaluated by Dr. Daniel Phillips, a neurologist, on July 10, 2018. Dr. Phillips performed EMG/nerve conduction studies on both upper extremities. The tests were positive for severe right carpal tunnel syndrome and mild left carpal tunnel syndrome (Petitioner's Exhibit 3).

Dr. Choi saw Petitioner on July 10, 2018, and reviewed the EMG/nerve conduction studies. He opined Petitioner had bilateral carpal tunnel syndrome, right greater than left, and recommended Petitioner undergo bilateral carpal tunnel release surgeries (Petitioner's Exhibit 2).

Dr. Choi subsequently reviewed the video of Petitioner working at the plate grinder and prepared a narrative report dated October 5, 2018, directed to Petitioner's counsel. In that report, Dr. Choi reaffirmed his opinion Petitioner's work activities could have contributed to or aggravated Petitioner's underlying carpal tunnel syndrome condition (Petitioner's Exhibit 2).

At trial, Petitioner testified he was not diabetic, did not have gout or any thyroid disorder. Petitioner continues to have symptoms in both hands and wants to proceed with the surgeries as recommended by Dr. Choi.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner did not sustain a repetitive trauma injury arising out of and in the course of his appointment by Respondent and his current condition of ill-being is not related to his work activities.

In support of this conclusion the Arbitrator notes the following:

Although the Application alleged a repetitive trauma injury to both hands and arms that manifested itself on October 7, 2016, Petitioner only had complaints referable to the right hand at that time. It was not until July, 2018, that a diagnosis was made in regard to the left hand.

Dr. Choi's opinion that Petitioner's carpal tunnel syndrome was related to his work activities was based, to a large extent, upon Petitioner's description of his work activities wherein he advised he was subject to a high level of vibration.

Respondent's vibratory analysis revealed vibration exposure to which Petitioner was subjected was lower than what would cause a repetitive motion disorder.

The Arbitrator watched the video of Petitioner performing work duties on the plate grinder and did not observe any visible vibration.

Respondent's Section 12 examiner, Dr. Katz, examined Petitioner, reviewed the vibration analysis, a job description and the video of Petitioner working at the plate grinder. Based on the proceeding, Dr. Katz opined Petitioner did not have work-related carpal tunnel syndrome and that, an alternative diagnoses might be indicated.

The Arbitrator finds the opinion of Dr. Katz to be more persuasive than that of Dr. Choi in regard to causality. Dr. Katz had a more accurate and thorough understanding of Petitioner's job duties than Dr. Choi.

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

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arthur Clark,

Petitioner,

vs.

NO: 17 WC 20778

Hampton's Kitchen & Appliances,

19IWCC0451

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 January 7, 2019, 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.

19IWCC0451

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 $900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

AUG 22 2019

DATED:
TJT:yl
o 8/13/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

CLARK, ARTHUR
Employee/Petitioner

Case# **17WC020778**

17WC020779

HAMPTON'S KITCHEN & APPLIANCES
Employer/Respondent

19IWCC0451

On 1/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

19 IWCC0451

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Arthur Clark
Employee/Petitioner

v.

Case # 17 WC 20778

Consolidated cases: 17 WC 20779

Hampton's Kitchen & Appliances
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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **November 15, 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. ☒ 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, **April 12, 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*** 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$30,992.00**; the average weekly wage was **$596.00**.

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

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

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

Respondent shall be given a credit of **$1,672.19** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of April 12, 2017, Petitioner's request for prospective medical treatment to the lumbar spine as recommended by Dr. Bernstein is denied.

Respondent shall pay for medical services **rendered during the timeframe of April 12, 2017 through July 11, 2017 as contained in Petitioner's Exhibit 8** 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 **for treatment rendered during the timeframe of April 12, 2017 through July 11, 2017 as contained in Petitioner's Exhibit 8** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of April 12, 2017 through July 11, 2017 as contained in Petitioner's Exhibit 8** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall be given a credit of **$1,672.19** 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. Rose Gillman
Signature of Arbitrator

1/3/19
Date

ICArbDec19(b)

JAN 7 - 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Arthur Clark
Employee/Petitioner

Case # 17 WC 20778

v.

Consolidated cases: 17 WC 20779

Hampton's Kitchen & Appliances
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he worked for Respondent for 15 years and that his job duties included delivering appliances, hooking up the appliances at customer's homes and warehousing items. Petitioner testified that on April 12, 2017, he was operating a delivery truck when he was rear-ended by another vehicle while he was waiting to make a left-hand turn. He testified that the force of the collision caused him to hit his head on the steering wheel and that he felt pain in his neck, right shoulder, right arm, and back. He testified that he was taken by ambulance to the emergency room. He testified that he underwent x-rays and a CT scan and was told to follow-up with his doctor, which he did about 12 days later.

Petitioner testified that when he saw his primary care physician he had neck pain, shoulder pain, arm pain and back pain. He testified that his primary care physician treated him and gave him lifting restrictions for work, and that at that time his employer did not have light duty. He testified that he started physical therapy in early May. He testified that physical therapy provided relief and that he was eventually discharged. He testified that he underwent physical therapy for about two months. He testified that when he was discharged from therapy, he followed-up with his primary care physician who sent him back to work. He testified that he was still having neck pain, shoulder pain, arm pain and back pain but that he was released back to work full duty. He testified that he when he was released to return to work, he was still having complications with his shoulder, arm and back and that he was not able to perform his job as well.

Petitioner testified that after he was returned to work, in July he had a delivery of 18 sets of appliances up to the third floor. He testified that while making the delivery, he had strapped a stacked washer and dryer onto a dolly and that as he was walking, he fell straight back on the stairs with the appliances on the dolly. He testified that after the incident, he felt excruciating back pain as well as tingling in his toes and numbness. He testified that he called a supervisor who picked him up and transported him to Proctor Hospital. He testified that he then saw his primary care physician who had him undergo additional therapy.

Petitioner testified that he next returned return to work on or about July 31, 2017 when he was tasked with unboxing refrigerators. He testified that he was still having back pain, shoulder pain and arm pain while performing these tasks. He testified that he was seen at Proctor Hospital on that date where he was given an injection and taken back off work. He testified that he followed-up with his primary care

physician, who ordered an MRI and took him off work. He testified that his primary care physician referred him to Dr. Bell at Midwest Orthopaedics.

Petitioner testified that Dr. Bell wanted to try injections before anything else, but that the two injections that were performed provided him with no relief. He testified that Dr. Bell recommended that he see a spine specialist. He testified that he was seen by Dr. Bernstein for an IME at his attorney's request. He testified it was understanding that Dr. Bernstein suggested that he had several herniated discs and that he could consider having surgery. Petitioner testified that he is unable to sleep, that he is unable to progress and that he is ready to return to work, and that he is inclined to undergo surgery.

Petitioner testified that he still has chronic back pain, leg pain and numbness, and that he is slow to move at times. He testified that since the accident occurred on July 12, 2017, his back pain has never resolved.

The Employee's Report of Injury Forms were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. As to the form pertaining to the date of accident of April 12, 2017, it was noted that the body parts affected were that of the head, neck and lower back, and that while waiting to turn left to enter a delivery location, Petitioner's vehicle was hit from behind, his head whipped forward, he hit his head on the steering wheel and he bit his lip from the impact. As to the form pertaining to the date of accident of July 12, 2017, it was noted that the body parts affected were that of the right neck, right side shoulder and right lower back, and that while walking up to the third floor with a stacked washer and dryer unit Petitioner's foot got caught in the step as he was lifting the unit to come up another step, that the unit fell on his right shoulder and that as he was walking, "Jessie" caught the unit to avoid Petitioner and the unit from falling down the steps. (PX1).

The medical records of OSF St. Francis Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen in the emergency room on April 12, 2017, at which time it was noted that he was seen for a motor vehicle collision. It was noted that Petitioner was the restrained driver of a freight liner truck that was rear-ended, that he presented with right-sided neck pain and right-sided lumbar pain, that the pain was at a severity of 4/10 and that there was no loss of consciousness. It was noted that the accident occurred while traveling at a low speed, that the vehicle's windshield and steering column were intact after the accident, and that the airbag was not deployed. X-rays of the lumbar spine performed on that date were interpreted as revealing essentially normal plain film evaluation of the lumbosacral spine. A CT of the cervical spine performed on that date were interpreted as revealing no evidence of acute fracture in the cervical spine. The clinical impression was noted to be that of neck strain, strain of muscle, fascia and tendon of the lower back, and encounter for examination following motor vehicle collision. (PX2).

The records of OSF St. Francis Medical Center reflect that Petitioner was seen in the emergency room on July 19, 2017, at which time it was noted that he was seen for chief complaints of back pain, shoulder pain and neck pain. It was noted that Petitioner had had a motor vehicle accident on April 12, 2017 as well as allegedly July 4, 2017 (per records), and that he also reported that he injured himself on July 12th while returning to work and carrying a washer that had fallen and hit him in the right shoulder. It was noted that Petitioner reported that this aggravated his prior pain and that he was now out of work again as it was a worker's compensation injury. It was noted that Petitioner complained of continued back, shoulder and neck pain, that he stated that he had returned to physical therapy and that he reported that his pain was better when leaning over rather than standing. It was noted that Petitioner had used Norflex and Naprosyn from his primary care physician without relief, and that he had a follow-up on Friday with his primary care physician. It was also noted that Petitioner was ambulatory and had no evidence of contusion or rash on his right shoulder, flank or low back. The Triage note indicated that Petitioner was complaining of right-sided neck, shoulder and low back pain since being involved in a motor vehicle collision on July 4, 2017. The diagnoses were noted to be that of low back strain and muscle spasm of the back. (PX2).

The medical records of Proctor First Care/Dr. Ausfahl were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on April 24, 2017, at which time it was noted that he stated that he was in a car accident on April 12,2 017 and had had right-sided neck pain and migraines. It was noted that Petitioner stated that he was seen at OSF emergency room and later his primary care physician's office, and that he was put on light duty, that he had received a 20-pound weight restriction but had had to lift stoves and refrigerators at work which were much heavier and that he could not abide by the restriction if working. It was also noted that it was hard for Petitioner to drive since he was unable to turn his head to the right to look due to neck pain on the right side and stiffness. It was also noted that Petitioner continued to have neck stiffness which was not improving, that he denied any numbness/tingling/weakness in his arms and that he had spoken with a worker's compensation representative who informed him that he could get a second opinion from another provider regarding further care since he was not improving and work was likely exacerbating his symptoms and delaying recovery. The diagnosis was noted to be that of injury to the head and neck due to motor vehicle accident. It was noted that Petitioner had a neck strain/whiplash injury with persisting symptoms. Petitioner was recommended to start Medrol, to continue Flexeril and Naproxen, to use heat packs twice daily along with stretches and rest and to stay off work for two weeks for recovery. (PX3).

The records of Proctor First Care reflect that Petitioner called on May 2, 2017, indicating that he was still having neck pain and wanted to be sent to physical therapy. It was noted that Petitioner was informed to schedule a follow-up appointment in the clinic since it was worker's compensation for documentation and for referral to physical therapy. The records reflect that Petitioner was seen on May 8, 2017, at which time it was noted that he stated that he still had neck pain and headaches and that he wanted to discuss possible physical therapy. It was noted that Petitioner was very insistent that he had to be held off work. The assessment was noted to be that of flexion/extension injury of the neck from motor vehicle accident on April 12, 2017. It was noted that Petitioner was to follow-up in two weeks and that he needed to follow-up with his primary care physician for his hypertension. It was also noted that Petitioner was to return to work on a restricted basis. At the time of the May 22, 2017 visit, it was noted that Petitioner stated that he was still having ongoing neck pain, that he stated that the pain was worse with certain movements and that he just began physical therapy. It was noted that Petitioner also stated that he had been having continual low back pain, that there had been some numbness and tingling to the lower legs over the weekend and that he stated that it had been progressing in nature. It was noted that the low back issue was noticed mainly in the last week or so, and that the low back pain had an onset subsequent to the neck pain. The assessment was noted to be that of neck pain from flexion/extension injury. Petitioner was recommended to maintain the Naproxen and physical therapy. (PX3).

The records of Proctor First Care reflect that Petitioner called on June 2, 2017 requesting a refill on his Norco and muscle relaxer for his lower back pain and neck pain. At the time of the June 5, 2017 visit, it was noted that Petitioner was seen for follow-up on his neck strain, that he stated that the pain radiated across his shoulders and that he also stated that there was some numbness and tingling over the weekend. It was also noted that Petitioner stated that he was having low back pain, that the pain was progressing in nature and that he had been attending physical therapy and had two weeks left. The assessment was noted to be that of neck strain and low back strain. Petitioner was recommended to continue physical therapy. At the time of the June 19, 2017 visit, it was noted that Petitioner was seen for a follow-up on neck pain. It was noted that Petitioner stated that he was having continual pain present, that the pain was worse with certain movements and that the pain was radiating into the right arm. It was noted that Petitioner stated that over the past week he had noticed numbness in the right arm and that he was not able to sleep at night due to the pain. It was also noted that Petitioner was making slow but steady progress in physical therapy. The assessment was noted to be that of a cervical strain. Petitioner was recommended to continue physical therapy. (PX3).

The records of Proctor First Care reflect that Petitioner was seen on July 5, 2017, at which time it was noted that he was there for follow-up of his neck strain. It was noted that Petitioner stated that he was released from physical therapy and was able to go back to work on July 10th. It was noted that Petitioner was better and that physical therapy had released him. The assessment was that of a trapezius strain. Petitioner was instructed to return to work on July 6, 2017. At the time of the July 12, 2017 visit, it was noted that Petitioner apparently fell ascending stairs while carrying furniture, and that he found himself wedged under a stacked laundry unit. It was noted that Petitioner had generalized right-sided discomfort, that it had happened at 11:30 on that date, that his main complaint was right arm/upper back pain and some bilateral low back pain, and that he was able to ambulate after the injury. The assessment was that of multiple contusions with secondary muscle spasm. Petitioner was given a prescription for Naproxen, Orphenadrine and Tramadol. At the time of the July 14, 2017 visit, it was noted that Petitioner was seen in follow-up on his back injury. It was noted that Petitioner had been seen two days ago, that he felt like the pain was getting worse in his low back, right shoulder and neck, and that he complained of a numbness sensation in the right lower arm. The assessment was noted to be that of multiple contusions. It was noted that on physical examination there was minimal remaining spasm both at the trapezius and lumbar level and that there was some complaint of pain on palpation of the right paralumbar and right trapezius area, but that it was rather less than the previous exam. Petitioner was allowed to return to work limited duty and was recommended to undergo physical therapy. (PX3).

The records of Proctor First Care reflect that Petitioner called on July 19, 2017 stating that he had been having back, neck, shoulder and low back pain and that he was asking whether he should use ice or heat. At the time of the July 21, 2017 visit, it was noted that Petitioner had apparently been spending a lot of time in bed, on the couch or in a chair, and that he was counseled that he was probably making his symptoms worse rather than better. It was also noted that Petitioner was still complaining of considerable pain going down the back of his legs to his knees, but not below his knees. The assessment was noted to be that of low back pain. Petitioner was recommended to undergo physical therapy and to return to work limited duty. It was noted that Dr. Ausfahl feared that Petitioner had been doing too much couch and bed time and not enough active time. (PX3).

The records of Proctor First Care reflect that Petitioner was seen on August 4, 2017, at which time it was noted that he was seen for a two-week evaluation of neck and low back pain. It was noted that Petitioner was injured at work on April 12, 2017 with a re-injury on July 12, 2017, and that he had been following with Dr. Ausfahl for his care. It was noted that Petitioner's last appointment was on July 21st and that he had been given a note to return to work light duty, that he stated that he received his letter to return to work from his job on July 28th to return on July 31st and that he stated that when he went to work on July 31st there was a work order for him to build ice machines. It was noted that Petitioner stated that he performed the jobs assigned and ended up in the emergency room the evening of July 31st due to increased pain, that he stated that he was given an injection for pain and that he rated his pain a 9/10 that was constant, sharp pain. The assessment was noted to be that of acute bilateral low back pain with bilateral sciatica and neck pain. Petitioner was recommended to undergo an MRI of the lumbar spine and was also recommended to continue his current medications. It was noted that a note was given for work. (PX3).

The records of Proctor First Care records reflect that Petitioner called on August 28th requesting a refill of his medications, but that he stated that he could not be seen. At the time of the September 14, 2017 visit, Petitioner was seen for an asthma flare-up. At the time of the November 9, 2017 visit, Petitioner was seen for pain in the left ear. At the time of the November 21, 2017 visit, Petitioner was seen for follow-up on his hypertension. It was noted that Petitioner was in a back brace. At the time of the November 28, 2017 visit, Petitioner was seen for follow-up of acute nasopharyngitis and hypertension. At the time of the January 3, 2018 visit, Petitioner was seen for a follow-up on his hypertension and labs. It was noted that Petitioner had been seen in the emergency room the night before for low back pain with bilateral leg numbness and pain, and that his blood pressure had been up but was down now. It was noted that Petitioner

stated that the Gabapentin was not working and was causing dizziness. It was also noted that Petitioner was having a lot of trouble with increasing stiffness at all times especially after getting up, that he was still using a back brace which was not helping, and that he was having trouble with GERD. (PX3).

The records of Proctor First Care reflect that Petitioner was seen on January 17, 2018, at which time it was noted that he stated that his back hurt continuously, that he was having trouble sleeping due to the pain and that his legs were in pain and had a numb and tingling sensation. It was noted that Petitioner's Lamotrigine was not "cutting it" with the low back pain, which meant that it was time to adjust the dose. The assessment was noted to be that of low back pain. It was noted that Petitioner's Lamotrigine dose was to be doubled "with some reticence" and that there was a court case over who would assume responsibility for the proposed surgery. Included within the records was a phone note dated January 18, 2018, which noted that Petitioner called indicating that he kept receiving Cyclobenzaprine through the mail that he did not believe that Dr. Ausfahl had prescribed, but that his name was on them. Another phone note dated January 19, 2018 noted that Petitioner needed an appointment with another orthopedic physician because Dr. Bell was not in his network, and that he was also needing a note for work stating that he was unable to work due to back pain. An entry also dated January 19, 2018 noted that, per verbal orders, Petitioner could return to work on Monday with restrictions of 15 pounds lifting, pushing, pulling and twisting and no reaching below the knees; it was also noted that Petitioner stated that Dr. Bell had him completely off work and that he wanted to know why Dr. Ausfahl would have him to go to work "knowing that his back is in the state it is" and that he would use the restrictions of Dr. Bell instead. (PX3).

Included within the records of Proctor First Care was an order dated July 14, 2017 for physical therapy evaluation and treatment for diagnoses of trapezius muscle spasm and lumbar paraspinal muscle spasm; an Orthopedic Surgery referral dated August 17, 2047 for the diagnosis of acute bilateral low back pain with bilateral sciatica, and a work slip dated April 24, 2017 which noted that it was Dr. Kowalska's opinion that Petitioner should remain out of work for the timeframe of April 24, 2047 through May 8, 2017 as he had a severe muscle neck strain status post work-related motor vehicle accident and needed time for recovery due to neck pain. Also included within the records of Proctor First Care was a work slip dated May 8, 2017 noting that Petitioner could return to work with limited participation immediately with restrictions of no lift, push/pull or twist over 20 pounds of force with the right arm; a work slip dated May 22, 2017 noting that Petitioner could return to work with limited participation immediately with restrictions of no lift, push/pull or twist over 20 pounds of force with the right arm; a work slip dated June 5, 2017 noting that Petitioner could return to work with limited participation immediately with restrictions of no lift, push/pull or twist over 20 pounds of force with the right arm; a work slip dated June 19, 2017 noting that Petitioner could return to work with limited participation immediately with restrictions of no lift, push/pull or twist over 20 pounds of force with the right arm; and a work slip dated July 6, 2017 noting that Petitioner could return to work full duty immediately with no restrictions as of that date and that he had reached maximum medical improvement. (PX3).

Included within the records of Proctor First Care was a work slip dated July 12, 2017, noting that Petitioner "should remain out of participation" until July 14, 2017; a work slip dated July 14, 2017 noting that Petitioner could return to work with limited participation immediately with restrictions of no lift, push/pull or twist over 20 pounds of force with either the back or right arm; a work slip dated July 21, 2017 noting that Petitioner could return to work with limited participation immediately with restrictions of no lift, push/pull or twist over 20 pounds of force with either the back or right arm; a work slip dated August 4, 2017 noting that Petitioner should remain out of work until after his MRI of the lumbar spine due to the low back injury related to work; and a work slip dated January 19, 2018 noting that Petitioner could return to light duty work immediately with restrictions of 15 pound lift, push, pull and twist and no reaching below the knees. (PX3).

Included within the records of Proctor First Care was an Initial Evaluation (physical therapy) from UnityPoint Methodist dated May 9, 2017, which noted that Petitioner reported to physical therapy with

complaints of neck pain, that he was rear-ended when driving at work on April 12, 2017, that he stated that it jerked his neck and right shoulder blade, that he went to the hospital right afterwards and had imaging that ruled out fractures, and that he also had pain in his low back but that had since resolved. It was noted that Petitioner also stated that he was now getting headaches that came and went, that he stated that they happened so often he could not keep track of them, and that he reported numbness and tingling in his bilateral upper extremities that did not go into his fingers. The Re-Evaluation dated June 29, 2017 noted that Petitioner reported no pain currently, that his worst pain was 4/10, that he was to see the doctor on Monday and felt that he was ready to return to work, and that he had been driving without difficulty. It was noted that Petitioner was able to lift increased weight at therapy but had not tried any heavy lifting at home, that he stated that he was mainly limited with sleeping through the night and that he denied any headaches. It was also noted that Petitioner had reached all his physical therapy goals and was ready to return to work. (PX3).

Included within the records of Proctor First Care was an Initial Evaluation (physical therapy) from UnityPoint Methodist dated July 18, 2017, which noted that Petitioner returned to physical therapy with a referral for neck and low back pain. It was noted that Petitioner reported that he returned to work and that in the first week had to go deliver multiple refrigerators and washer/dryer units up several flights of stairs in an apartment complex, that he was walking backwards up the stairs lifting a dolly with the appliance up each step with one other person on the other side assisting with lifting the dolly up the stairs, and that after doing this about ten times he was going up the stairs, his back got weak, he fell backwards and hit his back on the stairs and that the washer/dryer landed on his shoulder and the other worker was able to slow it down. It was noted that Petitioner stated that after that he had had significant low back pain and right-sided midback pain and neck pain, that he had had an increased heaviness sensation in his bilateral lower extremities whenever he tried to stand and walk, and that he returned to the doctor on Friday for x-rays. (PX3).

Included within the records of Proctor First Care was a physical therapy Re-Evaluation dated August 11, 2017, which noted that Petitioner reported 9/10 pain in his neck and low back, that he continued to have increased pain in his neck when he turned his head and in his back with standing/walking, and that he felt that the pool was helping to reduce his pain levels but that his progress as slow. At the time of the August 26, 2017 Re-Evaluation, it was noted that Petitioner reported 9/10 pain, that he stated that he was unable to sleep, that he had shooting pain that came from the neck and radiated down to the low back and up into the posterior skull, and that he continued to be limited in all functional activities including standing, walking and sitting for greater than 30 minutes. (PX3).

The medical records of Heartland Health Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on April 17, 2017, at which time it was noted that he was seen in emergency room follow-up due to posterior right lateral neck tension and strain after a motor vehicle accident, that he was seen at the OSF emergency room and that he had had a normal cervical spine CT scan. It was noted that Petitioner reported that his symptoms had not changed, that he denied any numbness or tingling in either arm, that he had no vision changes, and that he stated that his dizziness had resolved since changing his diet and eating better. The assessment was noted to be that of (1) essential hypertension; (2) neck muscle strain. Petitioner was given a prescription for Naproxen and Flexeril and was recommended to return in about three days. At the time of the April 20, 2017 visit, it was noted that Petitioner was seen for follow-up due to posterior right lateral neck tension and strain. It was noted that Petitioner stated that he needed clearance for Class E driver's license for work and that it was explained to him that he would need to go to IWIRC or a DOT-certified clinic. It was also noted that Petitioner denied any numbness, tingling, photophobia, weakness, vision changes or loss of consciousness. The assessment was noted to be that of (1) essential hypertension; (2) neck muscle strain. Petitioner was given a prescription for Propanolol for his headache and was also recommended to return in four weeks. (PX4).

The medical records of Midwest Orthopaedic Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on December 8, 2017, at which time it was noted that he had undergone a L5-S1 interlaminar epidural steroid injection on November 10, 2017, that his pain had not improved with injection therapy and that he continued to get pain in the middle of his low back and bilateral lower extremities tingling/numbness. It was noted that Petitioner reported that his pain was so great that it caused a spike in his blood pressure, that his primary care physician was following up on this and that he was taking anti-hypertensive medications. It was noted that Petitioner continued to take Gabapentin, Diclofenac, Norco and Skelaxin with limited benefit, and that he was currently rating his pain a 7-8/10. It was noted that Petitioner was referred to Dr. Bell for low back pain as well as right shoulder and right neck pain that had been ongoing for five months, that he stated that his right neck pain radiated down to his right shoulder and all the way down to his low back, and that he reported that his pain began when he was at work approximately five months ago and sustained a motor vehicle accident at which time he was hit from behind. It was noted that following the motor vehicle accident Petitioner went immediately to the hospital where x-rays were taken and he was released, that he was then taken off work for four months and finally went back to light duty in early July and that while at work at that time, he slipped and fell while carrying some appliances up some stairs. It was noted that Petitioner was once again taken off work and returned again to light duty on August 8, 2017, that he once again went back to work and was responsible for installing an icemaker and unboxing items and that during that time, he once again experienced the same pain in his back and went immediately to the emergency room where he was taken off work. It was noted that since that time, Petitioner had continued to complain of severe pain in his back with tingling sensations down his lower legs, and that he continued to take Hydrocodone and Flexeril as well as Ibuprofen with limited benefits. It was noted that Petitioner had had physical therapy in the past with no real benefit and that he had had no prior epidural steroid injections. The assessment was noted to be that of other intervertebral disc displacement, lumbar region, other intervertebral disc displacement, lumbosacral region, other intervertebral disc degeneration, lumbar region, and low back pain. It was noted that Petitioner was recommended to see one of the spinal surgeons as soon as possible given his persistent lower extremity tingling/numbness and his failure to respond to injection therapy. Petitioner was also recommended to continue Norco, Skelaxin, Diclofenac and Gabapentin, to continue to wear the corset as prescribed and to continue off work. Petitioner was given a work slip dated December 8, 2017, indicating that he was totally unable to work due to injury until his appointment with a spine surgeon. (PX5).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on November 10, 2017, at which time it was noted that he was scheduled for repeat L5-S1 interlaminar epidural steroid injection with fluoroscopic guidance. It was noted that Petitioner had had a similar injection on October 13, 2017 and that he stated that he had not had any sustained improvement in his pain. It was noted that Petitioner continued to rate his pain a 7/10. It was noted that Petitioner had complaints of a constant and daily pain that was more or less sharp in nature, that he also had a numb, tingling, shooting and spastic sensation in his back, and that he noted a subjective feeling of numbness and weakness in his bilateral lower extremities that radiated into his bilateral feet. The assessment was noted to be that of other intervertebral disc displacement, lumbar region, other intervertebral disc displacement, lumbosacral region, and other intervertebral disc degeneration, lumbar region. Petitioner was given an L5-S1 interlaminar epidural steroid injection on that date. Petitioner was also recommended to continue Norco, Skelaxin, Diclofenac and Gabapentin, to continue to wear the corset as prescribed and to continue off work. Petitioner was given a work slip dated November 10, 2017, indicating that he was totally unable to work due to injury until his next follow-up appointment with Dr. Bell. Petitioner was also given a work slip dated October 13, 2017, indicating that he was totally unable to work due to injury until his next appointment with Dr. Bell. (PX5).

The records of Midwest Orthopaedic Center reflect that Petitioner was seen on October 13, 2017, at which time it was noted that he was scheduled for an L5-S1 interlaminar epidural steroid injection with fluoroscopic guidance. It was noted that Petitioner's pain had not changed since he was seen as a new

patient on September 7, 2017. The assessment was noted to be that of other intervertebral disc displacement, lumbar region, other intervertebral disc displacement, lumbosacral region, other intervertebral disc degeneration, lumbar region, and low back pain. Petitioner was given an L5-S1 interlaminar epidural steroid injection on that date. Petitioner was recommended to return in 2-3 weeks to assess his response to the injection, to continue Norco, Skelaxin, Diclofenac and Gabapentin, to continue to wear the corset as prescribed and to continue off work. Petitioner was given a work slip dated September 7, 2017, indicating that he was totally unable to work due to injury until his next appointment with Dr. Bell. At the time of the September 7, 2017 visit, it was noted that Petitioner was referred by his primary care physician for low back pain as well as right shoulder and right neck pain that had been ongoing for five months. It was noted that Petitioner stated that his right neck pain radiated down to his right shoulder and all the way down to his low back, that he reported that his pain began when he was at work approximately five months ago and sustained a motor vehicle accident at which time he was hit from behind, and that following the motor vehicle accident he went immediately to the hospital where x-rays were taken and he was released. It was noted that Petitioner was then taken off work for four months, that he finally got to go back to work light duty in mid to early July and that while at work at that time, he slipped and fell while carrying some appliances up some stairs. It was noted that Petitioner was once again taken off work and returned to light duty on August 8, 2017, that he once again went back to work and was responsible for installing an icemaker and unboxing items and that during that time, he once again experienced the same pain in his low back and went immediately to the emergency room, after which he was taken off work again. It was noted that since that time, Petitioner continued to complain of severe pain in his back with tingling sensations down his lower legs, that he continued to take Hydrocodone, Flexeril and Ibuprofen with limited benefit, and that given his persistent pain he was referred to evaluation and treatment. It was noted that Petitioner had complaints of a constant and daily pain that was more or less sharp in nature, that he also had a numb, tingling, shooting and spastic sensation in his back, and that he noted a subjective feeling of numbness and weakness in his bilateral lower extremities that radiated into his bilateral feet. It was noted that Petitioner rated his pain a 9/10 but that he stated that it could range from 8-10/10, that he had increased pain with sitting, standing, walking, lifting, twisting, bending, looking up/down, lying down, climbing stairs and turning his head, that nothing improved his pain and that he reported poor sleep hygiene due to trouble falling asleep secondary to his pain. It was noted that Petitioner was currently taking Norco, Flexeril and Ibuprofen, that he had had physical therapy in the past with no real benefit, and that he had had no prior epidural steroid injections. The assessment was noted to be that of lower disc degeneration, low back pain and intervertebral thoracic disc disorder with radiculopathy. Petitioner was recommended to undergo L5-S1 interlaminar epidural steroid injections two weeks apart and was given prescriptions for Norco, Skelaxin, Diclofenac and Gabapentin. Petitioner was also fit with a corset for lumbar support given his very severe and persistent pain, and was also recommended to continue off work. (PX5).

The transcript of the deposition of Dr. Avi Bernstein was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Dr. Bernstein testified that he is a board-certified orthopedic surgeon who specializes in spine surgery. (PX6).

Dr. Bernstein testified that he saw Petitioner for an IME and that he gave him a history that on April 12, 2017 he was working at his job delivering appliances, that he was moving cabinets, granite and floor tiling as part of the job, that he was involved in a motor vehicle accident where he was rear-ended, that his vehicle was stopped and that the airbag did not deploy. He testified that Petitioner told him that he was driving a small Freightliner at the time, that he was struck by a high rate of speed that he believed was about 60 MPH and that he struck his head on the steering wheel and had immediate low back pain. He testified that Petitioner came under the care of his primary care physician, Dr. Ausfahl, that he was taken off work, that he pursued physical therapy including aqua therapy, and that he was given light duty restrictions. He testified that Petitioner told him that his symptoms were diminishing and that he was contacted on July 12, 2017 to return to work, that he told him that he was sent to the warehouse and sent out to do a delivery, that he delivered 18 sets of appliances up onto the third floor and that he used a dolly

and a helper to get the washers and dryers up the floors. He testified that Petitioner described that he fell while on the second landing and that he had acute low back pain and numbness radiating into his buttocks, into his legs and down to his toes. He testified that Petitioner was evaluated with an MRI scan and was told that he had disk abnormalities in his low back, that he saw a pain physician who gave him two epidural steroid injections that did not improve his pain, and that he was essentially fired from his job. He testified that Petitioner told him that he did not have any further treatment and that it was recommended that he pursue further evaluation by a spine specialist. (PX6)

Dr. Bernstein testified that on the date of the IME, Petitioner was complaining of low back pain radiating to his left buttocks, numbness in his legs and numbness and tingling to his toes, aggravated by prolonged sitting. He testified that Petitioner told him that he could stand for a short period of time, that he could walk for only about half a block before he needed to sit and change position, and that he was unable to describe any alleviating circumstances. He testified that on physical examination Petitioner had a fairly benign exam and had pain guarding in the low back, but that he was clearly recovering from another issue (*i.e.*, recent brain surgery), that Petitioner was in a wheelchair and that he had oxygen with him. Dr. Bernstein testified that he reviewed the MRI scan of August 15, 2017 and that the images showed bulging of degenerative disks from L4 to S1, what he described as a high-intensity zone at both L4-5 and L5-S1, and a central left-sided disk herniation at L5-S1 impinging the left S1 nerve root. He testified that one could get disk bulges and even herniations or tears in the disk as part of degeneration, but that a high-intensity zone was literally a tear in the disk and that it could result from trauma. He further testified that a herniation could result from trauma, and that it was a distinct injury to the disk and the displacement of disk material. (PX6).

Dr. Bernstein testified that he believed that the subjective complaints that Petitioner was complaining of the day that he saw him were consistent or common with the MRI findings that he observed. He testified that he felt that Petitioner suffered a discogenic injury to the low back, that he had disk herniation and annular tear at two levels in his lumbar spine, that he felt that the findings were responsible for Petitioner's symptoms and that conservative care was unlikely to change his condition, so he considered it permanent. He testified that in the future once Petitioner had recovered from his other medical issues and if he was still symptomatic, his options would either be living with the condition or considering surgery to try to relieve it. He testified that surgery would be a two-level decompression and fusion of the lumbar spine from L4 to S1. He testified that he did not believe that Petitioner's brain issue would have played a part in any of the symptomatology that he was complaining of when he saw him. (PX6).

Dr. Bernstein testified that he believed that the treatment that was rendered to Petitioner up through his IME was reasonable and necessary. He further testified that he believed that the surgical recommendation he made was causally related to the April 12, 2017 and July 12, 2017 work incidents. (PX6).

On cross examination, Dr. Bernstein testified that Petitioner did not make any complaints to him regarding his neck or shoulders. He testified that it was his understanding that Petitioner's use of a wheelchair was solely due to the recent brain surgery. He testified that the annular tear could be a result of degenerative changes. (PX6).

On cross examination when asked if any low back injury that Petitioner had sustained as a result of the April 12, 2017 injury had resolved itself by the time that he saw Dr. Kowalska in light of the fact that there were no complaints regarding the low back, Dr. Bernstein responded that if Petitioner did not have back pain over that period of time described he would call it a resolved strain, but that if he had back pain that was just less symptomatic and not reported then he would say that he still had an injury related to the incident. He testified that the second accident seemed to be the more dominating issue and that it was the one that substantially aggravated Petitioner's symptoms, that it left with him with an inability to function.

that it left him with chronic complaints of pain and that it left him seeking aggressive medical care for his low back. (PX6).

On cross examination, Dr. Bernstein testified that he did not have any non-anatomic findings. He testified that he did not have any impression of symptom magnification on the part of Petitioner. He agreed that it was possible that a person who had the findings that Petitioner had on his MRI could be asymptomatic. He agreed that different people would have different symptoms despite having similar findings on an MRI, depending on the findings. (PX6).

The IME Report of Dr. Avi Bernstein dated March 29, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The report reflects that Petitioner was seen for an IME on March 29, 2018, at which time it was noted that on April 12, 2017 Petitioner was at work delivering appliances, that he was involved in a motor vehicle accident, that he was rear-ended and that he was stopped. It was noted that Petitioner was driving a small freightliner, that he was struck by a van at a high rate of speed that he believed it was at 60 MPH, that he struck his head on the steering wheel and that he had immediate low back pain. It was noted that Petitioner was taken by ambulance to the hospital, that he was discharged to home and that he came under the care of his primary care physician. It was noted that Petitioner had physical therapy and also aqua therapy, that he was given light duty restrictions and that with time his symptoms appeared to diminish, and that he was contacted on July 12, 2017 to return to work. It was also noted that Petitioner was sent to the warehouse and then sent to a delivery, that he reported that he delivered 18 sets of appliances up onto the third floor, that it included washers and dryers, that he used a dolly and a helper to get them up the floors, and that he literally fell on the second landing. It was noted that Petitioner suffered acute low back pain and numbness radiating into his buttocks and to his legs down to his toes, and that he was subsequently evaluated with an MRI scan and was diagnosed with disc abnormalities. It was noted that Petitioner was seen by a pain physician and that he had two epidural steroid injections without any improvement whatsoever, that he was fired from his job and that no treatment was allowed. (PX7).

The report reflects that Petitioner had a chief complaint of low back pain radiating into his left buttock with numbness in his legs bilaterally and a numb and tingling sensation down into his toes. It was noted that Petitioner's symptoms were aggravated by prolonged sitting, that he could stand for a short period of time and that he could only walk for about half a block before he needed to sit and change position, and that he was unable to describe alleviating circumstances. It was noted that Petitioner's condition was somewhat complicated by the fact that three weeks ago he underwent a brain tumor resection through a left temporal craniotomy for cluster headaches, left eye drooping and a diagnosis of a brain tumor, and that the pathology was benign. It was noted that an August 15, 2017 MRI of the lumbar spine identified bulging and degenerative change from L4 to S1, that there was a high-intensity zone at L4-L5, and that there was a central and left-sided disc herniation at L5-S1 impinging the left S1 nerve root. (PX7).

The report reflects that Dr. Bernstein's assessment was that Petitioner appeared to have suffered two specific incidents resulting in injury to the low back, that the first was an April 12, 2017 motor vehicle accident, that the second was the July 12, 2017 work incident, and that Petitioner reported that he was improving substantially just prior to the work injury. It was noted that it was Dr. Bernstein's opinion that the work incident likely substantially aggravated Petitioner's condition, that he had a disc herniation and an annular tear at two different levels and that he believed that these levels were responsible for Petitioner's symptoms. It was noted that Petitioner was now more than six months out from the injuries, that further conservative care was unlikely to result in improvement in his condition and that Petitioner needed to recover completely form his brain surgery. It was noted that once that occurred if Petitioner remained substantially symptomatic, his options included either living with his condition or considering surgical intervention and that he would require two-level decompression and fusion which, per Dr. Bernstein, was causally related to the work incident of July 12, 2017. It was also noted that Dr. Bernstein felt that the treatment Petitioner had received had been reasonable and necessary. (PX7).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The transcript of the deposition of Dr. David Anderson was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Anderson testified that he is an orthopedic surgeon, that he is board-certified in orthopedic surgery with a subspecialty in sports medicine, and that he treats pretty much all orthopedic issues but does not perform spine surgeries. (RX1).

Dr. Anderson testified that he performed an IME of Petitioner on August 28, 2017. He testified that during his examination of Petitioner he made non-anatomic findings including hypersensitivity to light touch throughout his cervical spine, diffuse hypersensitivity to light touch over the deltoid and circumferentially in the right upper extremity including down to all his fingers and thumb, diffuse hypersensitivity to light touch throughout the thoracolumbosacral spine and paraspinal muscles, and circumferential bilateral lower extremity pain with bilateral hip range of motion that also caused diffuse low back pain. He testified that Petitioner also had diffuse and severe low back pain with passive and active lumbar rotation and with gentle axial loading, that there was no physical examination evidence of true radicular symptoms and that Petitioner complained of circumferential numbness and tingling in the bilateral lower extremities and right upper extremity which were not in a dermatomal or anatomic distribution. When asked what non-anatomic findings and symptom magnification lead him to conclude, Dr. Anderson responded that there may not be a true anatomic issue to support the subjective complaints and objective findings, and that it could affect treatment options and outcomes. He testified that credibility could be an issue in this situation. (RX1).

Dr. Anderson testified that his diagnosis was that of neck pain, periscapular pain and low back pain. He testified that he felt at that time that Petitioner's complaints appeared mainly to be due to the reported July 12, 2017 work incident as reasonable that he had sustained a strain to his cervical and lumbar spine. He testified that he did not have any treatment recommendations but that typically with this type of injury, maximum medical improvement would be expected within about three months of the July 12, 2017 injury. (RX1).

On cross examination, Dr. Anderson testified that it was possible that a motor vehicle accident could cause a disc protrusion. He testified that it was possible that a motor vehicle accident could aggravate a pre-existing disc protrusion to become symptomatic. He testified that it was possible that that the second work incident (*i.e.*, fall) could cause a disc protrusion, and that it was also possible that the fall could aggravate a disc protrusion. (RX1).

On cross examination, Dr. Anderson testified that based on Petitioner's MRI findings, someone may not have any symptoms at all. He testified that as of the date of his report, all the treatment that he reviewed was reasonable and necessary. He testified that the typical maximum medical improvement for what he saw in Petitioner would be three months, but agreed that it could change based on various factors including subjective complaints or the severity of findings. (RX1).

On redirect, Dr. Anderson testified that he was not able to state within a reasonable degree of medical certainty that either of the work accidents caused or permanently aggravated the bulging discs found on the MRI because there was just no way to tell the timing. (RX1).

On further cross examination when asked hypothetically if Petitioner were to testify that he never had any prior back issues before these two work incidents and whether that would change his opinion as to a cause or aggravation of the disc protrusions, Dr. Anderson responded that it would not. (RX1).

The transcript of the deposition of Dr. Timothy Van Fleet was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Van Fleet testified that he is a board-certified orthopedic spine surgeon. (RX2).

Dr. Van Fleet testified that he performed an IME on November 29, 2017. He testified that when he met with Petitioner, there was an exhibition of symptom magnification. He testified that he thought that the overall examination was quite magnified, that Petitioner's standing and gait across the floor was quite animated and that he was "creeping" across the floor in a very slow and exaggerated manner and was not consistent with how he was walking in the surveillance video. He testified that Petitioner would not bend at the waist, that he had superficial tenderness to palpation from the base of his neck all the way down to the low back, and that superficial tenderness was a non-organic pain manifestation. He testified that Petitioner had restricted flexion/extension so he did not move his neck hardly at all, that his reflexes were symmetric bilaterally and that strength testing of the upper extremities demonstrated that he gave way on his right side in all motor groups, which denied any kind of anatomical explanation. He testified that Petitioner gave way to motor testing in the right lower extremity at the quadriceps and dorsiflexors on the right side which did not fall into a good anatomical explanation, and that he had no pain without distraction but pain with distraction down the legs. He testified that these were non-organic pain manifestations, along with pain with simulated truncal rotation and axial compression of the head producing pain in the low back. (RX2).

Dr. Van Fleet testified that the diagnosis was that of strain of the neck and back, and that he did not have any recommendations for additional medical treatment for Petitioner as to the low back. He testified that no activity restrictions were suggested. He testified that he did not agree with the IME physician's suggestion that Petitioner was a candidate for a two-level decompression and fusion because he did not have a physical condition which would warrant a lumbar decompression and fusion, as Petitioner's imaging studies suggested that he had some degenerative disk disease and mild to moderate lateral recess stenosis at the worst at the L4-5 level and that more concerning and compelling was the fact that his symptom magnification was extremely significant. He testified that Petitioner had all signs of malingering, that he had surveillance video that showed that he had none of those findings that were seen on physical examination and that he was walking perfectly normal. He testified that malingers did not do well with surgery and that they had a terrible outcome. (RX2).

On cross examination, Dr. Van Fleet testified that Dr. Bernstein's interpretation of the August 15, 2017 MRI of the lumbar scan was inconsistent with what he viewed on the imaging as he reported that there was no evidence of focal neurological compression at L5-S1 which would be in contradiction to what Dr. Bernstein described as a disc prolapse at L5-S1. He testified that as to L4-5, he did not even offer an opinion on hyperintensity zone on Petitioner. When asked if a motor vehicle accident such as the one described by Petitioner could cause or aggravate the back issues that he diagnosed, Dr. Van Fleet responded that it was hard to know. He testified that he thought that the accident as Petitioner described it to him was that he was in a large delivery truck and that they were struck from behind by a car that was really impaled underneath the trailer of his truck, and that it was difficult to gauge an understanding of how much force was applied to his vehicle as the car was stuck underneath that truck. He testified that he could not definitively state that it would be the case based upon everything that he knew in this particular instance. He testified that it was not certainly possible that it could. (RX2).

On cross examination, Dr. Van Fleet testified that he supposed a fall could cause or aggravate the back issues that he diagnosed. When asked whether the objective findings that he saw in Petitioner were similar to symptomatology expressed by other patients or whether he saw a wide variety of symptoms expressed by patients, Dr. Van Fleet responded that aside from his observation of symptom magnification, everything else that was found on the physical examination was subjectively brought about by Petitioner's weakness of a non-myotomal fashion of the arms, the legs, etc. He testified that objectively he really did not find anything on Petitioner, and that he would say that if he did not find anything then there was

probably a wide array of complaints that someone could have and still have normal objective findings. (RX2).

On cross examination, Dr. Van Fleet testified that typically people with degenerative disk disease would have back pain, back stiffness and startle-type pain. He testified that an individual's pain could produce a wide array of symptomatic descriptions with MRIs that may look characteristically the same or widely different. He testified that when considering whether someone was a surgical candidate it was based on everything in the clinical picture, but was mostly based upon the fact that the individual had something that could be gained from an operation. (RX2).

On cross examination, Dr. Van Fleet testified that in general spinal fusions were done for individuals that had instability in the spine, meaning that they had abnormal motion or imbalance in the frontal plane or the plane when looking at them from the side (*i.e.*, sagittal plane); if one had trauma such as a fracture that had instability; that there were potentially threatening neurologic elements; or that they had an infection or a tumor. He testified that Petitioner had none of those and that he had degenerative disk disease with a nebulous complaint of non-specific low back pain. He further testified that, in general, pain associated with lumbar degenerative disk disease had a much poorer outcome when treated with a lumbar spinal fusion than the conditions leading to pain that he previously mentioned. (RX2).

On cross examination, Dr. Van Fleet agreed that as to Petitioner's gait, the three instances that he had a chance to view that were the date of the IME report as well as the two instances reviewed on video surveillance.[1] He agreed that this was the extent of his knowledge of Petitioner's gait. When asked if he knew whether Petitioner was on medication on the date of the video, Dr. Van Fleet responded that he assumed that he was as he listed his medications as Metaxalone, Gabapentin, Hydrocodone and Ibuprofen. When asked whether the medications would help improve an individual's gait, Dr. Van Fleet responded that they may or may not. He testified that it was possible for someone to ambulate normally even when they were in pain. (RX2).

CONCLUSIONS OF LAW

As it pertains to 17 WC 20778 for the alleged date of accident of April 12, 2017:

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of April 12, 2017.

The Arbitrator places greater weight upon the opinions of both Drs. Anderson and Van Fleet in this case in light of the fact that both physicians testified that Petitioner had significant non-anatomic findings and symptom magnification. (RX1; RX2). While Dr. Bernstein testified that Petitioner did not exhibit non-anatomic findings or symptom magnification, the Arbitrator further notes that when Dr. Bernstein examined Petitioner, he was in a wheelchair and had oxygen with him due to a recent brain surgery. (PX6). As such, the Arbitrator infers that Dr. Bernstein's examination of Petitioner may in all likelihood have been at least somewhat limited due to his other unrelated health issues, and the Arbitrator notes that even Dr. Bernstein testified that on physical examination Petitioner had a fairly benign exam. (PX6).

In accordance with the opinions of Drs. Anderson and Dr. Van Fleet, the Arbitrator finds that Petitioner suffered strains of the cervical spine and the lumbar spine as a result of the work accident of April

[1] The Arbitrator notes that, per the testimony of Dr. VanFleet, the surveillance video dates were that of November 10, 2017 and October 27, 2017; the Arbitrator further notes that no surveillance evidence was proffered by either party at the time of arbitration. (RX2).

12, 2017, and that Petitioner had attained maximum medical improvement from those strains as of July 11, 2017, which was the day prior to Petitioner's second injury at issue in 17 WC 20779. As a result of the foregoing, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of April 12, 2017.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment up through the date of July 11, 2017 was reasonable, necessary, and causally related to the work accident of April 12, 2017. As a result thereof, Respondent shall pay the reasonable and necessary medical services as contained in Petitioner's Exhibit 8 for medical services rendered **during the timeframe of April 12, 2017 through July 11, 2017,** 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 that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of April 12, 2017, Petitioner's request for prospective medical treatment to the lumbar spine as recommended by Dr. Bernstein is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of April 12, 2017, Petitioner's request for temporary total disability benefits for the timeframe of December 18, 2017 through November 15, 2018 is hereby denied.

As it pertains to 17 WC 20779 for the alleged date of accident of July 12, 2017:

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of July 12, 2017.

Similar to the Arbitrator's findings in 17 WC 20778, the Arbitrator places greater weight upon the opinions of both Drs. Anderson and Van Fleet in this case in light of the fact that both physicians testified that Petitioner had significant non-anatomic findings and symptom magnification. (RX1; RX2). While Dr. Bernstein testified that Petitioner did not exhibit non-anatomic findings or symptom magnification, the Arbitrator further notes that when Dr. Bernstein examined Petitioner, he was in a wheelchair and had oxygen with him due to a recent brain surgery. (PX6). As such, the Arbitrator infers that Dr. Bernstein's examination of Petitioner may in all likelihood have been at least somewhat limited due to his other unrelated health issues, and the Arbitrator notes that even Dr. Bernstein testified that on physical examination Petitioner had a fairly benign exam. (PX6).

In accordance with the opinions of Drs. Anderson and Dr. Van Fleet, the Arbitrator finds that Petitioner suffered strains of the cervical spine and the lumbar spine as a result of the work accident of July 12, 2017, and that Petitioner had attained maximum medical improvement from those strains as of the date of the IME with Dr. Van Fleet, which was that of November 29, 2017. As a result of the foregoing, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of July 12, 2017.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment up through the date of the IME with Dr. Van Fleet, *i.e.*, November 29, 2017, was reasonable, necessary, and causally related to the work accident of July 12, 2017.

As a result thereof, Respondent shall pay the reasonable and necessary medical services as contained in Petitioner's Exhibit 8 for medical services rendered **during the timeframe of July 12, 2017 through November 29, 2017,** 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 that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of July 12, 2017, Petitioner's request for prospective medical treatment to the lumbar spine as recommended by Dr. Bernstein is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability, in light of the Arbitrator's finding that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of July 12, 2017, Petitioner's request for temporary total disability benefits for the timeframe of December 18, 2017 through November 15, 2018 is hereby denied.

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

Arthur Clark,

Petitioner,

vs.

NO: 17 WC 20779

19IWCC0452

Hampton's Kitchen & Appliances,

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 January 7, 2019, 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 $900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

AUG 22 2019

DATED:
TJT:yl
o 8/13/9
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

CLARK, ARTHUR
Employee/Petitioner

Case# **17WC020779**

17WC020778

HAMPTON'S KITCHEN & APPLIANCES
Employer/Respondent

19IWCC0452

On 1/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

19IWCC0452

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Arthur Clark
Employee/Petitioner

v.

Case # 17 WC 20779

Consolidated cases: 17 WC 20778

Hampton's Kitchen & Appliances
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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **November 15, 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **July 12, 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*** 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$30,992.00**; the average weekly wage was **$596.00**.

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

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

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

Respondent shall be given a credit of **$1,672.19** in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of July 12, 2017, Petitioner's request for prospective medical treatment to the lumbar spine as recommended by Dr. Bernstein is denied.

Respondent shall pay for medical services **rendered during the timeframe of July 12, 2017 through November 29, 2017 as contained in Petitioner's Exhibit 8** 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 **for treatment rendered during the timeframe of July 12, 2017 through November 29, 2017 as contained in Petitioner's Exhibit 8** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for treatment rendered during the timeframe of July 12, 2017 through November 29, 2017 as contained in Petitioner's Exhibit 8** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall be given a credit of **$1,672.19** 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.

Signature of Arbitrator

1/3/19
Date

IC ArbDec19(b)

JAN 7 - 2019

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

Kendra S. Kelly,

Petitioner,

vs.

NO: 17 WC 18926

19IWCC0453

SIH Memorial Hospital of Carbondale,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 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.

19IWCC0453

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 $6,700.00. 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 22 2019
TJT:yl
o 8/13/19
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

KELLY, KENDRA S
Employee/Petitioner

Case# **17WC018926**

19IWCC0453

SIH MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

On 10/16/2018, 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 2.41% 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:

4689 HASSAKIS & HASSAKIS PC
JOSHUA A HUMBRECHT
206 S 9TH ST SUITE 201
MT VERNON, IL 62864

0693 FEIRICH MAGER GREEN RYAN
R JAMES GIACONE II
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

19IWCC0453

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kendra S. Kelly
Employee/Petitioner
v.
SIH Memorial Hospital of Carbondale
Employer/Respondent

Case # **17** WC **018926**

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **August 17, 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **6-29-16**, 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 $**21,792.87**; the average weekly wage was $**892.67**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services. Respondent stipulated that it will pay the following medical bills: (1) MRI Partners of Chesterfield MRI taken on 5/25/17; (2) WorkCare for services rendered on 8/10/16; and (3) an epidural steroid injection performed on 12/22/16.

Respondent ***shall*** be given a credit of $**2,295.48** for TTD, $**2,640.27** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**4,935.75**.

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

ORDER

Petitioner's current condition of ill-being in her lumbar spine is causally related to her accident; however, her request for prospective medical care is denied.

Respondent shall pay Petitioner temporary partial disability benefits of **$11,580.88** for TPD due and owing between **2/27/17 and 4/8/18** as provided in Section 8(a) of the Act. Respondent stipulated that no credits are to be applied to this award.

Respondent shall pay the medical bills found in PX 19 except for the interest charges and "special report" charges contained in Dr. Gornet's billing under "MFG Spine, LLC -- $21,390.88 (as further discussed in the Arbitrator's Decision). Said bills are awarded subject to the Medical Fee Schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any medical bills previously paid.

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

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

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

Nancy Lindsay
Signature of Arbitrator

October 11, 2018
Date

ICArbDec19(b)

OCT 16 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On June 29, 2016, Petitioner was employed by Respondent when she slipped and fell on water while attending to a patient in the course of her regular duties at the hospital. Accident is not disputed. Respondent does, however, dispute whether Petitioner's current condition of ill-being is causally related to the accident and whether the treatment being recommended by Dr. Gornet, in the form of a two-level disc replacement, is reasonable and necessary to treat her condition.

The Arbitrator finds:

Respondent offered into evidence medical records from Wittenauer Chiropractic spanning from 2002 through October 13, 2015. In March of 2007 it was noted that Petitioner had fallen off a stage and was seen in the ER. She complained of lower back pain. Beginning in 2010 the records consistently report pain in Petitioner's upper back, lower back and neck. No particular activities aggravated Petitioner's condition because her pain was always present according to her subjective reports. Her symptoms improved when she rested. The chiropractor consistently noted objective findings of tender taut fibers over her lower back and upper back. A functionally short right leg length was noted while she was in the prone position. (RX 5)

On June 12, 2014 Dr. Wittenauer saw Petitioner for an aggravation of her neck and upper back pain beginning on June 5, 2014. While she had no specific low back complaints, Dr. Wittenauer's treatment procedures included L2, L4, and L5. (RX 5)

On January 2, 2015, Dr. Wittenauer saw Petitioner for her upper back and neck complaints. Petitioner reported she had been improving until December 31, 2014 when she had "an aggravation." Biomechanical joint dysfunction was noted at L2, L4, L5 and her left and right sacroiliac joints. She had moderate tender taut fibers over her low and upper back. The doctor's procedures included treatment to the lower back regions. Dr. Wittenauer's records note that Petitioner was repeatedly diagnosed with, among other things, lumbosacral or sacroiliac pain and instability. It does not appear that she was released from care. The chiropractor indicated there was no need to deviate from Petitioner's treatment plan and that her next treatment should continue to follow the plan. (RX 5)

During the aforementioned time period Petitioner was also seen by her primary care doctor (N.P. Mariah Charles). In a visit dated March 2, 2015 Petitioner was complaining of bilateral knee pain after surgery in June of 2014 and she was requesting medication to help her with concentration as she prepared for upcoming boards. An MRI of her knees was ordered. (PX 10)

Petitioner had no further visits at Wittenauer Chiropractic after October 13, 2015. At the time of that visit Petitioner complained of her neck and upper back being "aggravated." Moderate taut fibers were noted in her low back and upper back. She had no specific low back or hip complaints. The doctor noted that there was no need to deviate from the treatment plan and her next treatment should continue to follow the plan. (RX 5)

Petitioner went to work for Respondent in January of 2016 as a nurse.

That same day, Petitioner was seen at the Memorial Hospital of Carbondale Emergency Room. Petitioner reported that one of her patients had spilled water on the floor and she did not realize it. When she went to assess her, she slipped on the water and fell on her back and right hip. She reported having trouble bending over and squatting. X-rays were taken which were normal and Petitioner was diagnosed with a lumbar strain. It was recommended that she follow up with her family physician. (PX 2)

Petitioner treated with SIH Workcare (the Occupational Medicine Clinic) on June 29, 2016, the day of her accident. At the initial visit Petitioner reported injuring her right elbow and her low back in her earlier accident. Petitioner reported that the elbow ached but wasn't painful. She had a small bruise on the olecranon. Petitioner's primary problem was low back pain. She described it as stabbing in the right buttock region and lower right lumbar region. She had moderate numbness in her right posterior thigh. On examination of her back there was no abrasion or bruising. There was no pain to palpation or swelling. There was pain with forward flexion and she had limited forward movement to about 30 degrees. She had no pain with twisting side to side and her reflexes were within normal limits bilaterally. Straight leg raise was negative and she had point tenderness on the SI joint over the mid buttock region. She was diagnosed with a low back strain and right elbow contusion. She was placed on restricted duty and prescribed physical therapy. (PX 3)

Petitioner attended her initial physical therapy evaluation on July 1, 2016. She reported no right elbow complaints or concerns. She only wished to undergo therapy for her low back. With regard to her back, Petitioner reported a difficult time bending and preferred to stand as it was less painful. (PX 3, PX 4)

At her SIH Workcare appointment on July 6, 2016 Petitioner reported that her right elbow pain was completely resolved. Her low back pain was constant and made worse by pulling and exerting. She also reported some anterior thigh numbness. NP Sullivan felt Petitioner's condition was work-related and restrictions remained in effect. She was to take over-the-counter Ibuprofen as needed. (PX 3)

Petitioner participated in physical therapy and continued to follow up with Workcare. As of July 18, 2016, Petitioner was reporting no improvement with therapy, so it was to be discontinued and an MRI was recommended and taken on July 20, 2016. The MRI was reported as revealing no evidence of fracture or dislocation. There was mild desiccation of the lower two lumbar discs but no evidence of central canal stenosis. Minimal foraminal narrowing of L4-5 associated with arthropathy and disc intrusion was seen. The report also revealed mild disc desiccation at L4-5 and L5-S1, minimal disc bulging reported at T12-L1, L1-L2, L2-L3, and L3-L4 and at L4-5 there was a modest broad-based disc bulge without significant spinal canal narrowing. There was minimal left foraminal narrowing associated with facet arthropathy and disc intrusion. At L5-S1 there was a modest broad-based disc bulge. The radiologist's impression was mild disc desiccation at the lower two lumbar discs with no evidence of central canal stenosis and a minimal left foraminal narrowing at L4-5 associated with facet arthropathy and disc intrusion. (PX 3; PX 4; PX 5)

The SIH Workcare nurse practitioner, Debra Sullivan, hand wrote an addendum to the July 22, 2016 record indicating that the MRI also showed moderate broad-based disc bulging at L5-S1. (PX 3)

On July 28, 2016 Petitioner returned to SIH Workcare and reported that physical therapy seemed to be making her symptoms worse. It was at that point that Debra Sullivan referred her to the Neurosurgical Brain and Spine Institute for consultation and management. (PX 3)

Petitioner attended therapy on August 3, 2016 reporting she had "two modest bulges" per her MRI. She still complained of right low back and mid-posterior thigh pain that was not getting any better. Workers' Comp was sending her to a doctor (believed to be Dr. Jones). Petitioner was uncertain about continuing with therapy. She was still on light duty and being in any position more than ten minutes increased her pain. Petitioner was noted to be in tears while in therapy partially due to frustration and also due to back pain. (PX 3; PX 4)

On August 10, 2016 Petitioner was examined by Dr. Burchill at Workcare. Petitioner reported ongoing low back, right-sided pain. Her diagnosis remained listed as a strain of the muscle, fascia and tendons of the lower back. The cause of her problem was listed as the work injury and she remained on work restrictions. A home exercise program was explained to her and the diagnosis "has been confirmed – there is no present need for further testing." She was to use ice to reduce pain and swelling and undergo a right SI joint injection. Therapy was put on hold at Petitioner's request. She was to continue her home exercise program. (PX 6)

Petitioner underwent a right SI joint injection on August 23, 2016 per Dr. Newell. (PX 6)

Petitioner underwent an insurance physical examination with Dr. Reyes, her primary care physician, on August 30, 2016. He noted she was being seen for back pain through workers' compensation. (PX 10)

On August 31, 2016 Petitioner advised Dr. Burchill that she wished to discontinue her care with Workcare. Dr. Burchill noted that Petitioner did not wish to resume physical therapy. She had an appointment pending with a neurosurgeon but it was Dr. Burchill's opinion that Petitioner was neurologically intact and was not a surgical candidate. (PX 3)

Petitioner presented to PAC Angela Arnold at the Orthopaedic Institute of Southern Illinois (Dr. Jones' office) on September 2, 2016. According to the Intake Comments, Petitioner was experiencing low back pain with right buttock pain that began after she fell on water at work on June 29, 2016. Petitioner had undergone physical therapy and one SI joint injection without relief. PAC Arnold diagnosed Petitioner with low back pain, piriformis syndrome on the right, and degenerative disc disease of the lumbar spine. She reported her symptoms as moderately severe in the lumbar spine. She described her pain as throbbing, discomforting and aching. She reported pain in the low back (not in the lower extremities). She indicated that her symptoms were aggravated by daily activities and relieved by rest and sitting. Her MRI was reviewed and reported as showing mild lumbar degenerative changes at L4-5 without significant central canal stenosis or foraminal narrowing. Petitioner was assessed with low back pain, right piriformis syndrome, and degenerative disc disease. The note indicated that, at that time, there was no clear indication that she would benefit from surgical intervention of her lumbar spine. However, it was felt that she might benefit from physical therapy with SI joint mobilization and piriformis stretches. In addition, it was recommended that she become established with Dr. Criste in the event she might need another SI joint injection in the future. She was instructed to follow up with her family physician. The visit notes were reviewed and approved by the supervising provider, Dr. Jeffery M. Jones, on May 20, 2017. Dr. Wood also signed off on work status, restrictions, and orders. Petitioner was given a 5 – 10 lb. lifting restrictions and advised she could work full days as tolerated "6 hours." (PX 7; RX 3)

On September 8, 2016 Petitioner underwent an Initial Therapy Evaluation at the Orthopaedic Institute of Southern Illinois. Petitioner reported slipping and falling at work on June 29th with an MRI having shown mild disc bulging. Petitioner reported that the SI injection had made her symptoms worse and she had no

benefit from the steroid dose pack, therapy or injections. She described lower back pain radiating to the right glute to the top of her calf although it had been as far down as the lateral two toes. She described the pain as shooting and electrical. She was not working at the present time. (PX 8; RX 3)

Petitioner initiated care with Dr. Bird, a chiropractor, at Allied Physicians & Rehab of Southern Illinois on September 8, 2016. Chiropractic treatment ensued. (PX 9)

Petitioner underwent chiropractic treatment with Dr. Bird on September 9, 2016. (PX 9)

In a script dated 9/9/16 Angela Arnold noted that Petitioner could work 12 hours a day with the lifting restriction. (RX 3)

At her therapy visit on September 12, 2016 Petitioner reported she had returned to work as a ward clerk sitting all day. She reported no change in her pain level. (RX 3)

Petitioner saw Dr. Reyes, her family doctor, on September 13, 2016. She reported pain in her lumbar spine and sacroiliac area after slipping on water at work. She denied any prior history of back pain. Her pain was worse with walking and sitting. She was in severe pain and unable to sit for six hours a day and wanted a few days off to try medicine and see if she could get in to Dr. Criste sooner. Petitioner was given medications for both low back pain and a UTI. She was excused from work for five days. (PX 10)

As of September 14, 2016, Petitioner was reporting to the therapist that she was feeling much better. She told the therapist she had been to her primary care doctor who treated her for a UTI which was adding to her pain. She was currently on medication and feeling better. As of September 19, 2016, Petitioner had been off work but was getting ready to return to work that day. She told her therapist she was using Tylenol and Ultram and was in less pain with sitting. Petitioner attended therapy on 9/21/16 and 9/26/16. At the visit on the 26th she reported making it through three days of work working 6 hours a day as a ward clerk. Sitting was increasing her right gluteal pain and standing, forward leaning and stooping hurt her back. She reported constant pins and needles in the right leg to her knee. Petitioner attended therapy on 9/28/16. She returned to therapy on October 5, 2016 advising that her pain was not as intense but beginning to go lower intro her right buttock. She had been performing her home walking program and only wished to do exercises that day. As of October 10, 2016 Petitioner was working limited duty of 4 to 6 hour shifts and noticing pain with mostly sitting and driving. Walking caused lower back pain but raduced her leg pain. Her leg pain was improved since the previous week. (RX 3)

Petitioner continued to receive chiropractic care from Dr. Bird on the following dates: 9/14/16; 9/15/16; 9/22/16; 9/28/16; 9/29/16; 10/3/16; 10/5/16; 10/6/16; 10/12/16; 10/13/16; 10/17/16; and 10/19/16. (PX 9)

Petitioner was referred by the Orthopaedic Institute of Southern Illinois to Dr. Criste at SIH Brain & Spine Institute. She was seen there on October 19, 2016 for back and right hip pain. Petitioner reported that physical therapy was helping with the pain, but the injection had made the pain worse. Her symptoms were aggravated by extension, standing and walking. Her pain was primarily located in the lower back and right buttock. Dr. Criste noted that Petitioner's MRI was relatively unremarkable for neuroaxial pathology, and her symptoms were non-radicular in nature. He recommended a medial branch nerve block at L4-5 and L5-S1. (PX 11; RX 2)

Petitioner also saw Dr. Reyes on October 19th. She was being seen "following a transition in care from a specialist provider." She was still in pain and was to see Dr. Criste on November 16th to undergo a lumbar block. Dr. Reyes took her off work until that visit and gave her restrictions. (PX 10)

Petitioner continued to receive chiropractic treatment with Dr. Bird on 10/24/16 and 11/7/16. (PX 9)

Dr. Gregory R. Polston (Physicians Review Network) issued a utilization report on November 10, 2016. The service requested was a medial nerve block. The reviewing physician reported that a medial nerve block was reasonable at that time. (RX 4; PX 16)

Petitioner saw Dr. Bird on November 10, 2016 for chiropractic care. (PX 9)

The medial branch nerve block took place on November 16, 2016. On November 17, 2016 there is a note indicating that Petitioner called and spoke with Kari M. Winters at Dr. Criste's office. Petitioner indicated that she had no relief from the injection and was asking for a work slip taking her off or providing work restrictions. She was advised multiple times that Dr. Criste did not feel she needed restrictions when she was evaluated, that she was not given restrictions by Dr. Criste and that he would not be taking her off work or extending any prior work restrictions that he did not set. The patient did not understand why Dr. Criste did not give restrictions. She was advised by Ms. Winters that when she was evaluated in the office he did not feel she needed them. There is a notation that Dr. Criste agreed with the contents of the phone conversation. (PX 11; RX 2)

Petitioner saw Dr. Reyes, her family doctor on November 21, 2016 reporting the epidural shots did not work. She was to see Dr. Gornet on December 19th. Dr. Reyes imposed a lifting restriction until she would see him as lifting aggravated her pain. (PX 10)

Petitioner's last appointment with Dr. Bird was on November 22, 2016. At that visit she complained of constant sharp, dull, aching and tightness in the buttocks as a 6 – 10/10. The discomfort was reported to increase with applied pressure and was better with rest, ice, and heat. She also complained of constant sharp and dull discomfort in the back of her right hip which increased with applied pressure and prolonged sitting and decreased with movement. She also had intermittent dull, tightness and throbbing discomfort in the back of her head. It increased with movement and coughing/sneezing and decreased with rest and chiropractic care. Petitioner told Dr. Bird that the injections with Dr. Criste were painful and she had blisters over her body afterwards. He noted that "her primary care doctor thinks there is something else going on so she is scheduled with Dr. Gornet." (PX 9, p. 68/74) Petitioner has increased stress and personal life. She has been using an inversion table with no change in her pain level. She gets relief while doing it but then it immediately returns. Her headaches haven't changed. She has tried to reduce carbs for the past month and a half and cut out soda but hasn't noticed a difference. Petitioner's diagnoses included: sprain of sacroiliac joint, sprain of lumbar ligaments; strain of lower back, myalgia; segment and somatic dysfunction of the sacral region; sacroiliitis; somatic dysfunction of the cervical region, thoracic region and lumbar region; lower extremity dysfunction; upper extremity dysfunction; pain in the right hip and headaches. She was to continue with her home exercises and to consult early next week to determine further care. She was also advised to see an acupuncturist. (PX 9)

Petitioner saw Dr. Matthew Gornet on November 23, 2016 having been referred by Dr. Reyes. She presented with the chief complaint of central low back pain to both sides, both buttocks and hips (right greater than left) and down both legs to her knees. She reported that her problems began on June 29, 2016 when she slipped on water while working. She had been seen in the emergency room and was placed on

light duty and undergone twelve weeks of physical therapy. Petitioner was still working light duty and had been seen by an occupational medicine doctor who recommended an SI joint injection. She was then referred to OIS and told she had piriformis syndrome. She was then seen by Dr. Criste who performed medical branch blocks. Petitioner did not "recall any previous problems of significance with her back." She acknowledged intermittent chiropractic care which she described as "routine" and her last visit was over two years earlier. Petitioner reported constant symptoms worse with bending, lifting or prolonged sitting. Changing positions helped. She also reported bilateral leg pain, right greater than left. Dr. Gornet reviewed the July 20, 2016 MRI which he described as being of "moderate quality." He felt it revealed "an obvious annular tear at both L4-5 and L5-S1." She had some mild facet changes at L4-5. He felt she had sustained a disc injury at both L4-5 and L5-S1 and did not feel she had an SI joint problems. He recommended epidural steroid injections at both levels. She could continue working light duty with a ten pound limit and no repetitive bending or lifting. She was given Meloxicam and Cyclobenzaprine to manage her symptoms. Based upon the information she provided to the doctor, Dr. Gornet felt her symptoms were causally connected to her work-related injury. His working diagnosis was disc injury at L4-5 and L5-S1 with a potential aggravation of facet joints at L4-5. (PX 12)

Petitioner saw her family doctor, Dr. Reyes on December 27, 2016 reporting low back pain. Her symptoms were unchanged since her last visit and the discomfort was most prominent in her lumbar spine and described as "throbbing." This was described as a chronic but intermittent problem with an acute exacerbation for which she had been off work yesterday and today. She was prescribed Lidocaine patches. (PX 10)

A second utilization report was authored by Dr. Michael R. Treister on December 30, 2016. The service requested was the reasonableness of all medical treatment including all chiropractic treatment. At that time no surgical recommendation had been made. The reviewing physician reported that all medical care he reviewed, with the exception of the chiropractic care, was reasonable. He felt there was no medical necessity for concurrent physical therapy and chiropractic care as this was considered unnecessary duplication. The examining physician further stated that even if Petitioner was shown to have discogenic pathology, she would be a poor surgical risk in view of her obesity and failure to have any symptom response to all of the treatment she has had. He further stated that he agreed with Dr. Gornet's recommendation for an epidural steroid injection as there was a reasonable possibility that the injection could give Petitioner significant relief. If one epidural steroid injection gave relief, two more sequential ones would be reasonable. (RX 4; PX 17)

Per Dr. Gornet's orders, Petitioner underwent injections with Dr. Boutwell in December of 2016 and January of 2017. (PX 13)

Petitioner saw her family doctor, Dr. Reyes on February 8, 2017 reporting low back pain. She was requesting a letter and was off work because of "back pain exacerbation." She was scheduled to see a neurosurgeon the next day and hoped to get an answer. (PX 10)

Petitioner returned to see Dr. Gornet on February 9, 2017. Her main complaint remained central low back pain to both sides, buttocks, and hips. The injections performed by Dr. Boutwell had not given her any significant relief and she was continuing to work light duty but was fairly miserable. Dr. Gornet recommended that she lose weight prior to any workup. Her diagnosis remained discogenic back pain at L4-5 and L5-S1. He wrote, "She can continue on light duty. I have placed her off work today." She needs to lose 25 lbs. and she then return. If she was still symptomatic he would recommend a repeat MRI, MRI

spectroscopy and, possibly, a CT discogram. She was given Meloxicam, Sertraline, and Cyclobenzaprine to help manage her symptoms. (PX 12)

Petitioner returned to see Dr. Gornet on April 20, 2017 reporting she had lost 28 pounds. She was to continue to lose weight and he ordered a new MRI, MRI spectroscopy and CT discogram. No other changes were made. (PX 12)

Petitioner underwent the discogram and spectroscopy on May 9, 2017. (PX 14)

Petitioner followed up with Dr. Gornet on May 25, 2017 and they reviewed her many tests she had undergone. She had lost thirty pounds. He was recommending disc replacement surgery at L4-5 and L5-S1. He noted that he explained to her that he might not be able to place the disc at L5-S1 due to her anatomy. She was to continue with her exercise. He still felt her condition was work-related. (PX 12)

Petitioner signed her Application for Adjustment of Claim herein on June 23, 2017. (AX 2)

Petitioner returned to see Dr. Gornet on July 27, 2017. They again discussed the procedure. She remained on office/sedentary duty. Her weight was recorded at 207 lbs. that day. He still recommended surgery. (PX 12)

Dr. Bernardi examined Petitioner for purposes of an independent medical examination on October 31, 2017. A written report followed (RX 1- Res. Ex. 2) Petitioner told Dr. Bernardi that she had injured her low back at work on June 29, 2016 and she had been off work for about six weeks after the accident until a light duty position could be found. That job accommodated a 10 pound lifting restriction and she sat for most of her 12 hours shifts. Petitioner acknowledged going to a chiropractor before her accident on what she termed an "intermittent basis" as she had back discomfort she described as "growing pains." Her most recent visits before her accident were in 2014 and 2015 for tension headaches. Prior to her work accident she denied seeing a medical doctor for symptoms referable to her low back nor had she undergone any surgery. She denied any prior work accidents and had retained an attorney. Petitioner reviewed her prior care and treatment with the doctor from being seen at the ER to her most recent visits with Dr. Gornet. She reported aching discomfort involving her lower lumbar region diffusely along with pain situated over her right posterior pelvis radiating to her buttock and down the lateral aspect of her thigh to her knee. Her symptoms, on that date, had neither improved nor worsened. She reported morning stiffness and soreness but it would improve after she had been up for a few hours. Her symptoms would spike near the end of the day. Any position, if maintained for an extended amount of time, was uncomfortable. She denied any left leg complaints or lower extremity weakness or alteration in bowel/bladder function. Dr. Bernardi also reviewed medical records and accident records furnished to him as part of the examination. (dep. ex. 2 to RX 1 – pp. 2 thru 4)

Dr. Bernardi had Petitioner furnish some additional information. Her Visual Analog Scale symptom diagram showed aching and burning over the right posterior pelvis and burning and paresthesia in the right buttock and descending down the posterolateral aspect of her right thigh. Her Zung Depression Index was "profoundly elevated" as was her score on the Modified Somatic Perception Questionnaire. He did not detect any Waddell's signs but noted that Petitioner became tearful intermittently while discussing her situation. Petitioner reported a weight loss of approximately 25 pounds since April 25, 2017. Because of her body habitus, Dr. Bernardi could not accurately assess muscle spasms, trigger points or step-offs. She did have tenderness over the right greater trochanter and around the right sciatic notch. Straight leg raising test was negative. Her hips were non-tender to range of motion. Dr. Bernardi

also reviewed x-rays taken on June 29, 2016, an MRI taken on July 20, 2016 and a post-discogram CT dated 5/29/17.

Dr. Bernardi acknowledged that Petitioner was experiencing some non-radicular pain in her right leg but he did not feel it was due to nerve root irritation; rather, it was non-specific in nature and, as such, could be due to many things – SI joint dysfunction, piriformis syndrome, facet disease or disc disease. Like the vast majority of individuals with similar complaints, the precise etiology of her symptoms was uncertain. He found no objective findings on her physical examination and no objective or subjective abnormalities on her neurological examination. Her imaging studies revealed no acute/post-traumatic changes to explain her complaints. Dr. Bernardi disagreed with Dr. Gornet's assessment that Petitioner was suffering from discogenic pain at L4-5 and L5-S1. He provided several reasons. First, he noted that Dr. Criste and Dr. Jones concurred. Second, her MRI did not reveal any findings that were acute, post-traumatic or attributable in any way to her slip and fall. All of the changes shown on her study were present prior to her fall. While Petitioner might seem too young to have arthritis in her low back, she really wasn't as aging occurs at different rates for different people. She had been treating with a chiropractor intermittently since she was 11 years old and while there were degenerative changes at L4-5 and L5-S1, there was more profound disease in her thoracolumbar junction where he saw bone spurs reflective of a far more advanced state of the process. Third, while Dr. Gornet found "obvious annular tears at both L4-5 and L5-S1," such a finding would be degenerative in nature and not acute. Fourth, he noted that MRI spectroscopy has been unproven for use in the management of lumbar conditions. Fifth, during the discogram Petitioner reported worsening of her typical symptoms at L4-5 and L5-S1; however, he took issue with the discogram findings.

Dr. Bernardi, like Dr. Jones, did not feel Petitioner was a candidate for surgery. He did not feel her symptoms could be attributed to a disc injury nor could her need for a two-level disc replacement be due to her slip and fall. Dr. Bernardi explained that Petitioner was only 31 years old and to undergo a two-level disc replacement at her age would be similar to undergoing a hip or knee replacement at the same age. While knee and hip replacements are very successful procedures, the utility of a two-level disc replacements would be questionable given the uncertainties of the future. Dr. Bernardi did not feel surgery would be in Petitioner's best interests and that she had a better chance of recovering without it. Dr. Bernardi felt Petitioner was at maximum medical improvement as a result of her accident. She needed to continue to lose weight and that was probably the single most important thing she could do for her back. She should also stay as active as her residual symptoms would allow her. "She should become fanatical about a home exercise program aimed at core conditioning." He did not think assigning her any activity restrictions was in her best interests. (RX 1 – Res. Ex. 2, pp. 1 – 11)

After the examination with Dr. Bernardi, Petitioner met with Dr. Gornet on November 27, 2017 to go over Dr. Bernardi's report. Dr. Gornet explained to Petitioner that he and Dr. Bernardi had differing opinions/philosophies regarding the treatment of structural back pain. He explained to Petitioner that his current testing had shown a statistical chance of improvement in structural back pain on FDA standards at 95%. That testing had been accepted for podium presentation and was peer reviewed. Dr. Gornet doubted that Dr. Bernardi had ever treated a patient with a lumbar disc replacement and, therefore, his opinions should be viewed with an err of caution. Dr. Gornet explained that a slip and fall as she had could easily injure a disc that was already showing some pre-existing signs of degeneration. (PX 12)

On December 11, 2017 Dr. Gornet made a chart note after speaking with a doctor performing a utilization review regarding the possible disc replacement procedure. In noting his concerns about ODG guidelines and "cherry picking" the literature it considers, he further pointed out that Dr. Jackson did not perform

fusions nor had she performed a lumbar disc replacement. It was difficult for the doctor to understand why, under those circumstances, she would be selected to perform the review. He hoped he had been able to educate her on the process and why he believed his rationale was appropriate. (PX 12)

A third utilization report was authored by Dr. Linda C. Jackson on December 12, 2017. The reviewing physician was asked to review the recommendation of a lumbar disc replacement at L4-5 and L5-S1. The reviewing physician discussed the case with Dr. Gornet on December 11, 2017. The reviewing physician reported that the request for an anterior lumbar disc replacement was not reasonable, necessary or appropriate. She reported that the procedure is considered experimental at this time and without evidence of objective functional impairment substantiating the complaints the request for an anterior lumbar spine disc replacement is not medically necessary. (RX 4)

Dr. Gornet's Deposition

Petitioner offered into evidence the deposition transcript of Dr. Matthew Gornet taken June 18, 2018. Dr. Gornet is a board certified orthopedic spine surgeon. He initially evaluated Petitioner on November 23, 2016. At that time, she reported to him that on June 29, 2016 she was assisting a patient when she slipped and twisted and fell landing on her back and buttocks. She described to him her course of treatment up to the date of that particular visit. Dr. Gornet testified that Petitioner told him she did not have any previous problems of any significance with her back other than some intermittent chiropractic care which she believed was routine. Her symptoms were reported as constant and worse with bending, lifting, prolonged sitting, or any sort of sitting. Her pain was relieved by alternating positions. She reported bilateral leg pain, right greater than left. Dr. Gornet testified that he reviewed an MRI study from July 20, 2016 and it indicated an obvious annular tear at L4-5 and L5-S1. It was his opinion that Petitioner had disc injuries at L4-5 and L5-S1 which he testified was common for falls such as the one she described. He initially recommended steroid injections at both levels and placed her on a light duty 10 pound lifting limit with no repetitive bending or lifting and alternating between sitting and standing as needed. Epidural steroid injections were performed on December 22, 2016 and January 5, 2017 which did not give her any significant long-term relief. He felt she still had pain which affected her quality of life and she still had not returned to baseline. (PX 1, p. 10)

Dr. Gornet testified that he identified objective tears of the disc which were no different than torn cartilage in the knee in that those tears can be painful. He testified that there was a structural component just like a torn rotator cuff in the shoulder or torn cartilage in the knee that cause pain because there are nerve fibers in the structure itself. He further testified that there are significant chemicals in discs that can cause irritation. Those chemicals are independent of the disc itself and can cause an inflammatory response, irritation of the nerves around them thus producing a bilateral leg component. Therefore, the leg component is not dermatomal in nature but is secondary to acid in the disc itself. Dr. Gornet recommended that Petitioner lose some weight prior to considering further surgical options. Following the weight loss he moved forward with discography on May 9, 2017. Dr. Gornet testified that the discogram showed tears in the disc at L4-5 and L5-S1 which correlated with her complaints of structural back pain. He called it a concordant test as far as pain was concerened which can be subjective in nature, but with the structural pathology which is objective he felt it correlated with her objective findings on the MRI scan. Dr. Gornet testified that the discogram was reasonable and necessary. (PX 1, pp. 10 – 12)

When Petitioner followed up on May 25, 2017 Dr. Gornet recommended an MRI spectroscopy. He identified this as a test that can measure tissues such as brain tumors, spinal cord inflammation and chemicals in a disc. He testified that he chemically tested the disc and found there were painful

chemicals in a disc at these levels and that objective information correlated with her objective MRI as well as her objective CT discogram. Based on this testing he believed the patient would have a 95% chance of a positive outcome. Dr. Gornet testified that at this point he felt that a disc replacement surgery at L4-5 and L5-S1 would give Petitioner the best opportunity to cure and relieve and effects of her injury and get back to work as a nurse. It was his opinion that this surgery was reasonable and necessary and causally connected to her work injury of June 29, 2016 and her fall. It was his opinion that the pathology he described as annual tears were directly caused by the fall and did not pre-exist June 29, 2016. (PX 1, pp. 12 – 16)

Dr. Gornet testified that as of July 27, 2017, Petitioner was still complaining of pain and it was affecting her day to day life. He believed surgery would be beneficial to Petitioner as because sudden mechanical falls, such as the one Petitioner described, do cause disc injuries. Second, her MRI showed objective pathology correlating with her structural back pain. Annular tears can be painful. Third, Dr. Gornet considers himself one of the main authorities in the world on disc replacements and, as such, is in a unique position to give more definitive opinions on treatment, especially when compared to another doctor's opinion who does not perform that type of treatment. (PX 1, pp. 18 – 19)

Dr. Gornet testified that when he saw Petitioner on May 24, 2018 she had gained back nearly all the weight she had previously lost and he discussed with her that she needed to get back to where she was and "I believe even if surgery was authorized today, I would follow her and do that." (PX 1, pp. 19 – 20) He pointed out that she has lost the weight in the past so he knows she can do it and he thinks it will help her. She originally came in at 245 lbs. and currently weighed 254 lbs. He would like her in the 210 – 220 range although she got down to 207 which was wonderful. (PX 1, pp. 20-21)

Dr. Gornet testified that he has no concerns as to her veracity. He does believe she had some level of pre-existing degeneration which is why those discs were injured (ie., they were already somewhat weaker than the others) but she had no indication in her medical history that she had problems of significance prior to this. She was working full duty and, but for her fall, they wouldn't be talking about the situation. (PX 1, p. 21)

On cross-examination, Dr. Gornet agreed that when Petitioner was seen at the Orthopaedic Institute of Southern Illinois she had predominantly back pain as opposed to pain in her legs. He further testified that she did indeed have pre-existing disc degeneration including a loss of hydration that would have pre-existed the accident. He did not believe she had any significant disc bulge or herniation. He further did not believe she has any significant nerve compression. He testified that, in his opinion, annular tears are not a progression of degenerative disc disease but are, instead, a result of a structural mechanical loading of the disc. Dr. Gornet testified that he did not believe overloading of the disc by significant weight could cause the annular tear. He testified that the amount of potential causes of an annular tear are infinite because anything that exceeds the mechanical loading of a disc could cause an annular tear. Dr. Gornet further testified on cross-examination that annular tears can be present but not symptomatic. He acknowledged that the MRI doesn't date the problem or indicate whether the findings are symptomatic. That is why other tests become necessary. He indicated that hypothetically if steroid injections had relieved her pain an MRI would still show the same annular tears that were present prior to the injections. The reason surgery was recommended was because she had never gone back to baseline in her complaints of pain and the proposed surgery would cure and relieve the effects of this injury. Dr. Gornet conceded that this is based on her subjective complaints of pain.

Finally, Dr. Gornet testified on cross-examination that if Petitioner doesn't lose the weight as he has recommended and requested, her prognosis to regain her normal level will be poor. He feels she needs a reasonable period of time to try and lose weight and if she can't he'll recommend an FCE and place her at maximum medical improvement. (PX 1, pp. 22 – 32)

Deposition of Dr. Bernardi

Dr. Bernardi was deposed on June 22, 2018. (RX 1) Dr. Bernardi testified that he saw Petitioner for purposes of an independent medical examination on October 31, 2017. Dr. Bernardi testified that he is a board-certified neurosurgeon. Dr. Bernardi testified that Petitioner described the accident that occurred on June 29, 2016 to him at her examination. She testified that her right leg slipped on water and she fell landing on her right buttock. She told Dr. Bernardi that she did not have any immediate symptoms, but about 15 minutes later when she leaned forward over the patient's bed she had an immediate onset of right sided back pain that radiated to her right buttock and leg. Dr. Bernardi said it is difficult to determine whether the mechanism of injury was the fall or the bending over incident. Dr. Bernardi testified that he reviewed a significant amount of medical records as set forth in his report. He indicated that she had seen a chiropractor intermittently for several years. Her records documented a first chiropractic visit when she was 11 years old and that she had complained of neck and back pain which pretty much stretched up to 2015.

At the examination, Dr. Bernardi had Petitioner perform certain questionnaires and testing described as the Zung Depression Index and Modified Somatic Perception Questionnaire. Dr. Bernardi testified that these tests can be useful in teasing out psychological morbidity that might be contributing to the development or the presence of chronic neck or low back pain. He testified that the transition from having an acute back ache to having chronic and disabling pain is much more accurately predicted by non-physiological factors than it is by physical ones. He explained that people who fall down and break their spine having a terrible injury many times go back to work in normal activities much more predictably than people who suffer minor trauma with no physical signs of injury. The reasoning behind that has nothing to do with the physical injury but more to do with psychological or non-organic factors. These two tests are designed to tease that out. Dr. Bernardi testified that Petitioner's results were abnormal on both tests. He said this would be considered a yellow flag. It does not mean that she does not have a physical problem, but it means there might be and a treating physician should be cognizant of the fact that non-organic factors may be contributing to her presentation. Dr. Bernardi also performed a physical examination when he saw Petitioner. He performed a general physical examination directed at her low back as well as a neurological examination. He felt that her exam was essentially normal. She had normal strength, normal reflexes, and symmetric reflexes. She complained of some pain over her right greater trochanter and some tenderness around her right sciatic notch but those were the only positive exam findings. Dr. Bernardi further testified that he reviewed the MRI from July 20, 2016. He indicated that the MRI showed degenerative disease at the thoracolumbar junction so that she had disc disease at T10-T11 and T11-T12. She then had some relatively minor degenerative disc disease at L4-5 and L5-S1. Dr. Bernardi also reviewed a post discogram CT from May 9, 2017. He said there was some dye in the discs that had been injected but otherwise it was pretty much a normal study. It did not show any facet changes, the vertebral body alignment was otherwise normal. (RX 1, pp. 10 – 13)

Dr. Bernardi testified that he was unable to establish any sort of diagnosis of a condition of ill-being in Petitioner's low back. Further, he did not have any explanation for the pain complaints she was having. He indicated that he disagreed with Dr. Gornet's opinion that Petitioner suffered from annular tears at L4-5 and L5-S1. Dr. Bernardi explained in detail that the term annular tear is a bad term because it implies a trauma or acute injury. It implies that the finding is analogous to a meniscal tear or rotator cuff tear when in fact nothing could

be further from the truth. He further stated that the most recent recommendations regarding disc nomenclature are that the term annular tear should no longer be used because it implies that the finding is traumatic when in fact it is a degenerative change. Dr. Bernardi described this degenerative change as the equivalent of mud that is drying in the sun. As it loses water, it begins to crack and that is what is happening in the disc. The disc is simply getting older and degenerating. As it loses water fissures form in the outer walls of the disc. He indicated that fissure is the more appropriate term for this type of degenerative finding as opposed to tear. (RX 1, pp. 14 – 16)

Dr. Bernardi testified that he does not necessarily look at or even describe that type of finding (an annular fissure/tear) when interpreting an MRI because he does not think it has any significance. It is not like a herniated disc that is displacing a nerve that will correlate with a certain kind of complaint. These fissures are an aging phenomenon that are the equivalent of gray hair and it does not reliably correlate with the presence of back pain. He testified that 50% of the population has one of these annular fissures in their back.

Dr. Bernardi testified that he also disagreed with Dr. Gornet's opinion that the fissures/tears were causally related to the fall. He explained that again this is a degenerative finding. He testified that there has never been a study that showed that these fissures develop after an accident and correlate with the presence of back pain. He testified that there have been studies where an MRI was taken at the beginning of a study showing a fissure. Then if a patient had an episode of back pain they repeated the MRI scan and found that the fissures never developed with any kind of temporal relationship to the presence of pain or an accident. (RX 2, pp. 16 – 17)

Dr. Bernardi also testified that he did not believe the two-level disc replacement surgery being recommended by Dr. Gornet was reasonable and necessary to treat Petitioner's condition. Dr. Bernardi explained that it is a very controversial area of spine surgery whether to operate on what is termed non-specific back pain, mechanical back pain, or degenerative back pain. Dr. Bernardi testified that there are two side to this issue with one side being comprised of surgeons who make their careers out of such surgery and other who don't. He is in the latter group because he does not believe there is sound scientific evidence to support such a surgery. Dr. Bernardi testified there have now been three prospective studies that have followed patients for approximately 20 years that have failed to show that surgery, whether it is a fusion or a disc replacement, works any better than conservative treatment for this type of mechanical back condition. The doctor explained that even in the very best of circumstances (which would be outside of any type of litigation arena) single level disease in people without psychological morbidity has a success rate of less than fifty percent. With mitigating factors, psychological issues, prolonged time off work, and pending litigation the success rate can be as low as 5 percent. He feels the outcomes from the operation are just dreadful and will not perform them or recommend them. He testified it is a self-limiting process. (RX 1, pp. 17 – 19)

Dr. Bernardi testified that, in his opinion, Petitioner was at maximum medical improvement from whatever injury she may have suffered as a result of the work accident of June 29, 2016. He did not see any objective basis for assigning any work restrictions. (RX 1, pp. 19 – 20)

On cross-examination Dr. Bernardi acknowledged that he noted annular fissures in his report. He also testified that degenerative disc disease can be symptomatic and it's a well-known cause of back pain. Petitioner's annular fissures are a degenerative finding and, therefore, can be symptomatic; however, most of the time they are not. (RX 1, pp. 21 -22)

Dr. Bernardi further testified that he abandoned the use of discograms about ten years earlier and agreed that they should never be used as the sole basis to operate on someone. He does not consider them to be valid. (RX 1, p. 23)

Dr. Bernardi felt Petitioner's complaints were genuine and he saw no Waddell signs. (RX 1, pp. 24 - 25)

He agreed that Petitioner had neither a facet joint nor SI joint problem. (RX 1, p. 26)

Dr. Bernardi was of the opinion that annular fissures or tears can never be the result of a trauma. His recommended treatment was for Petitioner to lose additional weight, to try to exercise as much as possible and to try to move on with this. He testified that the persistence of pain is not an indication for surgery. Just because someone hurts for a certain amount of time does not mean that all of a sudden he/she becomes a candidate for an operation, particularly an operation that alters the way your spine works for the remainder of your life. Dr. Bernardi testified that he would not have done a discogram or MR spectroscopy. He also would not have done facet injections or an SI joint injection. Because she does not have radiculopathy he would not have recommended epidural steroid injections. He did testify that medications, physical therapy and a short course of activity restrictions, as well as an MRI and plain films were reasonable and appropriate treatment. (RX 1, pp. 27 – 32)

On redirect, Dr. Bernardi testified that while he does not perform disc replacement surgeries he is very educated regarding the literature on such a procedure. He testified that he does not perform disc replacements because it is not a procedure he would have done to him. This is based on his understanding of the literature on the subject to date. More specifically he would not recommend it for a 31 year old woman. Dr. Bernardi explained that the lumbar spine goes through approximately a million to two million cycles of motion every year. Every time you turn over in bed you are putting it through a range of motion. With a disc replacement you would have a device that is going through two million cycles of motion a year in a 30 year old woman who might reasonably be expected to live to age 80. That represents 50 to 100 million cycles of motion. Dr. Bernardi testified that he does not even know if a door hinge he can open in his house 100 million times that will not eventually break. He testified it is not warranted for this to be going on around someone's spinal cord. He went on to explain that 90% of back pain episodes subside spontaneously. As such a disc replacement surgery does not seem warranted to him. (RX 1, pp. 32 – 38)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 17, 2018 pursuant to a 19(b) Petition. Petitioner seeks prospective medical care, payment of medical bills, and payment of temporary partial disability benefits. Respondent disputes causation for Petitioner's low back injury. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that she was 32 years old on June 29, 2016, the date of her accident. Petitioner testified that she was employed as a registered nurse there since January 4, 2016. Petitioner indicated that prior to being hired by Respondent she had to complete a pre-employment physical consisting of performing various tasks including transferring a patient from a wheelchair to a bed and back to a wheelchair. Petitioner worked in the cardiac neuro unit on the third floor of the hospital. Her duties included passing medications, taking patients to the bathroom, taking them from the bed to a wheelchair. She was required to walk patients down the hall or if unable to walk to transfer them from bed to wheelchair and back to bed. Petitioner testified that prior to her accident on June 29, 2016, there were no job duties she was unable to perform.

Petitioner testified that on June 29, 2016 she was working the 7:00 p.m. to 7:30 a.m. shift. She slipped and fell at a patient's bedside on some water that was on the floor. She testified that she hit her right

elbow on the bedside table as well as her right buttocks and that she landed on her right side. It was a concrete, tile floor. At first she was more embarrassed than anything and did not think she was hurt. After she left the patient's room to walk to the nurse station she noticed that her right leg and back were starting to hurt. It was at that time that she reported the accident to her supervisor who informed her to go to the emergency room where she had x-rays and was assessed by Dr. Maddipoti. She was also seen by Workcare at that time and was given some work restrictions which were accommodated by Respondent. She was given a light duty job of a resource nurse at the hospital to accommodate the restrictions. During the time in which she was a resource nurse she was paid the same amount of money that she was making pre-accident. On February 27, 2017 she was transferred to a job as a clerk at the telemetric desk watching heart monitors and heart rhythms. It was at that time that her pay decreased and she began receiving temporary partial disability benefits.

Petitioner testified to undergoing a course of physical therapy at Rehab Unlimited as prescribed by Workcare and was given a home exercise program which she complied with. She testified to undergoing an MRI at St. Joseph's Hospital of her lumbar spine. She came under the care of Dr. Newell who provided her with an SI joint injection that she testified did not provide long term relief. She was referred by Workcare to the Orthopaedic Institute where she saw Ms. Angie Arnold, PAC. She testified that that appointment was on September 2, 2016. Petitioner indicated that at no point during the visit did she see Dr. Jeffery Jones or speak with Dr. Jeffery Jones. Ms. Arnold recommended additional physical therapy for piriformis syndrome and referred her to Dr. Criste. Dr. Criste examined her on October 19, 2016 and recommended facet injections and a medial branch block. Those injections were performed on November 16, 2016. Petitioner testified that they did not provide her with any relief. The piriformis therapy provided her with no long-standing relief. Petitioner testified that following the injections she had a less than pleasant conversation with Dr. Criste's office. She did not understand why the doctor would not put any work restrictions on her.

Petitioner testified to treating with Chiropractor Bird at the same time she was doing physical therapy under the direction of Angie Arnold. She did so because she felt there was something "more towards her back" and that an adjustment might help. In November of 2016 she came under the care of Dr. Matthew Gornet. She testified that she learned about Dr. Gornet from some co-workers as well as a staff member of Dr. Bird's.

Petitioner testified that she saw a chiropractor named Dr. Wittenauer several times prior to her accident. She testified to having approximately 54 chiropractic visits between 1997 and January of 2015. She testified that between January of 2015 and June 29, 2016 she did not seek treatment for back pain with a chiropractor, medical doctor or anybody else. She testified that her symptoms when she saw her chiropractor were different than those following her June 29, 2016 accident. She testified that since June 29, 2016 there hadn't been a day where she didn't feel back or leg symptoms. Prior to the accident Petitioner's pain was like a dull muscle ache with pain. She had lost weight at the recommendation of Dr. Gornet but testified that her back pain did not go away with the weight loss. Petitioner testified that Dr. Gornet is recommending surgery and that she wished to undergo that surgery.

Petitioner testified that she was currently working for the Illinois Department of Employment Security in the internet claims processing center. She testified that the job was not physically demanding on her in any way. She testified that she was making relatively close to the same amount of money that she had made as an RN for Memorial Hospital of Carbondale. She testified that she currently has health insurance and that she did have health insurance while working at Memorial Hospital of Carbondale. It is her understanding that Dr. Gornet did not take her health insurance and therefore she did not attempt to process her surgery through the group health

insurance. She had no knowledge of whether Dr. Gornet's refusal to take her health insurance had to do with the procedure that was being recommended.

As of the day of arbitration, Petitioner testified to a "pins and needle" pain in her right leg and whenever she moves in certain positions, she has a sharp, almost lightning bolt feeling in her leg. Petitioner acknowledged that she has put some weight back on since losing some but is trying to reach Dr. Gornet's goal weight.

On cross-examination Petitioner testified that she went to Dr. Bird on her own and was not referred there. She also testified that Dr. Jones' office referred her to Dr. Christie.

Petitioner's claim for temporary partial disability is outlined in PX 18. Her medical bills are found in PX 19.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in her lumbar spine is causally related to her work accident/injury. Petitioner also sustained a right elbow injury at the time of the accident; however, based upon the medical records and Petitioner's lack of testimony as to any ongoing issues, it appears to have resolved.

A claimant has the burden of proving by a preponderance of the credible evidence all elements of her claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro, v. Industrial Commission, 260 Ill.App.3d 551, 553 (1st Dist., 1994).*

It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that the work-related accident 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 injury and not simply the result of a normal degenerative process of the pre-existing condition. *Sisbro, Inc. v. Industrial Comm'n, 2017 Ill.2d 193, 204-206 (Ill, 2003)* The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n, 141 Ill.App.3d 289, 296 (1st Dist. 1986)* A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. *International Harvester v. Industrial Comm'n, 93 Ill.2d 59, 63-64 (1982)*

The Arbitrator finds that Petitioner's current condition of ill-being with regard to her lumbar spine is causally related to her work accident. In so concluding, the Arbitrator relies upon a chain of events and the more persuasive opinion of Dr. Gornet over that of Dr. Bernardi regarding the condition of Petitioner's lumbar spine. The Arbitrator finds it significant that the record is lacking evidence that Petitioner was having lumbar problems or symptoms close in time to her undisputed accident herein. Prior to the accident Petitioner was working full duty with no restrictions and no purported limitations or difficulties. While she had a history of chiropractic treatment to her low back in the past, she credibly described that those complaints were different than the ones she experienced after her accident herein. While she did undergo some chiropractic treatment in 2014 and 2015 her presenting complaints for those two visits were her neck and upper back. While the chiropractor rendered some treatment to her low back, that appears to have been incidental given her presenting history. The Arbitrator also finds it important that there is a consistent record of Petitioner's complaints and objective findings

beginning immediately after the accident. No one, including Dr. Bernardi, has truly questioned the veracity of Petitioner's symptoms or complaints.

Both Dr. Gornet and Dr. Bernardi agreed that the mechanism of injury in this instance is a common cause of back complaints and pain. The records from N.P. Sullivan and Dr. Burchill support a work-related etiology for her complaints. Both Dr. Gornet and Dr. Bernardi agreed that Petitioner does not have a facet joint or SI joint dysfunction problem. Dr. Gornet testified that Petitioner has annular tears at two levels that resulted from the work accident. Dr. Bernardi disagreed that annular tears could be caused by trauma. While he also testified to some doubts as to the validity of annular tears/fissures as a viable condition he acknowledged (both in his report and in cross-examination) that she had annular "fissures". He did not think, however, that they were caused by the accident. Dr. Gornet, in his deposition, acknowledged that annular tears are not caused degenerative disc disease; however, he further explained that Petitioner most certainly probably had pre-existing degenerative changes in her lower spine that weakened it and, as such, made the risk of annular tears from the accident more likely. The Arbitrator finds it very significant that Dr. Bernardi was never asked if Petitioner's annular tears/fissures (which he felt were degenerative in nature) might have been aggravated and made symptomatic by her work accident. He never addressed whether any of her pre-existing chronic findings could have been aggravated by Petitioner's work accident. The Arbitrator has also considered Dr. Bernardi's opinion that Petitioner is not suffering from two level discogenic pain. In support of that opinion, Dr. Bernardi stated that Dr. Jones and Dr. Criste concurred. The Arbitrator disagrees that those doctors reached that same conclusion. Dr. Jones did not actually examine Petitioner. PAC Arnold did. Dr. Jones merely signed off on the record, approximately eight months after the actual visit. PAC Arnold suspected Petitioner had piriformis syndrome which both Dr. Gornet and Dr. Bernardi agreed she does not have. As for Dr. Criste, he was asked to perform an injection and not determine the cause of Petitioner's complaints. While he did look at the MRI he found it "relatively unremarkable for neuroaxial pathology." Dr. Criste was looking at Petitioner from a neurological perspective. Dr. Gornet is an orthopedist.

As such, the Arbitrator finds that Petitioner's annular tears at L4-5 and L5-S1 were caused, or aggravated, in whole or in part by the accident of June 29, 2016. As such, her current condition of ill-being in her low spine is causally related to her work accident.

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

Petitioner seeks payment of the following medical bills as found in PX 19:

(1) SIH WorkCare – 8/10/16 $ 115.00

This bill is awarded. Respondent stipulated that it would pay it.

(2) MFG Spine, LLC – 11/23/16 – 7/3/18 $21,390.88

Petitioner is awarded payment of Dr. Gornet's bill for services rendered from 11/23/16 through 7/3/18 except for the interest charges and "special report" charges. The record does not substantiate and Petitioner did not proffer evidence that interest was properly charged pursuant to Section 8.2(d)(3) of the Act. The Arbitrator also declines to award charges billed by Dr. Gornet for CPT code 99080, "Special Report." No evidence was presented regarding why he rendered these "special reports" and what they entailed. They appear to go beyond what would be included or considered as the normal course of treatment. Thus, the charges are not reasonable.

(3) Pain & Rehabilitation Specialists of St. Louis, LLC - 12/22/16 – 1/5/17 $ 2,735.00

Respondent stipulated that it would pay for the injection given on 12/22/16. Consistent with the Arbitrator's causation determination, Respondent shall pay for the second injection given on 1/5/17.

(4) Orthopedic Ambulatory Surgery Center Of Chesterfield - 5/9/17 $ 6,546.42

Consistent with the Arbitrator's causation determination and Respondent's stipulation that it would pay for the injection performed on 12/22/16, the charges to Orthopedic Ambulatory Surgery Center in the amount of $6,546.42 are awarded. Dr. Treister (UR) agreed with Dr. Gornet's recommendation for the epidural injections and, if one helped, two more sequential ones would be reasonable. As they were given at two different levels, both are reasonable.

(5) STL Spine & Orthopedic Surgery Ctr - 5/9/17 $ 9,313.00

Consistent with the Arbitrator's causation determination, this charge for the discogram is awarded. While Dr. Bernardi does not perform discograms in his practice, he acknowledged others do and no utilization report was presented regarding this bill.

(6) CT Partners of Chesterfield – 5/9/17 $ 1,650.00

Consistent with the Arbitrator's causation determination, this charge is awarded.

(7) MRI Partners of Chesterfield – 5/25/17 $ 2,700.00

This bill is awarded. Respondent stipulated that it would pay it.

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

At this time the Arbitrator declines to award Petitioner the prospective medical care recommended by Dr. Gornet – ie., a two-level disc replacement.

Dr. Gornet and Dr. Bernardi clearly have differing opinions regarding the reasonableness and necessity of the two-level disc replacement procedure recommended by Dr. Gornet. However, both doctors do agree as to what Petitioner currently needs to do regarding her low back.

A close reading of Dr. Gornet's deposition testimony shows that the doctor is not really recommending the procedure at this time. Rather, he recommends Petitioner lose weight. Dr. Gornet testified that when he saw Petitioner on May 24, 2018 she had gained back nearly all the weight she had previously lost and he discussed with her that she needed to get back to where she was and "I believe even if surgery was authorized today, I would follow her and do that." (PX 1, pp. 19 – 20) He pointed out that she has lost the weight in the past so he knows she can do it again and he thinks it will help her. She originally came in at 245 lbs. and currently weighed 254 lbs. He would like her in the 210 – 220 range although she got down to 207 which was wonderful." (PX 1, pp. 20-21) Dr. Gornet further testified on cross-examination that if Petitioner doesn't lose the weight, as he has

recommended and requested, her prognosis to regain her normal level will be poor. He feels she needs a reasonable period of time to try and lose weight and if she can't he'll recommend an FCE and place her at maximum medical improvement. (PX 1, pp. 22 – 32) Under those circumstances, there will be no surgery.

Dr. Bernardi was also of the opinion that Petitioner needs to lose weight to help with her low back condition. Thus, both doctors agree that Petitioner needs to engage in a serious effort to lose weight and work on core exercises and, as such, any award of surgery at this time would be premature. Accordingly, the Arbitrator declines to award the surgery being requested by Petitioner at this time.

The Arbitrator further notes that the procedure was not certified by Utilization Review as the procedure is considered experimental at this time. (RX 4)

Issue L: What temporary benefits are in dispute?

Petitioner is awarded temporary partial disability (TPD) from February 27, 2017 through April 8, 2018 ($11,580.88). Respondent did not dispute the dates of temporary partial disability, only liability for the benefits. Consistent with the Arbitrator's causation determination, Petitioner is awarded TPD for the aforementioned dates. A review of the medial records and work restrictions shows that throughout the entire time Petitioner claims entitlement to TPD, she was on light duty restrictions per her treating physicians.

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STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD MUELLER,

Petitioner,

vs. NO: 16 WC 32465

PRECISION PIPELINE LLC/MASTEC, INC.,

Respondent.

19IWCC0454

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, 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.

I. FINDINGS OF FACT

A. Background

Petitioner is a 57-year-old employee of Respondent, who described his job as a heavy equipment mechanic. He is a member of Operating Engineer's Local 520, Granite City, Illinois and he worked out of the union hall. Petitioner explained that a contractor calls the union hall and the business agent would dispatch him to a particular job. He had to travel for his job, and had been contracted to work in Ohio, Michigan, Missouri, Texas over the past few years as a union operator. Petitioner previously worked on pipeline jobs, such as the one with Respondent. He also previously worked as a mechanic in a coal mine and welding. Petitioner had been a union member for five to eight years, and always worked in a labor-type job.

Petitioner's truck[1] is a 4700 International mechanic's truck that has several components including a crane, compressor, welder, lube machine, and about $190,000 worth of other tools. Petitioner explained that Respondent knew about his tool truck. Respondent rented the truck from Petitioner at the rate of $17 per hour during each hour that he worked in addition to his wages[2] in accordance with the vehicle rental agreement[3] between them. Petitioner testified that he was required to properly maintain the truck while on the project. He further testified that he used his tool truck every day for every task, which was essential to perform his pipeline work for Respondent on October 10, 2016.

Petitioner testified that the truck undergoes constant maintenance to keep it operational for jobs. If a part breaks, Petitioner acknowledged that he has to fix it as it is his personal truck. However, Petitioner testified that the truck was part of his employment with Respondent. He did not go home after work, he went to an apartment that he was renting near the pipeline and, generally, he would drive the truck from the apartment to the job site. Petitioner testified that when he was working on the pipeline, Respondent was obligated to pay for his gas and parts to repair his truck.

Petitioner acknowledged that he received treatment related to his low back at Red Bud Regional Hospital with Dr. Flury in 2008. The medical records reflect that he was then under treatment for chronic and severe back discomfort. Petitioner also had a lumbar MRI on May 21, 2004. Petitioner explained that he had an accident involving his neck, which resulted in cervical spine surgery. He fell and had some back soreness as well as shoulder pain. Petitioner testified that it was horrible after this accident at work and unlike anything he had previously experienced. He was unable to walk without pain. No medical records were submitted reflecting any other medical treatment involving the low back between 2008 and the claimed date of accident.

B. Accident

On Sunday, October 9, 2016, Petitioner was working for Respondent on a pipeline project near Jacksonville, Illinois. Petitioner testified that his truck suffered a broken wheel bearing while transporting a necessary part from Decatur, Illinois to its destination. Petitioner contacted John Schmitz, master mechanic, who informed him to drive safely and get the truck to the laydown yard where he would meet Petitioner at the mechanic's tent. Petitioner did so and spoke to Mr. Schmitz who told him to take a company vehicle (pick-up truck) to return to his lodging. Mr. Schmitz also told him that, as it was late Sunday, there was no chance of getting parts until Monday. Mr. Schmitz would get the necessary parts for the truck at that time and Petitioner should come and work on the truck.

Petitioner testified that he arrived at work on Monday, October 10, 2016 at 5:30 a.m. He went to his truck to begin repairs. Petitioner used a jack to raise the truck and placed safety stands underneath so that he could take the wheel off and repair the broken wheel bearing. He explained

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1 *See* PX11 (photographs of Petitioner's truck).
2 The parties stipulated to Petitioner's earnings and average weekly wage at arbitration. In addition, Petitioner testified that per the union contract as a union operator he received $36 per hour for straight time work, $49 per hour for overtime, and $72 per hour for Sunday work.
3 *See* PX4 (vehicle rental agreement); PX8-PX9 (payroll records).

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that he had to bend over, basically on his hands and knees, and when he started to remove the lug nuts using a large, 10-pound heavy-equipment impact wrench, he stood up and injured his back. Petitioner testified that this is not the type of wrench used to repair a regular vehicle. When he stood up, Petitioner testified that he felt a sharp, stabbing pain in his right side from his hip and low back down to his toes. He stood up and tried to walk, but could not, so he laid down on the ground and got help.

Petitioner testified that he had the impact wrench in his hand at that time as well as a pair of channel-locks and a screwdriver when he stood up. No other mechanics witnessed the accident as they were doing something at the other end of the shop. Another mechanic eventually repaired Petitioner's truck for him, as he was still in that process when he was injured.

Respondent offered its investigation report dated October 10, 2016. RX1. Petitioner testified that he signed the report, which accurately reflects what happened with the accident. Specifically, it states bodily injury to the lower right back and the following accident description: "I jacked up a truck and put a jack stand under it. I then went around the other side of the truck. I bent down to take the hub cap off and when I stood up there was severe pain. The pain was mostly on the [right] side around my belly and down my leg to the knee. There was no snap or pop, just pain." Id.

Petitioner also testified that he did not disagree with the statements by Jonathan Filz, another mechanic, or Mr. Schmitz. In the report, Mr. Filz states "Saw Richard Leaned Against the Right Side of his Truck Complaining of Numbness in Right Side From the Nose Right Knee, Leg, Arm, and Pain in the Lower Back helped him to the ground to relax and make him more comfortable until ambulance." Id.

Mr. Schmitz states "I and my teamster Mech. Johnathan Filz were leaving tent for Monday safety meeting. Jonathan heard something & turned around, noticed Richard leaning against passenger side of his work truck. We went over and Richard stated he had severe pain down right leg and could not feel RH knee or foot, and it felt like pins on bottom of right foot. I Had told him he could repair his truck in the tent. A right wheel bearing had failed the night before which he was working on at time of his incident. He stated when he stood up he had the pain and numbness. I called for help, put down clean cardboard on the floor and we did what we could do to make him comfortable until the ambulance arrived. I had noticed some twitching and disorientation. So informed safety & emergency…." Id.

C. Medical Treatment

Petitioner was taken to the Passavant Area Hospital emergency room via ambulance. Petitioner described his pain then as a stabbing pain. The medical records reflect Petitioner's report of acute back pain after working on some heavy equipment at work. He was unable to walk, bend over, and he had numbness down the right lower leg and thigh. Petitioner underwent x-rays and a lumbar MRI. The physician's impression was acute lumbar radiculopathy, lower lumbar spine, spinal stenosis and a herniated disc.

Petitioner was then transported by ambulance to Memorial Medical Center in Springfield

on October 11, 2016 where he was examined by Dr. Payne, a spine surgeon. Petitioner was admitted with a diagnosis of a disc extrusion at L2-3, intractable back pain, and lumbar radiculopathy. The history reflects Petitioner's report that he was working on heavy equipment and felt the sudden onset of intense low back pain with radiculopathy to the right lower extremity. At time he was not lifting anything heavy. Petitioner also underwent a lumbar MRI at Passavant. The interpreting radiologist found a right paracentral caudal migrating disc extrusion at L2-3 impinging on right L3 nerve roots that correlated with the diagnosis.

Dr. Payne recommended surgery, which Petitioner underwent on October 12, 2016. Specifically, Dr. Payne performed a right side microdiscectomy for a pre- and post-operative diagnosis of right-sided disk herniation at L2-3. Intraoperatively, Dr. Payne noted direct impingement on the L3 nerve root and a free fragment of disc herniation with inferior migration at L2-3 down behind the L3 body impinging on the L3 nerve root. He further noted severely inflamed epidural vessels surrounding disc material. Petitioner was released the next day.

Petitioner returned to Dr. Payne for follow up after surgery and he ordered post-operative physical therapy, but it was denied by the workers' compensation insurance carrier. Petitioner testified that he tried to obtain the therapy through his union insurance, but they declined stating that it was a workers' compensation case. As a result, Petitioner did therapy at home, which consisted of stretching and certain regimens with ice and heat. He testified that the exercises did help.

Petitioner agreed that he was released back to work on July 26, 2017, but he returned to work before that date. Petitioner has not returned to see Dr. Payne since the November 22, 2016 visit.

D. Section 12 Examination & AMA Guides Impairment Rating – Dr. Petkovich

On December 20, 2017, Petitioner submitted to a Section 12 examination at Respondent's request with Dr. Petkovich. After performing a physical examination, taking a history from Petitioner, and reviewing various medical records, Dr. Petkovich rendered various opinions regarding the relatedness, if any, of Petitioner's condition to the alleged accident at work.

Dr. Petkovich diagnosed Petitioner with a right lumbar disc herniation at L2-3 and indicated that he was status post surgery. Dr. Petkovich opined that the herniation occurred while at work on October 10, 2016, and he indicated that Petitioner's subjective complaints were consistent with his objective physical findings. Dr. Petkovich also opined that Petitioner was at maximum medical improvement and no further diagnostic tests or treatment was required. Petitioner could return to work without any restrictions.

Dr. Petkovich also rendered an impairment rating pursuant to the AMA Guides to the extent of 8% of the whole person as a result of the lumbar disc herniation at L2-L3 level and subsequent surgical procedure.

E. James Hurley 19IWCC0454

Respondent called James Hurley, project safety lead, as a witness. Mr. Hurley testified that his duties include everything from inspecting equipment to evaluating potential hazards. He does a complete risk analysis of the project and implements Respondent's programs. Mr. Hurley had been employed by Respondent for approximately four years and doing pipeline safety work for 12 years.

Mr. Hurley testified that when a worker is injured on the job, they seek medical attention and he fills out an accident report. He testified that the number one priority was the employee's health and well-being. Sometimes safety personnel attend to the injured person on site and other times they call 9-1-1 or transport the person to an urgent care facility or doctor depending on the situation. Then, they try to reconstruct the injury, obtain the injured worker's statement, gather witness statements, and try to put together a model to find the root cause of the situation.

Mr. Hurley testified that he completed the report relating to Petitioner's incident on October 10, 2016. RX1. He was called over and talked to Petitioner who was laying on the ground. Mr. Hurley testified that he asked Petitioner what he was doing, and Petitioner had stated he was getting ready to change a wheel bearing. Mr. Hurley did view Petitioner's truck and all the wheels, one of which had the hub cap removed. Petitioner was lying right beside it. He testified that the lug nuts weighed approximately one pound each and were not off the truck where Petitioner was laying. The report reflects Mr. Hurley's statement that "employee was working on personal Mechanic's Rig. Employee's rig had broken down with a broken spindle/hub/wheel bearing (?). Employee had jacked truck up and placed jacked stands. Employee bent down to remove hub cap and when straightened up, employee experience severe pain in lower back traveling to right knee[.]" RX1. The report reflects Mr. Hurley's belief that the injury is not work related.

Mr. Hurley was familiar with the rig rental rate, which he stated was pursuant to the collective bargaining agreement. The mechanic furnishes the rig, tools, supplies and such. Mr. Hurley testified that the rental rate is $17 an hour. If the rig is not operational, then the mechanic is not entitled to that hourly rate.

Mr. Hurley acknowledged that Mr. Schmitz was their master mechanic and he would supervise Petitioner on the job site. He agreed that Mr. Schmitz would have authority to give orders, so long as they were not illegal, unethical, etc.

On cross-examination, Mr. Hurley agreed with the statement contained in his report that, when he filled it out, he did not believe Petitioner's injury was work related. However, Mr. Hurley acknowledged that he does not make that determination and he had little training in Illinois workers' compensation and no law school experience.

On cross-examination, Mr. Hurley acknowledged that pictures were taken of the lug nuts, but they did not include those photos with the report. He did not have an explanation why they were not included and explained that he sent the photos to corporate headquarters. Mr. Hurley acknowledged that the report was consequently incomplete as it did not contain the photos. He did not see anything else missing from the report.

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F. Additional Information

The parties stipulated that Petitioner was off work from October 11, 2016 through April 11, 2017. Petitioner testified that he did not work at all during that period and or draw any union benefits. Petitioner also viewed medical bills totaling $54,197.39. He testified that the bills remained unpaid and were related to treatment for his low back injury.

Regarding his current condition of ill-being, Petitioner testified that he must be very, very careful performing his daily work activities including how he picks things up and how he turns and twists, which is difficult in his field. When he lifts too much, he experiences pain that evening and the next day. Petitioner explained that he has low back discomfort every day. His lumbar spine condition affects his ability to get a good night's sleep. Weather also affects his condition, either increasing or decreasing his pain. Petitioner testified that he takes 7-8 Ibuprofen daily and two aspirins for his low back pain.

Petitioner testified that he was currently working for about the same wages, which varied from county to county, but were basically the same.

II. ANALYSIS

A. Accident

The Commission agrees with the Arbitrator that Petitioner established that he sustained a compensable injury that occurred in the course of and arose out of his employment with Respondent on October 10, 2016.

"An employee's injury is compensable under the Act only if it arises out of and in the course of the employment." *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910, 851 N.E.2d 72, 77 (1st Dist. 2006). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 803 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (citing *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (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*, 365 Ill. App. 3d at 910.

To determine whether a claimant's injury arose out of his employment, we must first determine the type of risk to which he was exposed. *Baldwin v. Ill. Workers' Comp. Comm'n*, 409 Ill. App. 3d 472, 478, 949 N.E.2d 1151, 1156 (4th Dist. 2011). There are three categories of risk

to which an employee may be exposed: (1) risks that are distinctly associated with one's employment; (2) neutral risks that have no particular employment or personal characteristics, such as those that the general public is commonly exposed; and (3) risks that are personal to the employee. *Springfield Urban League v. Ill. Workers' Comp. Comm'n*, 2013 IL App 120219WC, ¶ 27.

"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.'" *Mytnik v. Ill. Workers' Comp. Comm'n*, 2016 IL App 152116WC, ¶ 39 (citing *Caterpillar v. Industrial Comm'n*, 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667 (1989)). An incidental risk belongs to or is connected with the employment; that is, what an employee has to do in fulfilling his duties. *Id.* It is not necessary to perform a neutral risk analysis when the employee is injured due to a risk distinctly associated with the employment. *Young v. Ill. Workers' Comp. Comm'n*, 2014 IL App 130392WC, ¶ 23.

Petitioner was repairing his truck at the time of the accident, which is a large commercial vehicle specifically fitted with expensive, heavy machinery and tools. Both Petitioner and Mr. Hurley testified that Petitioner's truck was rented by Respondent pursuant to a contract in which Petitioner received an additional $17 per hour beyond his hourly wages. Petitioner testified that he needed his particular truck and the heavy commercial tools affixed to it to perform the specific pipeline repair work that Respondent hired him to do. No evidence was submitted to the contrary. Both Petitioner and Mr. Hurley also testified that it was Respondent's responsibility to pay for gas and any parts required by Petitioner to maintain and repair the truck. In addition, they testified that Mr. Schmitz, Respondent's master mechanic, had the authority to supervise Petitioner. Respondent's investigation report further corroborates Mr. Schmitz's authority given his statement that he told Petitioner that he could repair his truck in the tent on Monday.

The accident in question occurred while Petitioner was in the tent repairing the broken wheel bearing with parts provided by Respondent as authorized by Mr. Schmitz. Then, as Petitioner was in the process of removing lug nuts from the wheel, he stood up holding a 10-pound, industrial grade impact wrench along with other tools and felt a sharp, stabbing pain in his right side from his hip and low back down to his toes.

Respondent asserts that Petitioner is not credible regarding the mechanism of injury because his incident report and the medical records do not reflect that he was holding tools when he stood up. The Commission does not find this argument to be persuasive. While the exact moment when Petitioner stood up was not witnessed, both Petitioner and his surroundings immediately after the incident were observed by Mr. Filz and Mr. Schmitz. They documented how and where they came to find Petitioner immediately after the injury, which he reported to have occurred in the process of repairing his truck. The medical records generally corroborate Petitioner's testimony that he was in the process of repairing the wheel bearing when he felt pain. That Petitioner did not specify that he was holding tools while engaged in repairing a broken wheel bearing on a commercial truck does not undercut his credibility given the record as a whole.

The Commission takes note of the significance attributed by the Arbitrator to the

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finds that Petitioner is entitled to temporary total disability benefits for the claimed period from October 11, 2016 through April 11, 2017. The medical records reflect that Petitioner was placed off work during this period of time. Respondent denied benefits and medical treatment that prevented Petitioner from undergoing the full course of recommended treatment. Notwithstanding, Petitioner testified that he did not work during this period and he returned to work prior to his physician's recommendations with an eventual release to return to full duty work. Thus, Petitioner met his burden of proving entitlement to the temporary total disability benefits as claimed. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to total temporary disability.

D. Medical Expenses

The parties stipulated that Petitioner's medical treatment had been reasonable and necessary. However, Respondent disputed liability for payment of bills for such medical treatment. The Commission, with the above findings related to accident and causal connection, further finds that Respondent is liable for the submitted medical bills, which are supported by the records and the opinions of Dr. Petkovich. Thus, the Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to the award of medical expenses.

E. Permanent Partial Disability

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;

(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

With regard to subsection (i), the record contains an impairment rating of 8% of the whole person rendered by Dr. Petkovich, Respondent's Section 12 examiner. Thus, the Commission gives greater weight to this factor.

With regard to subsection (ii), the record reflects that Petitioner was employed as a heavy equipment mechanic. Petitioner has ongoing complaints related to the performance of his physically demanding heavy labor work, which requires the use of a variety of heavy-duty tools and equipment. Thus, the Commission gives greater weight to this factor.

With regard to subsection (iii), the parties stipulated that Petitioner was 57 years old at the time of the accident with some additional years of work remaining. Thus, the Commission gives some weight to this factor.

With regarding to subsection (iv), the record reflects no evidence of diminution in earnings. Petitioner testified that he continues to earn the same wages, or more, than he did at the time of the accident. Thus, the Commission gives some weight to this factor.

With regard to subsection (v), the record reflects that Petitioner sustained a traumatically induced disk herniation at L2-3 resulting in radicular symptoms and severe pain. His condition immediately after the accident required emergency treatment and surgery within days. Dr. Payne recommended post-operative care including physical therapy that Petitioner was unable to obtain. Dr. Petkovich examined Petitioner at Respondent's request and opined that Petitioner's condition was causally related to the accident at work. He also found that objective medical evidence supported Petitioner's subjective complaints at the time of his examination. Petitioner testified regarding his ongoing subjective complaints, which are supported by the medical records and findings of Dr. Petkovich and include ongoing low back pain, right leg pain, and difficulties performing all of his duties at work. Thus, the Commission gives greater weight to this factor.

In consideration of all of the enumerated factors, the Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to permanent partial disability.

The Commission affirms all else.

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IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,428.74 per week for a period of 26 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 $775.18 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 15% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $54,197.39 for medical expenses under §8(a) of the Act. Respondent shall be given credit for benefits paid and Respondent shall hold Petitioner harmless from any claims by providers of services for which Respondent is receiving credit, under 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.

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 2019

BNF/jsf
7/11/19
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Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MUELLER, RICHARD
Employee/Petitioner

Case# **16WC032465**

PRECISION PIPELINE LLC/,ASTEC INC
Employer/Respondent

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On 11/14/2018, 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 2.46% 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:

0135 COOK BARTHOLOMEW SHEVLIN ETAL
BRUCE R COOK
12 W LINCOLN ST
BELLEVILLE, IL 62220-2085

2542 BRYCE DOWNEY & LENKOV LLC
JESSE LANSHE
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

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

Richard Mueller
Employee/Petitioner

v.

Precision Pipeline LLC/Mastec, Inc.
Employer/Respondent

Case # **16** WC **32465**

Consolidated cases: **N/A**

19IWCC0454

An *Application for Adjustment 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 **Springfield**, on **5/25/18**. 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. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

On **10/10/16**, 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 $**112,320.00**; the average weekly wage was $**2,160.00**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**54,197.39**, as set forth in Petitioner's exhibit 7, 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 $**1,428.74**/week for **26** weeks, commencing **10/11/16** through **4/11/17**, 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 $**775.18**/week for a further period of **75** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **15% loss of use of the person as a whole**.

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

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

Michael K. Nowak, Arbitrator

9/26/18
Date

NOV 14 2018

FINDINGS OF FACT

Petitioner, Richard Mueller, is a heavy equipment mechanic. He is a member of the Operating Engineer's Local 520 in Granite City, Illinois.

As a heavy equipment mechanic, Petitioner performs his work from a large mechanic's truck, which he owns. In a typical day, he travels around construction sites in his mechanic's truck, makes repairs and performs routine maintenance on heavy equipment. Petitioner's mechanic's truck is an International 4700. It has a crane, a compressor, a welder, a lube machine and approximately $190,000.00 in tools. (Tr. 15, Pet. Ex. 11).

On October 10, 2016, Petitioner was employed by the Respondent, Precision Pipeline on a large-scale pipeline project. The pipeline went through several states and involved a large workforce, working seven days a week. Petitioner testified this was a once-in-a-lifetime job. (Tr. 22-23).

During the course of his employment with the Respondent, Petitioner rented his mechanic's truck to the Respondent for use on this project. The rental contract (Resp. Ex.4) provided that he received $17.00 an hour for the use of the mechanic's truck. The contract obligated Respondent to provide "routine maintenance", fuel, oil and parts. (Tr. 95). The Petitioner is responsible for providing "safe and legal maintenance" of the vehicle. (Resp. Ex. 4, Contract of 4/21/16).

Petitioner testified that he used the mechanic's truck for every task he engaged in while working for the Respondent and that it was essential to his job. (Tr. 16-17).

On October 9, 2010, Petitioner's mechanic's truck suffered a broken wheel bearing while performing a task in the course of his employment. Petitioner reported the issue to his supervisor who instructed him to bring it to the mechanics tent. As it was late in the day, the supervisor, John Smitz, gave Petitioner a company truck to drive home to his hotel. He instructed Petitioner to take the mechanic's truck apart Monday morning and he (Mr. Smitz) would have parts to make the repairs. (Tr. 27-29).

On the morning of October 10, 2016, Petitioner attended a work meeting and then went to the mechanic's tent to make the repairs. Petitioner jacked up the mechanics truck and kneeled on all fours to remove the chrome wheel cover, caps and started to perform the repairs. To perform this task, Petitioner used a ¾ inch impact wrench weighing over 10 pounds, a screwdriver and a pair of channel lock pliers. (Tr. 32).

Petitioner stood up from his kneeling position while holding the three tools and felt a sharp stabbing pain on his right side of his body from his hip to his low back into his toes. Petitioner testified that he was unable to walk and laid on the ground. (Tr. 33-34).

Petitioner testified that the impact wrench he was holding is a 3/4-inch Ingersoll Rand which is used specifically for heavy equipment. It is bigger than what would be used on an automobile. It weighs over 10 pounds (Tr. 32-33).

Respondent's project safety lead, Jim Hurley, testified that within 24 hours of the accident, he conducted an investigation. The report was offered into evidence. (Resp. Ex.1). On cross examination, Mr. Hurley testified that his investigation included numerous photographs of the scene. (Tr. 101).

The Arbitrator notes that these photographs are not contained within Respondent's Exhibit 1, nor were they offered into evidence as a separate exhibit. Mr. Hurley testified that these photographs were sent to Respondent's corporate headquarters (Tr. 102). On cross, Mr. Hurley testified that the investigative report offered into evidence is incomplete because it did not contain the photographs he had taken (Tr. 103). Mr. Hurley testified that he did not have any explanation for why the pictures were not included with the report. (Tr. 102). The Arbitrator finds that Respondent's failure to produce evidence within its exclusive control which bears on the central issue in this case, whether under the facts the incident resulting in injury constitutes an "accident" under the Act, gives rise to a presumption that the withheld evidence would have been favorable to Petitioner. *See, e.g. Chidishimo v. Ind. Comm'n*, 278 Ill. App. 3d 369 (1996). In particular the photographs could well have shown the removed lug nuts and the tools Petitioner was holding as he attempted to stand from working on his hands and knees.

After reporting the accident, Petitioner was taken to the emergency room at Passavant Area Hospital in Jacksonville. (Pet. Ex. 4).

Petitioner was examined by Dr. Gurprect Singh. He provided a history of the accident and had diagnostic tests including a MRI. The MRI revealed a lumbar disc herniation on the right at the L2-L3 level with inferior migration and compression of the L3 nerve root. (Pet. Ex. 2, P.2).

Petitioner was transferred via ambulance to Springfield Memorial where he was admitted. Petitioner was examined and treated by Dr. William Payne. He offered a consistent history of the accident which Dr. Payne memorializes in his initial intake. (Pet. Ex. 5). After examining Petitioner, and reviewing the MRI, Dr. Payne diagnosed "intractable pain due to a disc herniation" and scheduled surgery for the next day.

On October 12, 2016, two days after the accident at work, Dr. Payne performed a right side microdiscectomy at L2-L3. (Pet. Ex. 1). Petitioner was released from the hospital on October 13, 2016. Petitioner followed-up with Dr. Payne two times after the operation. Dr. Payne prescribed physical therapy, however, it was denied by both the Worker's Compensation carrier and Petitioner's group insurance. (Tr. 43). Unable to get approval for the prescribed therapy, Petitioner performed home exercises.

Petitioner returned to work in April, 2017.

The parties agree that the Petitioner was disabled from employment from October 11, 2016, through April 11, 2017 and that all of Petitioner's medical care during this time was reasonable and necessary. (Tr. 4).

On December 20, 2017, Petitioner was seen by Respondent's section 12 examiner, Dr. Frank Petkovich, a board-certified orthopedic surgeon. (Pet. Ex. 2).

In his report, Dr. Petkovich concludes that he believes "the above lumbar disc herniation at the L2-L3 level did occur at the time of the incident Mr. Mueller described as occurring while at work on October 10, 2016."

Respondent retained, Dr. Benjamin Crane to perform a records review. Dr. Crane concludes in his report of April 19, 2017, "It is my opinion within a reasonable degree of medical certainty that the actions and activities of 10/10/16 are the prevailing factor in causing his back and leg symptoms..." (Pet. Ex. 3).

Petitioner testified that while he has returned to work, he still endures significant painful symptoms in his low back and right leg.

CONCLUSIONS

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

The Respondent contends that the Petitioner did not suffer an accident arising out of and in the course of his employment. This position is contrary to the uncontradicted evidence presented at trial.

On October 10, 2016, Petitioner was performing maintenance on a large mechanics truck which, per a contract, was rented by the Respondent (Resp. Ex.4). This contract required him to perform this maintenance on the vehicle. Further, the work was ordered by his supervisor. Clearly the work was performed in the course of his employment.

In analyzing the arising out of prong of the inquiry Respondent seems to suggest that it would be proper to apply the neutral risk analysis. Even assuming arguendo that the neutral risk analysis is appropriate, Petitioner in this case was clearly exposed to a risk much greater than that faced by the general public at large. At the time of his injury Petitioner was making repairs on an extremely heavy-duty work truck. Performing this repair required Petitioner to get on all fours while working with tools. When Petitioner stood up, he was holding a screwdriver, a channel lock pliers and a large ¾ inch impact wrench. The impact wrench alone weighs over ten pounds. It is a large wrench, bigger than the type used on a normal sized vehicle. It is safe to assume that the vast majority on the general public at large has never seen a ¾ inch impact wrench much less held one.

This testimony regarding the size of the tools and equipment involved was not contradicted by Respondent's safety lead, who was present for Petitioner's testimony. As indicated above the Arbitrator found it significant that photos of the scene of the accident taken by the safety director as part of his investigation, although forwarded the carrier along with his report, were not included with the report in Respondents exhibit. As indicated above the Arbitrator presumes that these photos showed the tools, including the oversized impact wrench as well as the size of the disabled vehicle.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner met his burden of establishing he sustained an accident arising out of and in the course of his employment on October 10, 2016

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

Inexplicably, Respondent also disputes causal connection. Both Respondent's section 12 examiner and records reviewer concluded Petitioner's condition of ill-being was causally related to the accident.

Dr. Petkovich opined that "the above lumbar disc herniation at the L2-L3 level did occur at the time of the incident Mr. Mueller described as occurring while at work on October 10, 2016." (Pet. Ex. 2). Dr. Crane concluded "[i]t is my opinion within a reasonable degree of medical certainty that the actions and activities of 10/10/16 are the prevailing factor in causing his back and leg symptoms...." (Pet. Ex. 3).

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The Arbitrator finds Petitioner met his burden of establishing that his condition of ill-being is causally related to the accident of October 10, 2016

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

The parties stipulated at trial that Petitioner works sixty hours a week, forty hours of straight time and twenty hours of overtime. (Tr. 94-95). As a union operator, Petitioner earns $36.00 an hour straight time and $54.00 an hour for overtime. However, only the straight time rate is to be used in calculating average weekly wage. Thus, the Petitioner's average weekly wage is $2,160.00 ($36.00 / hour x 60 hours / week).

The Arbitrator notes that in addition to this amount, per the union collective bargaining agreement, Petitioner earns $17.00 an hour for the rental of his mechanics truck (Tr. 90) (Pet. Ex.9). Petitioner claims that this amount should be included in the average weekly wage. The Arbitrator is unaware of any precedent for including such an amount in the calculation of average weekly wage.

Based upon the foregoing the Arbitrator finds Petitioner's average weekly wage is $2,160.00.

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

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

The parties stipulated that the reasonableness and necessity of the treatment was not in dispute. The parties further stipulated that Petitioner was temporarily and totally disabled from 10/11/16 to 4/11/17 (26 weeks). Respondent's denial of benefits was based on their dispute on the issues of accident and causation. As these issues are resolved in Petitioner's favor, Respondent is responsible for $54,197.39 in medical expenses as set forth in Pet. Ex.7. Respondent is further liable for twenty six weeks of TTD benefits.

Respondent shall pay reasonable and necessary medical services of $54,197.39, as set forth in Petitioner's exhibit 7, 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 further pay Petitioner temporary total disability benefits of $1,428.74/week for 26 weeks, commencing 10/11/16 through 4/11/17, as provided in Section 8(b) of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Petkovich assessed Petitioner's impairment rating at 8% of the whole person. However, impairment does not equal disability. The impairment

rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator therefore gives *little* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner continues to work as a heavy equipment mechanic. Petitioner's work is physical in nature. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 57 years old at the time of his injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. Furthermore, Petitioner has physical employment as a heavy equipment mechanic. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. As a result of his work accident, Petitioner endured a spinal surgery that left him with a painful condition in his low back and right leg. Petitioner shared these ongoing issues with Respondent's examiner and expanded upon his ongoing symptoms at trial.

Petitioner testified that his lumbar spine is sensitive to the touch. His ongoing pain has resulted in having to do his job differently and his work duties aggravate his symptoms. Specifically, he testified that lifting and using tools, two essential elements of his job, intensify his lumbar pain. He testified that the weather affects his condition and he has difficulty sleeping. He still takes pain medication numerous times a day to deal with the daily pain.

Perhaps the physical therapy prescribed by Dr. Payne and denied by the carrier would have given the Petitioner a better recovery. But as it stands, Petitioner lives with pain every day.

Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints, 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 15% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

Respondent shall pay Petitioner the sum of $775.18/week for a further period of 75 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 15% loss of use of the person as a whole.

Issue (M) **Should penalties or fees be imposed upon Respondent?**

Given the current status of Illinois law with respect to the issue of accident, and more specifically the neutral risk analysis, Respondents defense of lack of accident arising out of the employment was, at least, arguable. Penalties are therefore 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHENEQUA CARTER,

Petitioner,

vs. NO: 14 WC 19076

CHICAGO TRANSIT AUTHORITY,

Respondent.

19IWCC0455

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability (nature and 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.

I. FINDINGS OF FACT

The facts of this case are detailed in two prior arbitration decisions, including the decision giving rise to the instant review. Petitioner was injured at work on May 30, 2014 in an undisputed accident involving her neck and right shoulder. She then underwent treatment with Dr. Sharma and Dr. Giannoulias including an arthroscopic subacromial decompression and extensive glenohumeral debridement to address a partial thickness rotator cuff tear, extensive glenohumeral synovitis, and subacromial impingement. Petitioner was also examined by Dr. Carroll at Respondent's request who agreed that her condition of ill-being was casually related to her accident. After undergoing necessary medical treatment and a functional capacity evaluation on January 9, 2017, Petitioner was released by Dr. Giannoulias to return to work with permanent restrictions that prevented her from returning to her prior bus operator position with Respondent.

Petitioner then began vocational rehabilitation with Mr. Blumenthal. Through vocational

services Petitioner obtained a full-time position working as a security officer for another employer, U.S. Security Associates, earning $12.00 per hour. Petitioner submitted payroll records into evidence which reflect her earnings from January 12, 2018 through August 23, 2018. PX2. The records reflect a total of 1071 hours over 32 weeks that results in an average of 33.47 hours per week. Petitioner's gross regular pay was $12,852. The foregoing results in an average weekly wage of $401.63 for Petitioner's work with U.S. Security. In addition, the record contains the relevant portion of the CBA reflecting that a full-time bus operator would have been earning $35.01 per hour effective July 1, 2018. PX6.

An investigation was conducted by the Office of Executive Inspector General (OEIG). RX3. The OEIG received a complaint that Petitioner has submitted a falsified documents in 2012 and 2013 in order to receive leave pursuant to the Family and Medical Leave Act (FMLA). *Id.* In a decision dated October 1, 2014, the OEIG concluded that Petitioner had submitted falsified FMLA forms and that she failed to cooperate with the OEIG. *Id.* After receipt of this information, Respondent conducted its own investigation to determine whether Petitioner was in violation of CTA's rules or policies. *Id.* Respondent determined that Petitioner was in violation and terminated her employment effective February 12, 2015 as reflected in its report dated February 20, 2015. *Id.*

II. ANALYSIS

The parties' dispute centers on the method of calculating Petitioner's wage differential award. In calculating the award, the Arbitrator found that Petitioner would be able to fully perform her usual and customary employment earning $35.01 per the CBA as of July 1, 2018. The Arbitrator also calculated the award based on Petitioner working 40 hours per week for her new employer, which is not borne out by the payroll records submitted into evidence. The Commission finds that Petitioner's wage differential award must be based on what she would have been able to earn at the time of her accident and her actual earnings for her new employer as reflected in the record.

"To qualify for a wage differential under section 8(d)(1) of the Act, a claimant must prove (1) partial incapacity which prevents him from pursuing his 'usual and customary line of employment' and (2) an impairment of earnings." *Gallianetti v. Illinois Industrial Comm'n*, 315 Ill. App. 3d 721, 730, 734 N.E.2d 482, 489 (3rd Dist. 2000). Petitioner was injured in an undisputed accident on May 30, 2014 and eventually released back to work with permanent restrictions that prevented her from continuing her work as a bus operator. Thus, Petitioner has been partially incapacitated from pursuing her usual and customary line of employment as a result of her accident.

Petitioner has also sustained an impairment of earnings. After her release to work with permanent restrictions in 2017, Petitioner found work as a security officer for another employer earning less than she had while working for Respondent. Petitioner was paid $12.00 per hour and worked an average 33.47 hours per week resulting in an average weekly wage of $401.64.

Section 8(d)(1) of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in calculating the wage differential award. The Section states, in pertinent part:

> If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, *equal to 66-⅔% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident.* For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later.

820 ILCS 305/8(d)(1) *et seq.* (LEXIS 2011) (emphasis added).

Between the date of Petitioner's accident and issuance of the first arbitration hearing decision, Petitioner was terminated from Respondent's employment. The record contains an independent OEIG investigation following a 2013 complaint, pre-dating Petitioner's accident, that she falsified FMLA paperwork. Respondent then conducted its own investigation and concluded that Petitioner had also violated CTA policies. On that basis, Petitioner was terminated, for cause, effective February 12, 2015.

The Commission declines to base Petitioner's wage differential award on the 2018 CBA rate of $35.01 per hour as asserted by Petitioner. The evidence establishes that she would not be able to earn that amount. The Commission further declines to base Petitioner's wage differential award on an anticipated 40 hours of work per week with U.S. Security Associates as asserted by Respondent. The payroll records submitted into evidence reflect that Petitioner is only earning $12.00 per hour for an average of 33.47 hours per week.

Based on the totality of the record, the Commission finds that Petitioner has established her entitlement to a Section 8(d)(1) wage differential benefit based on 66-⅔% of the difference between what Petitioner would be able to earn in the full performance of her duties as a full-time bus operator at the time of her injury ($918.83) and the average amount she is earning per week in her position with U.S. Security Associates ($401.63). Thus, the Commission, herein, modifies the arbitration decision to reflect a wage differential of $344.80 per week.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay permanent partial disability to Petitioner the sum of $344.80 per week commencing September 11, 2018, until Petitioner reaches 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

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the sum of $2,367.78 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.

The party commencing 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 2019

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

BNF/jsf
8/15/19
045

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARTER, SHENEQUA Case# **14WC019076**

Employee/Petitioner

CHICAGO TRANSIT AUTHORITY

Employer/Respondent

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On 12/27/2018, 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 2.48% 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:

2356 FOHRMAN, DONALD W & ASSOC
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

S. Carter v. CTA, 14 WC 019076

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

Shenequa Carter
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 14 WC 019076

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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **9/11/18**. 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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

On **5/30/14**, 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 **$47,779.16**; the average weekly wage was **$918.83**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$121,626.94** for TTD, **$19,124.59** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$140,751.53**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,742.78 to Metro Anesthesia Consultants, $191.75 to Illinois Orthopedic Network, and $433.25 to South Suburban Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 9/11/2018, of $613.60/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

December 26, 2018
Date

DEC 27 2018

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PROCEDURAL BACKGROUND

This matter was previously tried on December 1, 2014, pursuant to Section 19(b) of the Illinois Workers' Compensation Act. The issues decided were accident, causal connection, temporary total disability and medical bills. A decision was rendered on July 22, 2015 in which it was found that Petitioner did sustain an accident that arose out of the course of employment, that her medical condition at the time of trial was causally related to the claimed work injury, she was entitled to temporary total disability from May 31, 2014 through December 1, 2014 and that medical bills in the amount of $36,980.41 were compensable, as provided by Section 8(a) and 8.2 of the Act. (PX 7) The Arbitrator's Decision was not reviewed by either Party.

The current issues in dispute are medical expenses and the nature and extent of Petitioner's injuries.

FINDINGS OF FACT

Direct Testimony of Petitioner

Petitioner worked as a full-time bus operator for Respondent at the time of her injury. Following the December 1, 2014 hearing, Petitioner continued to treat with Dr. Sharma from Illinois Orthopedic Network. At her visit on December 23, 2014, Petitioner informed Dr. Sharma that the intra-articular shoulder injection performed on November 18, 2014 provided only two days of symptom relief. Dr. Sharma examined Petitioner and reviewed the MRI and recommend that she be seen by an orthopedic specialist. Dr. Sharma also provided a work limitation of 10 lbs. use of the right upper extremity until the patient was evaluated by the orthopedic surgeon. (PX 5)

On January 21, 2015, Petitioner was examined by Christos Giannoulias, M.D. concerning her right shoulder. He reviewed the MRI and performed a clinical examination. It was Dr. Giannoulias' impression that Petitioner had AC joint arthrosis and subacromial impingement. Petitioner's options were discussed and Petitioner opted to undergo surgical intervention. (PX 5)

After the favorable Decision from the Commission was received, Petitioner returned to Dr. Giannoulias on July 29, 2015. Dr. Giannoulias charted that his office would work on obtaining surgical authorization. (PX 5)

Respondent had Petitioner seen by Dr. Charles Carroll, M.D., for a Section 12 examination, on November 2, 2015. Dr. Carroll opined that Petitioner failed conservative treatment for her shoulder impingement and advised her to consider arthroscopy of the left shoulder and subacromial decompression. (PX 5)

On April 6, 2016, Petitioner underwent a right shoulder arthroscopic subacromial decompression and an extensive glenohumeral debridement. The surgery was performed by Dr. Giannoulias. (PX 5)

Petitioner subsequently underwent rehabilitative care for her shoulder with South Suburban Physical Therapy (PX 4) and followed-up with Dr. Giannoulias on a monthly basis through December 13, 2016. On that date, Petitioner continued to report pain of the right shoulder. Dr. Giannoulias examined Petitioner and felt that she had reached maximum medical improvement and prescribed a Functional Capacity Evaluation. (PX 5)

The FCE was performed by ATI on January 9, 2017. The evaluator determined that Petitioner's evaluation was valid and that it demonstrated that she was capable of working at a physical demand level of light to medium, which fell below the occupational demand level of a bus driver established by the DOT. (PX 5)

Petitioner returned to Dr. Giannoulias on January 18, 2017. Dr. Giannoulias reviewed the functional capacity evaluation and stated he did not feel she could return to commercial bus driving, secondary to shoulder and persistent neck symptoms. He further recommended that she avoid lifting, pushing or pulling anything greater than 20 lbs. Petitioner was released from care. (PX 5)

Respondent provided vocational rehabilitation assessment of Petitioner through Blumenthal Associates. Petitioner first met with Steven Blumenthal, MS, CRC, CVE, LCPC, on March 23, 2017. Mr. Blumenthal obtained Petitioner's background and had her undergo various vocational testing. It was his conclusion that she could earn approximately $10.20 -$12.00 per hour. On June 27, 2017, Blumenthal Associates began job placement services for Petitioner. Petitioner first underwent computer training through August 16, 2017. She then participated in job readiness training and job placement with Blumenthal Associates, wherein they assisted here in writing a resume and identifying various employers with which she could apply for work. (PX 3) Through an extensive job search, Petitioner found a position with US Security Associates as a security guard. Her primary duty consists of monitoring employees that enter a warehouse building. Petitioner stated that her job is a full-time position and that she is paid $12.00 per hour. Petitioner further testified that her supervisor at US Security Associates does not always schedule her a 40-hour week. Petitioner introduced sixteen payroll check stubs covering the bi-weekly periods between January 12, 2018 through August 23, 2018. The check stubs reflect that Petitioner worked an average of 66.98 hours biweekly or 33.49 hours per week. (PX 2)

Petitioner testified that she aware that the if she were still employed with respondent as a full-time bus driver, she would be earning $35.01 per hour. Respondent's counsel stipulated that $35.01 is the current wage rate for full time bus operators. (PX 6)

Petitioner stated that she still currently has issues with repetitive motion and that weather and climate changes bother her. She related that she experiences periodic swelling and shooting pain down her arm.

Cross-Examination of Petitioner

Petitioner acknowledged that she was employed with Anchor Staffing from April 17, 2015 through July 2, 2015. Petitioner was asked if she informed Mr. Blumenthal of that information during her initial vocational meeting. Petitioner provided an unclear response to Respondent's counsel, but it was clarified on re-direct that she did tell Mr. Blumenthal of the job, but he did not include it in her work history because she did not work there very long.

Petitioner identified several photo postings taken from her Facebook account between July and August of 2015. (RX 4) Petitioner stated that the photos that she posted were old photos that pre-dated her employment with Respondent.

Petitioner confirmed that she was terminated by Respondent in February of 2015. She was terminated pursuant to a finding of the Inspector General's Office involving falsified FMLA forms. Respondent introduced the Final Report of the Office of Executive Inspector General (OEIG) wherein it found that Petitioner falsified FMLA forms in November of 2012 and February of 2013, concerning her son's chronic asthma condition. (RX 3)

Re-Direct Examination of Petitioner

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Petitioner stated that she worked for Anchor Staffing during the period between the date of her 19(b) hearing and the date the decision was received. During that interim, she did not receive workers' compensation benefits from Respondent.

Petitioner restated that the pictures on her Facebook account were not made contemporaneously with the postings on her Facebook account. The photos used were from a period of time when Petitioner worked as a school bus driver between 2003 and 2008. The Arbitrator believes Petitioner's testimony on this issue.

Petitioner's termination in 2015 concerned conduct that happened in 2012 and 2013. Petitioner first heard of the allegation when she was called into the offices of the OEIG in 2014. The OEIG believed the allegation of falsifying FMLA forms was founded. The OEIG also found that Petitioner knowingly lied to OEIG investigators. Respondent conducted its own investigation based upon the OEIG's findings and recommendations. Petitioner's employment was terminated due to several rule violations. (RX 3)

The Parties agreed that all TTD, Maintenance and TPD benefits have been paid through the date of trial.

CONCLUSIONS OF LAW

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

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

In support of the Arbitrator's Decision relating to *(J) has respondent paid all appropriate charges for all reasonable and necessary medical care?* The Arbitrator finds:

Petitioner introduced into evidence three medical bills that have outstanding medical balances. The first medical bill is from Metro Anesthesia Consultants. That bill is associated with services related to a right intraarticular shoulder joint injection performed by Dr. Sharma on November 18, 2018. (PX 1, PX 5) The Arbitrator has reviewed the bill in the amount of $1,742.78 and the corresponding medical record and finds that the charges of Metro Anesthesia Consultants reasonable and necessary to treat Petitioner's shoulder injury. The Arbitrator awards Petitioner the sum of $1,742.78, subject Section 8.2 of the Act.

The second bill is a balance of $191.75 owed to Illinois Orthopedic Network. (PX 1) The Arbitrator has reviewed the entire medical bill of Illinois Orthopedic Network and the corresponding medical records and notes that the majority of the charges have been paid or adjusted leaving the said $191.75 balance. The Arbitrator finds the medical bill of Illinois Orthopedic Network corresponds to charges for reasonable and necessary medical care and awards Petitioner the sum of $191.75, subject to Section 8.2 of the Act.

The final bill is a balance of $433.25 from South Suburban Physical Therapy. (PX 1) The Arbitrator has reviewed the corresponding medical records (PX 4) and find that the charges of South Suburban Physical Therapy to be reasonable and necessary to treat p\Petitioner's shoulder injury. The Arbitrator awards Petitioner the sum of $433.25, subject to Section 8.2 of the Act.

Respondent is entitled to a credit for any awarded bill that it has satisfied.

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In support of the Arbitrator's Decision relating to *(L) what is the nature and extent of the injury?* the Arbitrator finds:

The uncontroverted FCE findings and the final assessment of Dr. Giannoulias support that Petitioner is physically unable to perform the job duties of a commercial bus driver. The Commission and courts have mandated that permanent partial disability benefits be awarded under section 8(d)1 of the Act when the claimant has elected and proved entitlement to such an award. See: Gallianetti v. Industrial Commission, 315 Ill. App. 3d. 721, 734 N.E.2d 482 (2000) In this case, Petitioner stated that she was making a claim under Section 8(d)1 of the Act which states that:

> "If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall, except in cases compensated under the specific schedule set forth in paragraph (e) of this Section, receive compensation for the duration of his disability, subject to the limitations as to maximum amounts fixed in paragraph (b) of this Section, equal to 66-2/3% of the difference between the average amount which he would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident and the average amount which he is earning or is able to earn in some suitable employment or business after the accident. For accidental injuries that occur on or after September 1, 2011, an award for wage differential under this subsection shall be effective only until the employee reaches the age of 67 or 5 years from the date the award becomes final, whichever is later."

After Petitioner was determined to be at maximum medical improvement on January 18, 2017, Respondent initiated vocational rehabilitation with its chosen vocational counselor. Based on the reports of Blumenthal Associates, it appears that Petitioner worked diligently and cooperated fully in the job search process. Consistent with Steven Blumenthal's initial assessment, Petitioner found a full time job for herself, with US Security Associates, paying $12.00 per hour as of January 13, 2018.

The Parties agreed that if Petitioner was physically able to fully perform the job duties of her occupation as a bus driver for Respondent, she would currently earn the contractual rate of $35.01 per hour or $1,400.40 per week based on a 40-hour work week. The Arbitrator finds that Petitioner is able to earn $480.00 per week ($12.00 per hour for 40 hours) in her security job, which is suitable employment for her based upon the results of her injury. This finding is based upon PX 2 and Petitioner's testimony. The Arbitrator is not persuaded that PX 2 supports a finding that Petitioner's employment as a security guard contemplates a less than 40 hour work week.

Accordingly, the Arbitrator awards Petitioner wage differential benefits of $613.60 per week [($1,400.40 - $480.00 x 66⅔%), pursuant to §8(d)1 of Act, beginning September 11, 2018 and ending when she reaches the age of 67 years.

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

KEVIN WIELAND,

Petitioner,

vs. NO: 13 WC 32511

STS STAFFING,

Respondent.

19IWCC0456

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary disability, medical, and prospective treatment, 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 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 Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED: AUG 26 2019

L. Elizabeth Coppoletti

LEC/mck

O: 8/20/19

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIELAND, KEVIN
Employee/Petitioner

Case# **13WC032511**

STS STAFFING
Employer/Respondent

19IWCC0456

On 8/30/2018, 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 2.21% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

0000 RUSIN & MACIOROWSKI LTD
THOMAS P CROWLEY
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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

Kevin Wieland
Employee/Petitioner

v.

STS Staffing
Employer/Respondent

Case # **13** WC **32511**

Consolidated cases: **N/A**

19IWCC0456

An *Application for Adjustment 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 **12/19/17**. 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 **Prospective medical**

19IWCC0456

FINDINGS

On **6/7/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**30,959.24**; the average weekly wage was $**595.37**.

On the date of accident, Petitioner was **33** 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 $**any** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to establish he sustained an accidental injury which arose out of his employment with Respondent, benefits are denied. All other issues are moot.

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

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

Michael K. Nowak, Arbitrator

8/17/18
Date

AUG 30 2018

FINDINGS OF FACT

Petitioner testified that he was employed by STS Staffing on two separate occasions. The first period of employment was in 2009. The second period of employment began in January of 2013.

Petitioner claims he sustained accidental injuries on June 7, 2013. The Arbitrator notes that the issues of accident and notice were not initially disputed. The Petitioner testified that on June 7, 2013 he was employed by the Respondent. The following testimony then was given:

Q. Okay. And do you recall a day of June 7th, 2013?

A. Yes, sir.

Q. What were your job duties that day?

A. I believe at that time I was not doing my typical job duties, I was actually part of a special program with plant managers, engineers, welders and other manufacturers and assemblers such as myself.

Q. Okay. And what happened?

A. We were in the process of discussing and implementing new and improved ergonomics for the employees, make everything easier for employees during production, also improve production for the company. We were sitting down in a meeting office down in the office area. I believe the first that day when it happened we had been down there sitting around a large table for about an hour discussing many options pertaining to our objective. At the end of the meeting I proceeded to get up out of my chair when I felt a very sharp pain, like a stabbing, hot knife, in the back, lower back pain.

Q. When you were sitting at this meeting were you lifting anything?

A. No, sir.

Q. Okay. What happened after that?

A. It took me I would say roughly about 15 to 20 minutes before I could actually walk on my own without having to grab onto a wall or bookshelf as we were leaving the meeting.

Q. Were you lifting bearings that day?

A. No, sir.

Q. Okay. And this was June 7th, '13?

A. Yes, sir.

19IWCC0456

Q. Okay. What happened next?

A. I proceeded to go on along with the rest of the day with the rest of the members of our group. Um, I mean we just finished up that day with what we were supposed to do. Like I said I was not doing manual labor at that time. The next day we had the exact same situation happen where we had a meeting, we were having discussions, and the exact same pain, action that I felt happened again the next day.

MR. YOUNG: Could I take a break for a second,Judge –(T. 12-14)

After a recess Respondent moved to amend the Request for Hearing to reflect that accident and notice were in dispute in light of Petitioner's testimony and the motion was granted.

When Petitioner's testimony resumed the following exchange occurred:

Q. Let's go back to June 7th, 2013, and your prior testimony about a meeting that you had; do you recall that?

A. Yes, sir.

Q. Okay. Prior to this meeting on that date, what happened?

A. I was working my -

MR. CROWLEY: Objection, asked and answered.

THE ARBITRATOR: I think it's been asked and answered.

MR. YOUNG: Before the meeting hasn't.

THE ARBITRATOR: Overruled.

BY MR. YOUNG:

Q. Go ahead.

A. During that time I was doing my normal job of assembling what we call gang packages which is the tillage equipment. I was assembling it with 60 pound bearings and other various items.

Q. Okay.

A. Bending over -- Sorry.

Q. Go ahead.

A. Bending over into a metal Caterpillar-style metal tub where they were located, lifting them up without any devices and assembling the package.

Q. Okay. And did you injure yourself while you did that?

MR. CROWLEY: Objection, calls for a conclusion -

THE WITNESS: Yes.

THE ARBITRATOR: He can tell what he observed.

BY MR. YOUNG:

Q. Go ahead.

A. Yes, I noticed some back pain, some lower I guess they call it lumbar back pain. I then went and asked my foreman if I could go see the nurse. Went to the nurse, described what was going on, she gave me a drug called Naproxen, I believe it's similar to Advil.

Q. You don't have to get specific. Go ahead.

A. She gave me Naproxen and told me to take it for a specific period of time and then check back with her and let her know whether it improved or not.

Q. Okay. And then your foreman's name?

A. Sue Mulligan.

Q. Did you tell Sue Mulligan, your supervisor at that point, that you had injured yourself at work?

A. Yes.

Q. And did you explain exactly how you just testified how you hurt yourself?

A. Yes.

Q. Okay. And then you went to a meeting; is that correct?

A. Yes.

Q. Okay. What happened then?

A. We discussed our project information, our plans. After an hour of sitting in this conference room that's when I got up and that's when I felt

additional sharp, burning pain which was worse than the initial lumbar pain.(T. 16-20)

During cross-examination, Petitioner testified that the meeting he testified to earlier on direct examination was actually a "week, a couple days after" he reported his injury to the nurse at the employer.

The Petitioner testified that he noticed some back pain, and what he described as lumbar back pain. The Petitioner testified that he went and asked his foreman if he could go see the nurse. The Petitioner went to see the nurse and he believes that she gave him a drug called Naproxen.

The Petitioner then testified that after he returned from the nurse he went to a meeting and it was during this meeting, after an hour of sitting in the conference room, when the Petitioner got up and felt additional sharp burning pain which "was worse than the initial lumbar pain".

The Petitioner followed-up with IWIRC approximately 10 days later on June 17, 2013. The records from that date suggest the Petitioner's pain has been ongoing since June 7, 2013. The records state that the Petitioner developed bilateral shoulder burning with popping, tension pain in both wrists, right upper back and right SI tension pain. He denied any radicular symptoms down his leg and no paresthesia. He also complained of intermittent soreness in his bilateral shoulder and wrists. The Petitioner's diagnosis was a lumbar muscle strain and generalized muscle soreness (Rx.3).

The Petitioner followed-up at IWIRC on June 20, 2013. The Petitioner stated that his tailbone was sore at that visit. His examination was entirely normal, and his diagnosis was a lumbar muscle strain with no objective findings and the report of the Petitioner's pain was not consistent with his objective exam. He also had resolution of his generalized muscle soreness (Rx.3).

The Petitioner followed-up at IWIRC on June 25, 2013. The Petitioner stated his low back was better although he was still experiencing tightness in his tailbone region. He also complained of pain in his wrists and anterior bilateral shoulders after being returned to regular duty. Again his exam was normal and the assessment was a lumbar muscle strain with no objective findings (Rx.3).

The Petitioner was discharged from IWIRC on July 3, 2013. At that visit the records suggest the Petitioner stated his lumbar pain had resolved. He had low grade lumbar pain that he had prior to his inciting event. The record also suggests the Petitioner is a bodybuilder as a hobby, and states he cannot perform curls due to his wrist pain. The diagnosis from that visit was lumbar muscle strain with no objective findings, resolved. His complaints of wrists and shoulder pain had also resolved. The Petitioner has returned to base line without additional symptoms, and the medical director of IWIRC, Dr. Dru Hauter gave the Petitioner 0% impairment as of July 5, 2013 (Rx.3).

It was at or about this time that the Petitioner's employment with the Respondent had ended. At the time of his employment ending with the Respondent, the Petitioner had no work restrictions, and no additional appointments scheduled with any medical provider.

The Petitioner then chose to follow-up on his own with Dr. Richard Kube. He was first seen on September 5, 2013. Dr. Kube took x-rays and diagnosed the Petitioner with spondylolisthesis at L5 - S1. Dr.

Kube also diagnosed bilateral pars defect and foraminal stenosis. Bilateral pars defect injections were recommended at the initial visit (Px.4).

On September 27, 2013 the records reflect that the Petitioner called Dr. Kube's office and did not want to go forward with injections (Px.4).

After the initial visit to Dr. Kube's office on September 5, 2013, the Petitioner was not actually seen again by Dr. Kube until August 19, 2014, eleven and one- half months later. The Petitioner testified that he had moved to Texas during this interim period and worked from time to time in various capacities, although none of his jobs were very physical. The Petitioner also testified that when he moved to Texas he moved himself with the use of his pickup truck, and this included moving his bed.

When he returned to see Dr. Kube on August 19, 2014 his examination was unchanged. He received bilateral transforaminal lumbar epidural steroid injections at L5-S1 (Px.4).

On or about August 22, 2014 the Petitioner became employed by the Target Corporation. In this job, Petitioner testified that he worked in the warehouse unloading trucks and then would restock shelves. His job required him to lift various items from 30-40 pounds on a regular basis. The Petitioner also acknowledged to his physical therapy provider on August 25, 2014 that he performed controlled activities and exercises in his local gym. He referenced an incident in March of 2014 that exacerbated his low back pain while he was doing household chores (Px.4).

The Petitioner had a second round of bilateral epidural steroid injections at L5-S1 on September 8, 2014, and a third round in a series of three injections on October 13, 2014.

On October 28, 2014 Dr. Kube took the Petitioner off work while he finished a work conditioning program after which he would have an FCE (Px.4).

The Petitioner testified that he never underwent work conditioning program recommended by Dr. Kube, and did not undergo an FCE as it was recommended by Dr. Kube.

On August 25, 2015 Petitioner was examined pursuant to Section 12 of the Act by Dr. Kevin Walsh. Dr. Walsh noted that Petitioner had a normal examination. Dr. Walsh opined the Petitioner has spondylolisthesis, which is not caused by lifting as alleged by the Petitioner. Dr. Walsh opined the Petitioner's condition and need for treatment for his spondylolisthesis were not related to his alleged workplace injury (Rx.1).

The Petitioner received no medical treatment for approximately 18 months, when he followed-up with Dr. Kube's office on April 26, 2016. At that time Dr. Kube's records suggest the Petitioner would be treated as a new patient for back pain. His lower extremity strength was very good and there was no provocative exam testing that was positive at that visit (Px.4).

The Petitioner testified that he was then employed by SpeeDee Delivery Service as a delivery van driver. He needed to drive long periods of time and make deliveries to businesses and residential addresses of various packages that could weigh up to 100 pounds. A job description was offered and admitted by the Respondent as

exhibit number six, and Petitioner testified that the job description was accurate. This required the Petitioner to have the ability to lift up to 100 pounds in order to complete his assigned tasks (Rx.6).

Dr. Kube's record reflects that the Petitioner stated any type of bump could definitely be felt in his low back and cause an increase in his pain. Dr. Kube put a work restriction on the Petitioner including taking a break every 45 minutes or so during his driving activities. The records do not reflect any other work restrictions imposed by Dr. Kube at any time (Px.4).

The Petitioner underwent another series of epidural steroid injections and facet block injections from the L4 - S1 levels. On August 31, 2016 the Petitioner underwent a motion study analysis at Dr. Kube's office, and was diagnosed with grade II anterolisthesis at L5 - S1 without instability. Dr. Kube performed a discogram on October 17, 2016 that was negative at the L3-4 and L4-5 levels. Dr. Kube did not test the L5-S1 level during the discogram procedure (Px.4)(Rx.1).

Dr. Kube then recommended a decompression and fusion at L5-S1 for radiculopathy and stenosis which he felt would help stabilize the petitioner bilaterally in his lumbar spine.

Dr. Kevin Walsh again examined the Petitioner pursuant to Section 12 on November 1, 2016. Petitioner again had a normal examination, with no objective findings to support his subjective complaints. Dr. Walsh again opined the Petitioner's condition and need for surgery were not related to any workplace accident or injury (Rx.1).

The last visit to Dr. Kube was on November 17, 2016, however the Petitioner testified that a few months before the arbitration hearing in this case he did have another visit with Dr. Kube, and has a follow-up with Dr. Kube scheduled in March of 2018, however there are no records or exhibits provided in support of this testimony.

The Petitioner testified that he currently wished to resume treatment with Dr. Kube and does wish to have the proposed surgery performed that was recommended by Dr. Kube in November of 2016.

The Petitioner is currently unemployed, and testified that he also has recently moved out from his parent's house into his own apartment, again utilizing his pickup truck.

CONCLUSIONS

The Petitioner testified early in his direct examination that his accident occurred when he got up out of a chair while attending a meeting along with other employees at Respondent's place of business. He also clearly testified that he did not perform his normal duties as an assembler on the date of accident and in fact performed no manual labor that day. Instead he was working as part of a special group which was discussing and developing new ergonomic methods for the work they performed. He further indicated that another episode of severe back pain when he arose from a chair on the date following the accident.

At this point in the proceedings Petitioner's attorney requested a recess which was granted. When the hearing resumed Petitioner then testified that prior to attending the meeting he was working his normal job as an assembler and had bent over to remove a 60 pound part from a bin and felt some lower back pain. He testified

he reported the incident to his foreman and asked to see the company nurse who provided Naproxen. He then went to the meeting.

After Petitioner's attorney requested a break in the testimony, the Petitioner and his attorney left the hearing room for several minutes. When the petitioner and his attorney returned, the direct examination of the Petitioner resumed, and the Petitioner's testimony about his injury clearly changed. The Petitioner later testified that his lifting injury may have occurred days or maybe a week before this meeting. The Petitioner again testified on cross examination that when getting up out of his chair at this meeting he experienced a worsening and increase of his low back pain. The Arbitrator finds the original description of the incident having occurred while arising from a chair after the meeting to be the most credible.

For an injury to have arisen out of the employment, the risk of injury must be a risk peculiar to the work or a risk to which the employee is exposed to a greater degree than the general public by reason of his employment. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 45, 109 Ill.Dec. 166, 509 N.E.2d 1005, 1008 (1987). 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. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 667 (1989)). 129 Ill.2d at 59, 133 Ill.Dec. 454, 541 N.E.2d at 667.

The act of getting out of a chair is not a risk specific to the Petitioner. No evidence was offered by the Petitioner indicating that anything about him getting out of a chair and experiencing severe back pain exposed him to a greater risk than that to which the general public is exposed.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the Petitioner failed to prove he sustained an accident which arose out of and in the course of his employment on June 7, 2013. Benefits are therefore denied. All other issues are 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

SCOTT E. HUGHES,

Petitioner,

vs. NO: 15 WC 25640

STATE OF ILLINOIS/
DEPARTMENT OF TRANSPORTATION,

19IWCC0457

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week, that being the statutory maximum for his date of accident, for a period of 38 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused a 10% loss of use of the left hand (19 weeks) and a 10% loss of use of the right hand (19 weeks).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $560.00 to Petitioner as reimbursement for co-payments and deductibles related to his medical treatment for this injury as provided in §8(a) of the Act.

19IWCC0457

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

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: AUG 26 2019

L. Elizabeth Coppoletti

LEC/mck

O: 8/20/19

43

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUGHES, SCOTT E
Employee/Petitioner

Case# **15WC025640**

SOI/DEPT OF TRANSPORATION
Employer/Respondent

19IWCC0457

On 8/29/2018, 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 2.21% shall accrue from the date listed above to the day before the 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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0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
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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

AUG 29 2018

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

19IWCC0457

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

SCOTT E. HUGHES
Employee/Petitioner

v.

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # **15** WC **25640**

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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Springfield**, on **June 19, 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 **March 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 $**79,196.00**; the average weekly wage was $**1,523.00**.

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

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

Respondent ***has 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 $**ANY AND ALL** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent on March 11, 2015. Petitioner's current condition of ill-being is causally related to his work accident. He reached maximum medical improvement on November 8, 2017.

Respondent shall pay Petitioner **$560.00** as reimbursement for co-payments and deductibles related to his medical treatment for this injury.

Respondent shall pay Petitioner the sum of **$735.37 per week**, that being the statutory maximum for his date of accident, for a further period of **38 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused a **10% loss of use of the right hand** (19 weeks) and a **10% loss of use of the left hand** (19 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.

Signature of Arbitrator

August 27, 2018
Date

AUG 29 2018

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

19IWCC0457

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SCOTT E. HUGHES
Employee/Petitioner

v. Case #: **15 WC 25640**

STATE OF ILLINOIS/DEPARTMENT OF TRANSPORTATION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim on July 28, 2015, alleging an injury to his left and right hands that occurred as the result of repetitive trauma from repetitive laboratory work and data input. The Application alleged an accident/manifestation date of March 11, 2015.

Petitioner Testimony

At the time of his alleged accident, Petitioner was 48 years old, married, and had no dependent children. He was employed by Respondent in the Bureau of Materials and Physical Research and had been so employed since May 1, 1991. Petitioner testified that he has held four positions within the Bureau. He started as a Laboratory Technician in the Aggregate Section, was promoted to Aggregate Lab Supervisor, then had a lateral transfer to Quality Assurance Supervisor, and is currently the acting/temporary Field and Training Coordinator for the Metals and Miscellaneous Laboratory.

With regard to job duties, Petitioner testified that for the biggest part of his career, from the time of his promotion from lab tech, his jobs have involved administrative type work such as data input, Excel databases, Access, and a lot of emails. For the first eight years of his career, while in the Aggregate Lab, his job included physical testing on materials, which involved shaking aggregates through 12-inch diameter sieves. He testified that this involved "a lot of hand shaking".

Petitioner testified that he has experienced problems with his hands "for many years" but could not give an exact date that the problems began. He noted that it started off as just minor aches and pains but worked its way up to a lot of numbness and tingling in the fingers and, at the end, losing the feeling in most of his fingers. He sought treatment with his primary physician, Dr. Prabu, who referred him to Dr. Narla for an EMG, and then referred him to Dr. Greatting. He first saw Dr. Greatting in January of 2015, at which time he received injections in both wrists.

Petitioner testified that he talked with Dr. Greatting about his job duties and how they applied to his injuries. He was diagnosed with bilateral carpal tunnel and his understanding was that the condition was aggravated by the work he was doing. Based on that understanding, he reported the injury to his employer, at which time an Employer's Report of Injury, Employee Notice of Injury, and Supervisor's Report of Injury were completed. He subsequently he underwent two separate surgeries by Dr. Greatting. Each surgery was performed on a Friday and he returned to work the following Monday.

Petitioner testified that he was also examined by Dr. Stewart at Respondent's request and provided a history of his work activities. He confirmed that Dr. Stewart's description of his work duties in his deposition testimony was accurate.

Petitioner also confirmed that Dr. Stewart showed him photographs of his work space but noted that they did not show the current configuration of his work space. He testified that sometime after he was diagnosed with carpal tunnel syndrome his employer performed an ergonomic study. As a result of the study, his work space was reconfigured from a sit-down work station to a stand-up work station, with an adjustable stool to allow for sitting or standing. Petitioner reviewed Petitioner's Exhibit 9 and identified it as a diagram of his previous work station, when he was working as the Quality Assurance Supervisor from 2007 to 2014. He noted that the computer monitor was on top of his desk and the keyboard was on a permanent pull-out drawer. He explained that the way his chair went under the drawer, he had to put his elbows and forearms on his legs and type with his hands up on the keyboard with his hands bent at the wrist. Petitioner confirmed that Dr. Stewart performed some measurements of him and his typing position, based upon the configuration of his work station shown in the photographs. He noted this was not based on his current work configuration, nor based on the work station diagram shown in Petitioner's Exhibit 9.

Petitioner testified that after he received Dr. Stewart's report he met with Dr. Greatting, at which time he discussed in more detail the work duties he had, including the fact that he had his elbows on his knees so that he could type. He requested a narrative report from Dr. Greatting based on this discussion and information.

Petitioner testified that he missed only one day of work with each surgery and received no temporary total disability benefits. His medical bills were submitted to his group carrier and to the best of his knowledge they have been paid, with the exception of co-pay and deductibles. He reviewed Petitioner's Exhibit 7 and identified it as a record of two co-payments of $30.00 and one deductible payment of $250.00, for a total of $310.00. He testified that he paid another deductible of $250.00 for the second surgery but could not find a copy of the receipt for it. As such, his total out-of-pocket expenses were $560.00.

With regard to his current condition, Petitioner testified that since his surgeries he has had no issues with tingling or numbness in his fingers and is back to his normal self. He continues to perform his job duties and is still doing the same amount of typing that he did before surgery.

On cross-examination, Petitioner confirmed that he is currently working full duty without any restrictions and that he is not currently seeing a doctor, undergoing physical therapy, or taking

any medication for his condition. He does not have to wear any brace or protective device. He is able to perform his job, has had no complaints from his supervisors regarding his job performance, and has received satisfactory job performance evaluations since he returned to work.

Petitioner believed he was first diagnosed with carpal tunnel syndrome in January 2015, when he saw Dr. Greatting. He testified that he did not submit paperwork to his employer until March because that was when he and Dr. Greatting talked about his work activities being "the aggravating cause that was making it worse and worse". Petitioner was asked about the description on the Application for Adjustment of Claim of the accident occurring from repetitive lab work. He noted that would have referred to the shaking of the sieves during the sieve analysis and soundness testing, activities he performed in the entry level technician job that he last performed in 1991. He testified that he believed this hand shaking of sieves in 1991 "was an aggravating portion that could have made the injury worse" but also noted that he had had symptoms for many years after that.

Petitioner was asked about Dr. Stewart's testimony regarding him having a Vitamin B-12 deficiency. He testified that he currently did not have such a deficiency but at one point in time he was on Vitamin B-12 pills for a short period. He denied use of any tobacco products. He acknowledged that he is a motorcycle driver and that he had owned and ridden a Harley Davidson Ultra Classic motorcycle since about 2011 or 2012. He testified that he rides primarily on the weekends to go on benefit runs and averages 1,000 to 1,500 miles a year.

Petitioner testified that he underwent the EMG on December 29, 2014, but did not get the results of the study until he met with Dr. Greatting. He did not disagree with the findings that he had minor carpal tunnel in the right hand and mild carpal tunnel in the left. He confirmed he is right-hand dominant and did not know why his left hand results were worse than his right. He testified he has never been diagnosed with hyperglycemia and did not know why the records mention it as a medical issue. He has been told he is "borderline" but has never been diagnosed with the condition.

When asked how many hours a day he types at work Petitioner stated, "Pretty much all day. I would say anywhere from 6 to 6 ½ hours a day I would be doing some type of data input or emailing." He estimated that he types in excess of 100 words per minute. The daily typing includes input into data fields on Access, Excel, and similar databases. He agreed that inputting data was different than typing a document in Microsoft Word. With regard to Word documents, he testified that he has written and/or updated several test procedures/specifications, policy memorandums, Qualified Producer Lists (QPL's), emails, and the like. As to the size and frequency of these documents, assuming a single-spaced Word document in 12-point font, Petitioner testified as follows.

1. The test procedures vary from 4 to 40 pages. He creates procedures from scratch for 13 or 14 tests and thereafter updates them bi-annually.
2. The policy memos vary from 3 to 70 pages. He updates the memos bi-annually, with the updates being 10 pages or less.
3. The QPL's vary from 2 to 20 pages. He works on at least one or two QPL's a week.
4. The emails are generally only a few paragraphs.

5. The data entry (Excel, Access, etc.) is an unknown number of keystrokes. The data is primarily put into their "Mystic System", with multiple lines of data entry and multiple pages, "running hundreds through at a time" that he had to input, as well as the inputting the final results.

Petitioner testified that he moved to the Metals & Miscellaneous Department in April or May of 2015, after he filed his worker's compensation claim. Prior to that he was in Aggregate Testing. He entered units into a data spreadsheet, but also typed in remarks about where the samples were taken from, if they passed or failed, the basis of the failure, and the like. He also entered units into a quarry ledge database, which would be the equivalent of no more than five pages of a Word document. Petitioner estimated that of the 6 to 6 ½ hours a day spent in typing, over 50 percent of it was data entry.

Medical Records

On December 16, 2014, Petitioner presented to Springfield Clinic and was evaluated by Nurse Practitioner Sandra Brummet. It was noted he was a patient of Dr. Prabhu's who requested an urgent appointment due to his hands going numb and waking him in the middle of the night. He reported it had been "going on for probably 10 or 12 years", as he remembered having an EMG and nerve conduction studies that many years ago, but it was not until recently that he has decided to have something done because it was waking him up in the middle of the night. He reported that he tried wearing splints, but they disrupted his sleep so much that he could not wear them. It was noted, "He does work for the State up in Springfield and he is on the computer at least 6 hours a day, so he does do a lot of repetitive motions." On examination, Tinel's was positive bilaterally and there was slight swelling to both hands. NP Brummet's assessment was carpal tunnel syndrome, and she ordered TSH and vitamin B-12 testing, as well as an EMG/NCS. PX2.

On December 29, 2014, Petitioner presented to Dr. Koteswara Narla for an EMG/NCS. Dr. Narla noted that he had previously seen Petitioner in 2011 for tremor in his right upper extremity, with TSH and brain CT scan being normal. He further noted Petitioner was treated in 2006 for disc bulges at C4-5 and C5-6, with cervical steroid injections. On examination, Tinel's and Phalen's were normal and cervical range of motion was full. The testing showed minor carpal tunnel compression on the right and mild carpal tunnel compression on the left. There was no evidence of ulnar entrapment neuropathy or radial sensory neuropathy. PX2.

On January 28, 2015, Petitioner presented to Dr. Mark Greatting for bilateral hand complaints, right worse than left. Dr. Greatting noted, "He gets numbness and tingling at night as well as doing typing/data input. It does not bother him with driving. He bow hunts a lot, and he says if he would pull the bow and have to hold it for a period of time, his hands would go numb. He also noticed last summer numbness and tingling in his hands when he did longer rides on his motorcycle." Petitioner reported he had tried night splint but found the splints to be uncomfortable so did not use them consistently. On examination, Tinel's was positive bilaterally, and Phalen's and compression tests were negative bilaterally. After examination and review of the EMG/NCS, Dr. Greatting's assessment was mild chronic carpal tunnel syndrome. He noted that splinting was unsuccessful and offered corticosteroid injections, which were performed that day. PX2.

On March 11, 2015, Petitioner returned to Dr. Greatting and reported that the injections helped for about a month, after which his symptoms then recurred. Examination showed positive Tinel's and positive compression test bilaterally. Surgery was recommended. PX2.

On March 12, 2015, Petitioner completed an Employee's Notice of Injury. He noted "no specific date" as to date of injury, and noted that the duty he was performing at the time of injury was "normal activities—data input". RX1.

On March 12, 2015, a Supervisor's Report of Injury was completed by Sheila Beshears. She noted for job description, "Quality Assurance Supervisor—data input and data review". She indicated Petitioner had been in that position for seven years (five acting and two permanent) and in his previous job of Aggregate Testing Supervisor for eight years. As to the description of accident, Ms. Beshears wrote, "This has been an ongoing issue for years. Scott does a lot of input and has been in pain for a while now." With regard to witnesses, Ms. Beshears wrote, "I have watched Scott input for years. This can, at times, be an all day thing." RX1, PX 6.

On March 12, 2015, an Employer's Report of Injury was completed by Heidi Britt at TriStar. The report indicated the accident occurred due to repetitive motion of typing and that, "per doctor", Petitioner had carpal tunnel in both hands "from repetitive typing". RX1, PX 5.

On April 17, 2015, Petitioner underwent a right carpal tunnel release and on June 5, 2015, he underwent a left carpal tunnel release. Both surgeries were performed by Dr. Greatting. He followed up with Dr. Greatting on June 17, 2015, and reported that the numbness in both hands was markedly improved. He was to return in four to six weeks if he had significant problems; otherwise, he was released on an as-needed basis. PX2, PX3.

Petitioner presented to Springfield Clinic on August 6, 2015, for sinus issues, on September 18 for insomnia, and on November 6 for a rash. There was no mention in those records about his carpal tunnel syndrome. PX2.

On June 3, 2016, Petitioner was evaluated by Dr. Patrick Stewart of Southern Illinois Hand Center, Respondent's Section 12 examiner. Dr. Stewart noted that Petitioner brought with him "a background of his employment record through the State of Illinois"; however, to the extent such background was in written form, it was not included in the exhibits proffered at hearing. Dr. Stewart went through Petitioner's work history with him and described same in his report, which the Arbitrator notes was consistent with Petitioner's testimony at hearing. He also reviewed with Petitioner pictures of a work station that consisted of two desks angled at 90 degrees from one another (RX2, PX8), with one desk containing two monitors and a keyboard in a tray. Dr. Stewart asked Petitioner to demonstrate the position he was in when doing his data entry work while at the keyboard, as depicted in the photographs. RX2, Dep. RX2.

The Arbitrator notes Petitioner's testimony that (1) these pictures did not show the current configuration of his work space, which was reconfigured from a sit-down work station to a stand-up station, with an adjustable stool to allow for sitting or standing; (2) these pictures did not show Petitioner's previous work station, when he was working as the Quality Assurance Supervisor from 2007 to 2014, which required him to put his elbows and forearms on his legs and type with his

hands up on the keyboard with his hands bent at the wrist; and (3) the measurements of him and his typing position were based upon the configuration of his work station shown in the photographs and not based on his current work configuration nor the Quality Assurance work station diagram shown in Petitioner's Exhibit 9.

Dr. Stewart reviewed Petitioner's treating records and conducted a physical examination, which was unremarkable except for noted positive Tinel's bilaterally. He found Petitioner to be "very direct and forthright" and noted that his treatment to date had been reasonable and necessary. He did not anticipate further treatment would be required. He believed Petitioner's prognosis was excellent, noted he was back to all normal activities, and opined that he had reached maximum medical improvement. RX2, Dep.RX2.

With regard to causation, Dr. Stewart opined that both force and repetition must occur in concert with one another for activities to cause carpal tunnel syndrome. As to data entry, he noted that although there may be repetitive activity, there is no coincidental force during the activity. He further opined that Petitioner's work in and of itself would not serve as an aggravating causal factor for the development of the condition. He also noted, however, that Petitioner did not have any of the known risk factors for carpal tunnel syndrome such as diabetes, rheumatoid arthritis, thyroid dysfunction, or hypertension, though did have a slightly increased risk due to his BMI of 32, noting that anything greater than 30 increased the risk. RX2, Dep.RX2.

Dr. Stewart testified by way of deposition on April 17, 2018. He is a Board Certified Surgeon with a certificate of added qualification in hand and upper extremity surgery. His practice consists of treating patients with upper extremity problems, primarily from the elbow down, and less than 1% of his practice is devoted to IME's. Dr. Stewart testified consistent with his report of June 3, 2016. He confirmed his opinion that Petitioner's carpal tunnel syndrome was not related to the data entry work he performed, in that it did not involve both repetition and force. He noted, however, that Petitioner's prior job duties in the Aggregate Lab of picking up and shaking the sieves did involve both force and repetition, and possibly vibration, "all of which are of concern when they're seen collectively". With regard to Petitioner's other risk factors, Dr. Stewart noted that the only factor present was his slightly elevated BMI of 32. He did not believe that Petitioner's motorcycle riding was a factor and testified, "With that infrequency, I don't think it's significant." He noted that the riding could make Petitioner more aware of his symptoms, but that it did not have a significant impact on causing the problem. RX2.

On cross-examination, Dr. Stewart testified that the pictures of Petitioner's work station simply gave him insight as to what it was like and what position he would be in when doing his work. He noted that ergonomics in the workplace was used to ensure that there is reasonable positioning in a work station, to decrease the likelihood of problems occurring. RX2.

On November 8, 2017, Petitioner returned to Dr. Greatting, approximately two and one-half years after being released. He reported good resolution of his carpal tunnel symptoms following surgeries and denied any numbness, tingling, pain, or weakness in either hand. Dr. Greatting noted, "He is here to discuss whether his carpal tunnel syndrome was work related and for me to gather further information to reply to a narrative request from his attorney." PX2. The Arbitrator notes this is the final treatment record.

On November 15, 2017 Dr. Greatting authored a report addressed to Petitioner's counsel, in response to a letter from counsel. He noted that Petitioner had been employed by the Department of Transportation for more than 25 years and worked 7.5 hours a day, 5 days a week. He further noted that Petitioner performed data entry with the use of a keyboard or mouse for up to 6.5 hours per day on his normal work days, and would also occasionally have to carry equipment and perform testing on metal structures. Petitioner reported that over time his symptoms of numbness and tingling progressed to the point where he would type or do data entry for only 15 to 20 minutes and would then have to stop to allow his hands to rest before he could continue. He also reported that when he had time off work his hands were much less symptomatic than when he was working. Petitioner reported that his work area had a keyboard holder under his desk and that he would work with his elbows resting on his thighs, resulting in his wrists being extended while doing his keyboard activities and using his mouse. He indicated he had a recent ergonomic evaluation which resulted in him now having a stand-up type desk. PX4, Dep.PX2.

Dr. Greatting noted that Petitioner was not obese, did not smoke, and did not have diabetes or other medical condition which would predispose him to developing carpal tunnel syndrome. Further, he did not have any outside activities, hobbies, or interests which he did on a regular basis. Dr. Greatting opined that although Petitioner's work activities were not the direct cause of his bilateral carpal tunnel syndrome, they "were a significant factor aggravating or accelerating" his symptoms, to the point where he required surgery. PX4, Dep.PX2.

Dr. Greatting testified by way of deposition on April 30, 2018. He is a Board Certified Orthopedic Surgeon with a certificate of added qualification in hand surgery. His practice is limited to upper extremity problems. Dr. Greatting testified consistent with his treating records and narrative report of November 15, 2017. He explained that extreme flexion (in the direction of the palm) or extension (the opposite direction) increased the pressure in the carpal tunnel and the nerve therein. He testified that when Petitioner rested his elbows on his thighs and extended his wrists when using the keyboard, the extended position increased or accelerated his carpal tunnel condition to the point that surgery became necessary. As such, Petitioner's bilateral carpal tunnel and resultant surgeries were related to his work activities. PX4.

On cross-examination, Dr. Greatting testified that hyperglycemia was not a current active problem for Petitioner. Although it was listed as a problem in 2015, he reviewed the labs for that period of time and noted there was nothing in there which indicated elevated blood sugars. As such, it was unclear to him where the diagnosis of hyperglycemia originated. He opined that hyperglycemia would not be a risk factor for developing carpal tunnel, but noted that a diagnosis of diabetes would be a factor that would predispose someone to getting carpal tunnel syndrome. Dr. Greatting recognized that Petitioner's chart listed hyperglycemia as a problem in several entries, but explained that the "problem list" includes things that simply never got removed. He again reiterated that there were no labs showing abnormal blood sugars. With regard to the noted problem of vitamin B12 deficiency, Dr. Greatting did not believe this would be a risk factor for developing carpal tunnel syndrome. PX4.

Dr. Greatting testified that he had never seen a picture of Petitioner's desk or workspace. He agreed that his opinions on causation were based on what Petitioner described and reported to

him as respects his workstation. In addition, Petitioner reported to him he would keyboard or type six to six and a half hours per day on his normal work days. He did not know how many words per minute he typed, nor whether the typing was more paragraph style or data entry into fields. Dr. Greatting was not aware of whether or not Petitioner's keyboard height could be adjusted, but was aware that it was an "under-the-desk keyboard". He opined that Petitioner's keyboarding or typing did not cause the carpal tunnel syndrome, but rather the volume of typing in combination with the positioning of his hands and wrists aggravated or accelerated his symptoms. He did not know the exact degree of extension that Petitioner experienced when typing. Dr. Greatting did not believe that any of Petitioner's outside activities or hobbies were done with enough regularity or frequency to have caused his carpal tunnel syndrome. When asked specifically about motorcycle riding, Dr. Greatting opined that unless someone rode a motorcycle several hours a day and several days a week, it would not be a factor. With regard to BMI being a factor, Dr. Greatting testified that, although Petitioner's was slightly elevated, he did not believe that a BMI between 30 and 33 qualified as obese and thus would not be a factor. PX4.

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 notes that Petitioner put forth a theory of repetitive trauma in support of his claim that he sustained an accident which arose out of and in the course of employment. Illinois recognizes that a claimant's condition may not always arise out of a single incident of trauma and, thus, benefits may be awarded for repetitive trauma. However, even when repetitive trauma is asserted as a theory of accident, the employee must still show that the job duties were, in fact, repetitive. *Williams v. Industrial Comm'n*, 244 Ill.App.3d 204, 211 (1st Dist. 1993). An employee who suffers a repetitive trauma injury is still required to meet the same standard of proof as an employee who suffers a sudden injury. *Durand v. Industrial Comm'n*, 224 Ill.2d 53, 64 (2006). A work-related injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Dunteman v. Ill. Workers' Compensation Comm'n*, 2016 IL App (4th) 150543WC, citing *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003).

In this case, the Arbitrator finds that Petitioner met his burden of proof in establishing that he sustained an accident which arose out of and in the course of his employment. In so concluding,

the Arbitrator finds significant Petitioner's unrebutted testimony that he typed six to six and a half hours every day and did so with his hands in an extended position.

The Arbitrator is mindful that Petitioner's current workstation was reconfigured as a result of the ergonomic study conducted by Respondent. However, from 2007 through 2014, his workstation was such that his keyboard was in a pull-out drawer and his chair was of a height that required him to rest his elbows and forearms on his legs, with his hands in an extended position when typing. The measurements taken by Dr. Stewart were based on the pictures of Petitioner's workstation at the time, which was different than his workstation from 2007 through 2014. Though Dr. Stewart opined that both repetitive activity and force were needed to consider an activity a risk for carpal tunnel syndrome, he did concede that Petitioner's job as described was repetitive. Both Dr. Stewart and Dr. Greatting testified that Petitioner had none of the known risk factors for developing carpal tunnel syndrome, except for a slightly elevated BMI which did not rise to the level of obesity. Further, they also both agreed that Petitioner's hobby of motorcycle riding was not a factor in the development of his condition.

Petitioner testified at length about the documents he generally types and the fact that he types six to six and a half hours every day. Respondent presented no evidence to rebut this testimony. To the contrary, the Supervisor's Report of Injury completed by Sheila Beshears documents that Petitioner "does a lot of input and has been in pain for a while now". When asked about witnesses to the alleged accident, Ms. Beshears stated, "I have watched Scott input for years. This can, at times, be an all day thing."

The Arbitrator finds that Petitioner's work activities of typing six to six and a half hours each day, especially with his hands in an extended position, were sufficiently repetitive to have been a causative factor in his carpal tunnel syndrome.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met his burden of proof on the issue of accident.

In support of the Arbitrator's decision relating to issue (E), whether timely notice of the accident was given to Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner provided timely notice to Respondent. In so concluding, the Arbitrator notes that Petitioner testified he reported the injury to his employer after he talked with Dr. Greatting about his job duties and how they applied to his injuries, at which time his understanding was that his condition was aggravated by the work he was doing. Based on that understanding, he reported the injury to his employer in March 2015. Timely notice was therefore given.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Comm'n*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

In light of the Arbitrator's findings above with respect to issue (C), the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work accident of March 11, 2015. The Arbitrator further finds that Petitioner reached maximum medical improvement on November 8, 2017, that being the last time he saw Dr. Greatting.

In support of the Arbitrator's decision relating to issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered to date were reasonable and necessary in Petitioner's care and treatment relative to his accident of March 11, 2015. The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for all payments previously made to providers, including those made pursuant to Section 8(j), for which a credit is allowed. Petitioner testified that to his knowledge all of his medical bills, with the exception of his deductibles and co-pays, were paid by his health insurance. He testified that his out-of-pocket medical expenses were $560.00, that being a $250.00 deductible for each surgery and a $30.00 co-pay for each surgery. The Arbitrator finds that Respondent is liable for reimbursement to Petitioner in the amount of $560.00.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

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 this 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 places no weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as the Aggregate Lab Supervisor at the time of the accident and subsequent thereto had a lateral transfer to Quality Assurance Supervisor, and is currently the acting/temporary Field and Training Coordinator for the Metals and Miscellaneous Laboratory.

He did not miss any work as a result of his accident and subsequent surgeries. 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 48 years old at the time of the accident and can be expected to work for several more years. Over the coming years his condition could improve, stay the same, or get worse. There was no evidence to indicate with any degree of likelihood how his age would impact his disability. 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 places no weight on this factor.

In regard to factor **(v) evidence of disability corroborated by treating medical records**, the Arbitrator notes that Petitioner underwent two separate surgeries for his bilateral carpal tunnel syndrome. The treating records show that he had a good result and was released with no restrictions. With regard to his current condition, Petitioner testified that since his surgeries he has had no issues with tingling or numbness in his fingers and is back to his normal self. He continues to perform his job duties and is still doing the same amount of typing that he did before surgery. The Arbitrator found Petitioner to be credible throughout his testimony, and especially so with regard to his current state. 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 as a result of his accident of March 11, 2015, Petitioner sustained a 10% loss of use of the right hand (19 weeks) and 10% loss of use of the left hand (19 weeks), pursuant to Section 8(e) of the Act. The parties stipulated that Petitioner's average weekly wage was $1,523.00. The Arbitrator finds his permanent partial disability rate is $735.37, the maximum rate in effect at the time of his injury.

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

ANTONIO MILLENDER,

Petitioner,

vs. NO: 16 WC 24535

AMERICAN STEEL FOUNDRIES,

Respondents.

19IWCC0458

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 affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the following correction: Petitioner's Temporary Total Disability rate is $616.53. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 22, 2019, with the above correction, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $616.53 per week for a period of 9 3/7 weeks, representing June 26, 2018 through August 30, 2018, 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 reasonable and necessary medical expenses as identified in Petitioner's Exhibit 7; however, with respect to

19IWCC0458

the Multicare Specialists bill the Respondent shall only be responsible for the first chiropractic visit, but all of the physical therapy bills 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 prospective medical treatment including, but not limited to, the ulnar nerve transposition surgery recommended by Dr. Paletta 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,200.00. 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 26 2019

L. Elizabeth Coppoletti

LEC/mck

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

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

MILLENDER, ANTONIO
Employee/Petitioner

Case# **16WC024535**

AMERICAN STEEL FOUNDRIES
Employer/Respondent

19IWCC0458

On 5/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

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

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)

Antonio Millender
Employee/Petitioner

v.

American Steel Foundries
Employer/Respondent

Case # **16** WC **24535**

Consolidated cases: _____

19IWCC0458

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **3/25/19**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **2/18/16**, 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 $**44,431.00**; the average weekly wage was $**924.80**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**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 $**2,461.71** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner Exhibit 7; however, with respect to the Multicare Specialists bill the Respondent shall only be responsible for the first chiropractic visit, but all of the physical therapy bills as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for respective medical treatment including, but not limited to, the ulnar nerve transposition surgery recommended by Dr. Paletta.

Respondent shall pay Petitioner temporary total disability benefits of $16.53 per week for 9 and 3/7 weeks commencing June 26, 2018 through August 30, 2018, as provided in Section 8(b) of the Act.

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

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

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

Signature of Arbitrator

5/19/19
Date

ICArbDec19(b)

MAY 22 2019

19IWCC0458

STATEMENT OF FACTS

Petitioner, Antonio Millender, worked for the Respondent, American Steel Foundries, for approximately 13 years beginning in August of 2004. Prior to his employment with Respondent, Petitioner testified that he both passed a preemployment physical and had no problems with his hands or upper extremities.

Petitioner testified that for the first 8 years he was employed by the Respondent he worked as a chipper and grinder. Petitioner described this job as grinding on steel with a pneumatically powered, vibrating grinder weighing approximately 8 to 10 lbs. He would do this for approximately 8 hours a day. Petitioner testified that he was smoothing train parts and steel couplers and worked in uncomfortable or awkward positions to reach his work. Petitioner then worked as a welder for the last 5 years of his employment with the Respondent. Petitioner resigned from his position in July of 2017. Petitioner reviewed a job description which was admitted as Petitioner's 4 Depo Exhibit 2. Petitioner testified that this was a roughly accurate description of his job activities for Respondent. The job description was inaccurate in that it was a job description for a Small Parts Department welder and the Petitioner worked in the Chipping and Finishing Department as a welder. Petitioner described the difference between these two departments as the Chipping and Finishing Department would grind and smooth steel more frequently than in the Small Parts Department.

The Arbitrator also reviewed a video admitted as Respondent's Exhibit number 3. This video depicts an individual using a cutting torch approximately four feet in length and the individual is moving his arms in full extension, as well as past 90 degrees in flexion. The Petitioner did this throughout the work day and then grinded out defects with a pneumatic chipping hammer to smooth the steel throughout the work day. Petitioner testified that he would use the chipping hammer for approximately 1 hour a day and the remainder of the day would be spent moving the cutting torch back and forth. Petitioner indicated that the cutting torch weighed approximately 2 to 3 lbs. and that the hose would get caught frequently and then he would have to pull this back and forth and down the rail as he worked. There was resistance when he was pulling on the torch hose.

Petitioner testified that he initially sought medical treatment for hand problems from Dr. Prieb. (Generally, PX 1). Petitioner had an EMG Nerve Conduction Velocity Test performed on June 22, 2017. (PX 1 at 2). This test was positive for mild sensory left carpal tunnel syndrome. (Id. at 4). Petitioner complained of numbness, tingling, and pain into his left hand and wrist since February of 2016, which was getting worse. (Id. at 2). On June 22, 2017, Dr. Prieb recommended bilateral carpal tunnel surgeries, but Dr. Prieb then retired. (PX 1 at 1). Because Dr. Prieb retired, Petitioner chose to treat with Dr. Paletta.

Petitioner was first seen by Dr. Paletta on July 17, 2017 and gave a history of numbness and tingling in both hands, predominately the right hand, for greater than a year. Petitioner gave Dr. Paletta a history of working as a chipper and grinder, but then moving into the welder position in the recent years. (PX 4 at 21). Dr. Paletta recommended a repeat EMG Nerve Conduction Velocity test since the first test was done over a year previously. (Id. at 22). Further, Dr. Paletta opined that Petitioner's peripheral compressive neuropathy was related to his job

duties at American Steel Foundries. (Id.) Dr. Paletta is a board-certified Orthopedic Surgeon who is Fellowship trained in Sports Medicine Research, Adult Sports Medicine, and Pediatric and Adolescence Sports Medicine. (PX 4 at 4) Dr. Paletta is also the Medical Director for the St. Louis Cardinals. (PX 4 at Depo Exhibit 1).

Petitioner was referred for an Independent Medical Examination by the Respondent with Dr. Katz on two occasions. Dr. Katz is a board-certified Doctor of Physical Medicine and is not a surgeon. (RX 1 at 4) After taking a history and conducting a clinical examination, Dr. Katz performed an EMG/NCV Test. This test was performed on September 23, 2016 and was negative for median neuropathy on either the left or right hand, but Dr. Katz noted an anastomosis between the medial and ulnar nerve of no clinical significance. (RX 1 at 11). Dr. Katz saw the Petitioner again on November 10, 2017 and this test noted a definitive abnormality of the ulnar nerve at the left elbow. Dr. Katz felt that although there was not clear-cut evidence of ulnar nerve entrapment of the right elbow, that the reduction of sensory nerve conduction velocity distally represented ulnar nerve entrapment on the right side as well. (RX 1 at 16). Dr Katz explained that the Petitioner's condition of anastomosis is not clinically significant, but it is a traveling of motor fibers from the median nerve to the ulnar nerve in the forearm. (RX 1 at 12). This can confuse inexperienced electro diagnosticians. (Id.) Dr. Katz did not feel that the bilateral nerve entrapments were related to his work conditions. (Id. at 20). On cross examination, Dr. Katz opined that only professional baseball pitchers have sufficient flexion and extension of the elbow to cause repetitive trauma ulnar neuropathy at the level of the elbow. (RX 1 at 23) Dr. Katz has had a relationship with American Steel Foundries for 20 years and in over half of the cases that he examined persons for American Steel were repetitive trauma disorders either of the hands or the elbows. (Id. at 22).

Petitioner was examined again on March 23, 2018 by Dr. Paletta. Dr. Paletta reviewed the EMG nerve conduction velocity test of Dr. Katz and conducted a clinical examination. Based upon that study, Dr. Paletta opined that Petitioner had bilateral ulnar nerve symptoms with evidence of cubital tunnel syndrome and compression of the nerve at the Guyon's canal and that the Petitioner did not have carpal tunnel syndrome. (Id.). To correct this condition, Dr. Paletta performed surgery on June 26, 2018. This surgery consisted of a right ulnar nerve transposition as well as a right ulnar nerve release at the level of the wrist performed by Dr. Hagen. There was a typographical error as it reads left instead of right. (PX 3 and 6). Petitioner missed work from June 26, 2018 through August 30, 2018, a period of 9 and 3/7 weeks. Petitioner was last seen by Dr. Paletta on August 29. 2018. Dr. Paletta noted an excellent outcome on the right side, that the Petitioner was asymptomatic, and he placed the Petitioner at MMI on the right side. Dr. Paletta recommended a similar procedure on the left side pending the appropriate approval. (PX 2 at 1).

The following medical bills were submitted into evidence:

Vascular Hand Surgery: $923.98
Dr. Paletta: $15,544.00
Dr. Hagen: $4,555.09
Orthopedic Ambulatory Surgery Center of Chesterfield: $15,054.10
Advanced RX Management: $484.52
The Orthopedic Center of St. Louis: $10,209.16

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Premier Anesthesia: $880.00
Multicare Specialists: $8,895.00

The Parties reached a stipulation regarding the Multicare Specialist bill that should this case be found compensable, that only the first Chiropractic visit, and all Physical Therapy would be paid pursuant to the fee schedule.

CONCLUSIONS OF LAW

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

The Arbitrator concludes Petitioner sustained an accidental injury that arose out of and in the course Petitioner's employment by Respondent on February 18, 2016

In support of this conclusion the Arbitrator notes the following:

Petitioner's description of the job, as well as the review of the video indicated that Petitioner was engaged in heavy work with flexion and extension past 90 degree in his elbow throughout his work day. This activity is consistent with causation of cubital tunnel syndrome.

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the injury of February 18, 2016.

In support of this conclusion, the Arbitrator notes the following:

The Arbitrator is more persuaded by Dr. Paletta's testimony and gives greater weight to said testimony that to Dr. Katz's opinion regarding causal connection. Petitioner had to work at a job which required flexion and extension of his upper extremities past 90 degrees throughout the work day. Further, the Petitioner did not have any systematic condition such as diabetes, thyroid condition, or gout which would predispose him to peripheral neuropathies.

The Arbitrator is also more persuaded by Dr. Paletta's testimony regarding a work relationship to Petitioner's condition rather than Dr. Katz's testimony that ulnar nerve entrapment does not occur in the work place absent a specific strike to the ulnar nerve or in Major League pitchers. Dr. Katz's opinion concerning repetitive trauma causes of ulnar nerve entrapment is not consistent with Illinois precedence in this area.

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

The following medical bills are reasonable and necessary and are awarded pursuant to the fee schedule:

19IWCC0458

Vascular Hand Surgery: $923.98
Dr. Paletta: $15,544.00
Dr. Hagen: $4,555.09
Orthopedic Ambulatory Surgery Center of Chesterfield: $15,054.10
Advanced RX Management: $484.52
The Orthopedic Center of St. Louis: $10,209.16
Premier Anesthesia: $880.00
Multicare Specialists: $8,895.00

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

The Arbitrator concludes that Dr. Paletta's proposed left ulnar nerve surgery is reasonable and necessary and is awarded.

In support of this conclusion, the Arbitrator notes the following:

Petitioner's testimony that his left arm is still symptomatic indicates Petitioner's need for Dr. Paletta's proposed ulnar nerve transposition. Further, Petitioner had an excellent result on the right which would indicate that Petitioner should have a resolution of his symptoms on his left side if this surgery is performed.

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

The Petitioner is entitled to TTD benefits from June 26, 2018 through August 30, 2018 a period of 9 and 3/7 weeks. Petitioner was disabled from his customary work by Dr. Paletta following his right ulnar nerve surgery for this time period.

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

Jay Lovelace,
Petitioner,
vs.

NO: 13WC 2490

City of Springfield,
Respondent.

19IWCC0459

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, prospective medical, occupational disease, permanent partial disability, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 26, 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 26 2019
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SJM/jrc
044

Stephen J. Mathis
Stephen Mathis

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

D. Douglas McCarthy
D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOVELACE, JAY
Employee/Petitioner

Case# **13WC002490**

CITY OF SPRINGFIELD
Employer/Respondent

19IWCC0459

On 11/26/2018, 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 2.45% 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:

5757 HAXEL LAW
MARTIN J HAXEL
310 E ADAMS ST
SPRINGFIELD, IL 62701

0332 LIVINGSTONE MUELLER ET AL
DENNIS S O'BRIEN
PO BOX 335
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS.
COUNTY OF **SANGAMON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAY LOVELACE
Employee/Petitioner

v.

CITY OF SPRINGFIELD
Employer/Respondent

Case # **13** WC **2490**

Consolidated cases: _____

19IWCC0459

An *Application for Adjustment 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 **Springfield**, on **September 25, 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 **Prospective Medical**

FINDINGS

On **September 6, 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 $**84,467.15**; the average weekly wage was $**1,624.37**.

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

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an occupational disease which arose out of and in the course of his employment with Respondent on September 6, 2012. Petitioner's current condition of ill-being with regard to his bilateral hearing loss is causally related to the occupational disease and Respondent shall pay for prospective medical treatment related thereto.

Respondent shall pay Petitioner the sum of **$712.55 per week for 36.4 weeks**, as provided in **Section 7** of the Occupational Diseases Act, because the disease caused a **27.3% loss of hearing in the right ear** (27.3 weeks) and a **9.1% loss of hearing in the left ear** (9.1 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.

Signature of Arbitrator

November 19, 2018
Date

NOV 26 2018

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

19IWCC0459

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAY LOVELACE
Employee/Petitioner

v. Case #: **13 WC 2490**

CITY OF SPRINGFIELD
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging he was exposed to an occupational disease that arose out of and in the course of his employment as a firefighter with Respondent, which resulted in a bilateral loss of hearing. Respondent disputed that the injury arose out of and in the course of employment and that Petitioner's current condition was causally related to his employment. Respondent further disputed liability for prospective medical treatment and permanent partial disability.

On September 6, 2012, Petitioner was 55 years old, married, and had no dependent children. He testified that he worked for the Springfield Fire Department from 1991 until his retirement in November 2012. He held various positions throughout his tenure, including a Junior Firefighter (5 years), Firefighter (12 years), Driver Engineer, and Captain. He worked in different firehouses during that time but was principally at Station 1. He worked at Stations 4 and 5 for extended periods of time, and Stations 6 and 12 for short periods of time. He testified that all but one year of his career was spent in the busiest firehouses, which were Stations 1, 4, and 5.

Petitioner testified that his duties included testing of equipment at the beginning of each 24-hour shift. At Station 1 there was a truck, an engine and a squad, each of which had its own equipment to be tested. He examined all of the medical equipment, checked the rig's tools to make sure they were all present and that the nozzles worked, tested the pressures and knobs on pumps, tested the extraction equipment, and the like. He used the equipment in training, with one training cycle a week, and trained on something every day, which could include bookwork. He used fans for smoke removal, which had a motor similar to a lawn mower.

Petitioner testified that he worked with and rode in several different types of fire engines during his time with the department. The first engine was a 1965 Seagrave, which was open air in

the rear, where the engine itself was, and had an exposed jump seat behind the captain's seat (passenger side). Petitioner sat in this jump seat, facing the rear of the vehicle. He testified that his right ear was the one nearest to the vehicle's engine and that his right ear was worse than his left with regard to hearing issues. He noted that while riding in the rig it was so loud that you had to yell to hear each other. In the late 1990's, they began using a Laverne fire engine but continued using the Seagrave as well, "until it died". The Laverne was quickly replaced by a Pierce engine, which had a big ladder on it. Both the Laverne and the Pierce had enclosed cabs and air conditioning, though he noted that the Laverne's air conditioning did not work very well. He testified that the Seagrave was louder than the Laverne, that you could talk to each other on the Laverne, but that you could not really do so on the Seagrave due to the noise. The Pierce was quieter still. He testified that the engines on the newer rigs were better insulated.

Petitioner testified that the fire engines came with different types of sirens—an electronic siren, a wind up (or "Q"), and air horns. The electronic siren could be heard a block away; the air horn could be heard a couple of blocks away; and the wind up/Q could be heard five or six blocks away when it was at full speed. He testified that when he was a captain he would run the Q siren quite a lot, as he felt the electronic sirens were useless. He noted that the sirens were on the bumpers of the newer rigs.

Petitioner testified that after 12 years as a firefighter he then became a driver for three years. His job duties were the same and he was also in charge of the pump. He had added duties of checking the equipment at the beginning of the shift, along with the firefighter, which included running the pump. He also ran the pump at the fires. He testified that the pump engine was louder than the fire engine, because of the need to increase the RPMs to get sufficient water pressure for the fire hoses.

Petitioner testified that whenever an emergency call came in you never knew exactly what it might involve. For example, a call for an auto accident may turn out to be a tractor trailer with three cars underneath it. During his career he worked on hundreds of fires of varying sizes. He would occasionally encounter an explosion while fighting a fire, such as with a trailer fire or when hot tires exploded after cold water was put on them.

Petitioner testified that after having the rank of driver he became a captain and held that rank for six years. Despite his rank, he continued to start the equipment every shift to make sure it was working. He was also on the Tech Rescue Team, which involved specialized training. He also took courses in order to train others. This specialized training included training on air systems, hydraulic tools for structural collapses, jackhammers to break through concrete, and diving. He noted that the tech training equipment was less noisy than the other equipment, as it ran on batteries, and that the diving was not noisy, as it was under water.

Petitioner testified that he did not remember the department recommending or forcing firefighters to wear hearing protection. The only hearing protection was in the air room where they ran the air compressor to fill the air tanks, which was very loud.

Petitioner testified that while working for the Springfield Fire Department he also worked as a police officer for the Village of Southern View for 25 years. He worked part time, four to six

days per month. He explained that his shifts as a firefighter were 24 hours on and 48 hours off. His shifts as a policeman were 8 hours for the first 21 or 22 years, and then 10 hours for the final years. He described Southern View as a compact area of approximately 2,000 people. He testified that he never used his gun, a pistol, while working as a police officer. He only discharged his weapon once a year at the range, and always used noise cancelling headphones when doing so. He testified that he rarely activated the siren on his squad car, as most of the time the other vehicle's driver would see the lights on the police car. If he did use the siren it was only for a couple of seconds at a time. He kept the windows of the squad car up and the air conditioning on, as his bullet proof vest was hot. He did crack the window when the siren was activated so he could hear if a person yelled at him.

Petitioner testified that he was in the Army from 1976 to 1980 and was a paratrooper. He went to the shooting range for the day once a year to be qualified but otherwise did not discharge firearms while in the Army. He was exposed to explosions, but only from a distance. While in basic training he wore ear protection and he testified that he never discharged a firearm without ear protection.

Petitioner testified that he was an avid hunter but uses a bow, not a gun. His parents are in their 80's and neither of them have hearing problems or use hearing aids. He has never had anything happen to him which physically damaged his ears.

Petitioner testified that he had his hearing tested in 2012 because he was having hearing issues and it was tested again in the summer of 2018. His issues started in the early 2000's. He noted that currently his hearing is "not good", that he has trouble following a conversation, and that his co-workers used to make fun of him at work because he could not hear. He has learned how to read lips and has gotten pretty good at it. If he is lying in bed on his good (left) ear, he cannot hear his wife talking to him. He has trouble listening to the television and his neighbors complain that the volume is too high. He has also had tinnitus for a long time and sleeps with a fan on so that he doesn't hear the ringing.

On cross-examination, Petitioner testified that he is right-handed. He acknowledged that he actually started working as a police officer in 1985, for the City of Springfield. He then worked as an officer for SIU School of Medicine for three months before being hired by the Springfield Fire Department in 1991. While an officer for the City, the annual tests involved 30 to 50 shots, pulling the gun from the holster and shooting at targets at various distances. He stated he was able to score 30 out of 30 or 50 out of 50 without any practicing.

Petitioner testified that he used different engines, depending on which station house he was working in. He tested different equipment on different days. Not all fire department equipment was used on all emergency runs. Medical calls were the most frequent runs and fire calls were the exception rather than the rule. He noted that medical calls did not involve any of the equipment but still used the siren and air horns. When he worked, he responded to all emergency calls on the fire engine, the truck, or the squad. The sirens and lights were not used to check on invalids or while going to community functions, testing of fire hydrants, shopping for the station house food at the grocery store, and the like. When the sirens were used, they were turned on when they left the firehouse for an emergency call and were turned off upon arrival to the scene. He agreed that

the average time for the siren to be on during a run was about 6 minutes and 37 seconds. He agreed that a typical 24-hour shift included sleep time, meal time, and television time.

Petitioner testified that he had no idea how many decibels were created by any of the old fire engines or the equipment that he used. He also did not know how long he was exposed to any particular decibel level during his shift. He testified that he retired at age 55 and that he would have liked to work longer but he had problems with his knees, ankles, neck, and back. He agreed that age 60 was the mandatory retirement age for firefighters. He acknowledged that he had lost no time from work as the result of his hearing issues.

On re-direct examination, Petitioner reiterated that the sirens, air horn, and lights were all used on all medical calls.

Petitioner called Mr. Keith Rigdon as a witness. Mr. Rigdon testified that he worked for Respondent from 1989 until his retirement in May 2018. He worked with Petitioner on the same shift and at the same firehouse downtown (Station 1), for about 15 years. He started as a firefighter, then became a driver engineer, and then a captain. His final eight years he was a battalion chief. He also worked at Stations 5, 6, and 7. He testified that out of all 12 fire stations, Stations 1, 4, 5, and 6 are the busiest ones with the most calls.

Mr. Rigdon testified that while working with Petitioner at Station 1, their rig averaged four emergency runs per day. He explained that on each emergency run the sirens and lights were used and that three to four people would ride on the responding fire engine. Seated in the cab was the driver and the captain. Seated behind them, in jump seats facing the rear, was the junior firefighter and the senior firefighter. He noted that in the 1990's these jump seats were open air. He testified that the Seagrave engine at Station 1 was old and that if a person in the jump seat wanted to talk to someone in the cab they did so through a sliding window. To communicate you had to shout. The jump seat was right next to the motor powering the fire engine, which he described as being loud with very little soundproofing. For the firefighter sitting behind the captain, the right ear is the one nearest to the motor. Mr. Rigdon testified that two sirens were used—a mechanical siren and an electronic siren. On the early rigs, the mechanical siren was mounted on the bumper and the electronic siren was on the roof of the cab. Both sirens were used continuously, and the air horn was used when needed.

Mr. Rigdon did not recall ever being issued hearing protection while working for the fire department. He testified that the driver and captain rode in the cab with the windows rolled down 9 out of 12 months of the year in the early years, as the vehicles back then did not have air conditioning. He noted that even with the windows up, however, the sound of the engines and sirens was loud. He stated that the older rigs had higher noise levels than the later, fully enclosed, cabs and that the newer generation of vehicles was even better.

Mr. Rigdon testified that when they were at a fire they would use fans and saws, and when doing an extrication they would use hydraulic operated equipment and possibly saws. The chain saws they used were comparable to chain saws anyone might have, and the hydraulic equipment had a motor similar to a lawn mower engine. In older fire engines, the engine ran at a higher RPM than idle to produce operating pressure for hose lines.

Mr. Rigdon testified that at the beginning of each shift all of the equipment had to be checked to ensure it was operating properly. This involved starting the fire engine, engaging the motor that operated the pump, and starting the chainsaws, powered fans, hydraulic power units, and other tools. The amount of time it took to do this varied from 10 to 20 minutes, depending on the rig, as each rig did not always carry the same equipment.

Mr. Rigdon testified that there were various non-emergency runs that would be made with the fire engines, such as for training, district memorization, pre-planning, checking fire hydrants, fire drills, going to the grocery store, and the like. The number of those trips per shift was about equal to the number of emergency responses. He noted that the seating arrangements were the same on these runs as they were on emergency runs.

Mr. Rigdon testified that he has worked as a police officer for the Village of Sherman for nine years. The Village population is approximately 4,500. He is a patrol officer and the only time he has ever discharged his weapon was at the firing range and a few times for the destruction of animals. He seldom activates his siren. He testified that the noise he is exposed to while working as a police officer is far less than the noise he had working as a fireman.

On cross-examination, Mr. Rigdon testified that there are three kinds of rigs in the station house—a truck, a fire engine, and a squad. The truck carries more equipment than the fire engine, including the big ladder, and is supposed to be the first unit to arrive at a fire. When he first joined the department, the squad was a pumper, but it is now an SUV. He stated that in the 1990's new equipment was obtained, but it was several years before it arrived. He noted that the older rigs had an enclosed cab for the driver and captain. He testified that the only place where the department always had hearing protection was the SCBA fill station, as it was an enclosed room and it was very loud. He believed the newer battalion cars were equipped with hearing protection at some point.

Mr. Rigdon testified that he had no idea how many decibels were produced by any of the equipment. He also did not know how many decibels the noise was in the cab with the windows up or down, though believed it was probably less decibels when up. He noted that the firefighter and the driver would test all of the equipment, including the radio and the loudspeakers. This was not generally done by the captain. Checking the equipment meant starting it and running it long enough to get the equipment up to operating temperatures. The truck check took about 20 minutes and the engine check took about 10 minutes.

On re-direct examination, Mr. Rigdon explained that the SCBA fill station involved an air compressor which refilled air bottles. He noted that the machine was quite loud and the person operating it would definitely want to use the hearing protection.

Respondent called Mr. Lyndal Neighbours as a witness. He has been with Respondent for nearly 25 years and his current rank is the Division Chief of Operations. He is immediately below the Chief in rank. He testified that his division runs the firehouses with 215 firefighters. He has worked as a firefighter, driver engineer, and captain prior to being promoted to his present rank.

Mr. Neighbours testified that he was involved in the testing for hearing exposure evidenced in Respondent's Exhibits 1 and 2. He noted that the testing company randomly picked days to test and that the day they tested Station 1 was a day when bad storms had taken place. There were numerous automatic alarms going off in buildings, as well as sirens, and it was not an average day by any means. He explained that the testing company asked that Station 1 be tested again, as the normal number of runs was 8 or 9, rather than the 20 on the test day, and that the automatic alarms caused a great deal of background noise.

Mr. Neighbours testified that he always carried hearing protection in his rig coat and that the battalion cars had small, squishy ones that you could stick in your ears. He noted, however, that while fighting fires hearing protection does not work as you need to communicate with other firefighters via radio.

Mr. Neighbours disagreed with Petitioner's description of Stations 4 and 5 being busy and having 14 or 15 calls per day, noting there were days when they would have zero, one, or two. He believed 14 or 15 calls would be a busy day, and that the average would be 8 or 9.

Petitioner's Exhibit 1 is the report from his audiology testing in Springfield, Illinois, on September 6, 2012. The testing revealed hearing loss in both ears. The examiner noted, "Patient has a moderately severe hearing loss. This affects his ability to understand speech in noise and causes patient to frequently ask people to repeat. Patient would benefit from hearing aids." PX1.

Petitioner's Exhibit 2 is the report from his audiology testing in Cape Coral, Florida, on September 3, 2018. The testing showed a slight worsening of hearing loss. The examiner opined that this type of hearing loss "is most commonly a result of exposure to loud noises such as sirens, alarms, explosions, use of firearms, as well as other extremely loud noises". Hearing aids were recommended for Petitioner for the rest of his life. PX2.

Petitioner's Exhibit 3 is a publication by the Federal Emergency Management Agency and the United States Fire Administrator that discusses the results of several noise exposure studies involving firefighters. One of the studies was conducted by the National Institute for Occupational Safety and Health (NIOSH). The NIOSH study measured the decibel levels of several fire engines manufactured in the 1960s and the 1970s and found that the firefighter sitting in the jump seats were exposed to decibel levels ranging from 105 to 112 (PX3, page 35, Table VII). Another study performed by the University of California produced 8-hour time-weighted averages (TWA) for a captain, a driver engineer and a firefighter all exceeding 90 dB (PX3, page 37, Table X). A 1982 study performed by NIOSH in New York City produced similar results in which all of the firefighters in riding positions were exposed to average decibel levels in the mid-90s. Most studies found that firefighters suffer hearing loss worse than the general population. PX3.

A time-weighted average (TWA) is a calculation that always averages the sound over an 8-hour period. It represents a constant sound level lasting 8 hours that is based upon the noise that was sampled (RX 1, Appendix A, page 4).

Respondent introduced two reports from James Barnes, MS, CIH, President of Occupational Environmental Health Solutions, Inc., relating to noise dosimeter data from three of

Respondent's fire stations. The methodology of the testing was explained at length in the reports, with testing being conducted at Station 1, Station 6, and Station 11. As explained at arbitration by Mr. Neighbours, based upon the unusual activity created by storms activating alarms during the initial test date of Station 1, the testing personnel recommended a second test on a more normal day. The test report for testing at the three stations done on July 10, 12, and 13, 2017 stated:

> The values for the nine employee's data collected by the noise dosimeters reflect values which are less than the OSHA PEL of 90 dBA. However, the Hearing Conservation Standard Data Table 9, Column 8, the "Adjusted Action Level for 24 hours" indicates a level of 79.0 dBA. The 24-hour Time Weighted Average (i.e. Column 4) for station #1 varied between 83.2 and 88.5 dBA during the shift. Therefore, these sound levels are over the Action Level for the Station #1 personnel. In addition, the Projected TWA for 8-hours (i.e. Table 9, Column 5) was also exceeded for the Captain of Station #1. The other 6 employees of the remaining 2 fire stations were below the 24-hour action level criteria of 79.0 dBA and the projected 8-hours TWA. RX1, p.21.

The report noted the unusual number of incident responses for Station 1 on the testing day (21) compared to Station 6 (5 incidents) and Station 11 (2 incidents). The fire department reported to the testers that the average number of incident responses for Station 1 was about 6.5. RX1.

Based on the unusual number of incidents on the test date for Station 1 that station was retested on August 9-10, 2017. The test report for Station 1 for that date states:

> The values for the three employee's data collected by the noise dosimeters reflect values which are less than the OSHA PEL of 90dBA (see Table 6). The Hearing Conservation Standard Data located in Table 4, Column 8 the "Adjusted Action Level for 24 hours" indicates a level of 79.0 dBA. The 24-hour Time Weighted Average (i.e. Column 4) for fire station #1 varied between 72.4 and 82.8dBA during the shift. Therefore, these sound levels are less than the Action Level for the fire station #1 personnel. In addition, the Projected TWA for 8-hours (i.e. Table 4, Column 5) was also not exceeded for the three employees of fire station #1. RX2, p.12.

Respondent also introduced Weapon Qualification Testing records from Southern View Police Department, which confirm Petitioner's testimony that he shot between 30 and 50 rounds in annual testing by that department. RX3.

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:

Section 1(d) of the Illinois Occupational Diseases Act states:

> Any condition or impairment of health of an employee employed as a firefighter, * * * 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 * * * 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 * * *. However, this presumption shall not apply to any employee who has been employed as a firefighter * * * 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 310/1(d).

The Arbitrator finds that, having worked for Respondent as a firefighter for more than five years, Petitioner qualifies for the rebuttable presumption of an occupational exposure being the cause of his hearing loss. The question then becomes whether Respondent has successfully rebutted the presumption. The Arbitrator finds that Respondent did not.

The Appellate Court has specifically reviewed the rebuttable presumption language in the case of *Johnston v. Illinois Workers' Compensation Comm'n*, 2017 IL App. (2d) 160010WC, which involved coronary artery disease. After reviewing prior decisions, including the Supreme Court case of *Diederich v. Walters*, 65 Ill.2d 95 (1976) cited by Respondent, the Court concluded that clear and convincing evidence was not necessary to rebut the presumption. Rather, Respondent must "offer *some* evidence sufficient to support a finding that something other than claimant's occupation as a firefighter caused his condition". *Johnston*, at ¶45. (Emphasis in original.)

Respondent also cited the case of *Simpson v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 160024WC, involving a firefighter who suffered heart disease and had experienced a heart attack. The Appellate Court noted that "once the employer introduces some evidence of another potential cause of the claimant's condition, the presumption ceases to exist, and the Commission is free to determine the factual question of whether the occupational exposure was a cause of the claimant's condition based on the evidence before it but without the benefit of the presumption to the claimant." *Simpson*, at ¶46.

Respondent asserts that it has introduced evidence which is contrary to the presumption, thereby eliminating the presumption and requiring Petitioner to prove by a preponderance of the evidence that he suffered an exposure to noise levels in excess of the standards set out in Section 7(f) of the Occupational Diseases Act.

Having reviewed the evidence presented by Respondent, the Arbitrator finds that such evidence does not rebut the presumption set out in Section 1(d) of the Act.

Respondent's evidence consisted of RX1 and RX2 which are reports prepared by OEHS after measuring the noise levels produced by the equipment used by Springfield firefighters at its

Stations 1, 6 and 11. However, these noise samples were taken in 2017 and Petitioner retired from the Springfield Fire Department in 2012 after more than 21 years of service. It is undisputed that the engines that Petitioner rode in for many years early in his career were much noisier than those currently in operation. As such, the Arbitrator does not rely upon these reports.

Respondent also presented RX3 which are records from the Southern View, Illinois police department showing that Petitioner maintained his firearm qualification in the years 2005 through 2011. These records show, consistent with Petitioner's testimony, that he made one trip per year to the firing range. Further, Petitioner testified that he always used hearing protection whenever shooting at the firing range for his annual qualification.

Petitioner testified that he worked for the Village of Southern View as a part-time policeman for 25 years. He worked 6 days per month, and for 21 or 22 years of his career as a policeman he worked shifts that were 8 hours in length. This means he worked 32-48 hours per month. As a firefighter, Petitioner's shifts were 24 hours on, 48 hours off. Consequently, in a typical month he would work 240 hours as a firefighter.

Petitioner further testified that the Village of Southern View is a very small community. If he ever used his siren on his squad car it was only for a couple seconds at a time. Most of the time the window in the squad car was rolled up. He usually wore a bullet proof vest which is hot to wear, and he frequently turned on the air-conditioning.

Both Petitioner and Keith Rigdon testified that the amount of noise they were exposed to working as a firefighter far exceeded the noise levels exposed to while working as a policeman. They both testified that the noise levels produced by the older fire engines used in the 1990s were much louder than the fire engines used today. This is corroborated by the data contained in PX3, which measured the noise levels of fire engines built in the 1960s and 1970s and which also found that firefighters who rode in the jumpseats of those vehicles (as Petitioner did for many years) were exposed to noise levels higher than a time-weighted average of 90 dB. PX 3, pages 35, 37.

Petitioner's years of sitting in the jumpseat behind the captain, on the passenger side facing the rear, also meant that his right ear was nearest the motor. Petitioner testified that his right ear was worse than his left one and this is corroborated by both hearing tests admitted into evidence.

The Arbitrator finds it significant that none of this evidence was refuted by Respondent.

Moreover, Adam Tasler, who performed Petitioner's most recent hearing test, stated that Petitioner's hearing loss is attributable to his exposure to loud noises such as sirens, alarms, explosions, use of firearms as well as other extremely loud noises. With regard to firearms, the evidence showed that any time Petitioner was exposed to noises generated by firearms, he was wearing hearing protection. There was no evidence to the contrary.

The Arbitrator finds that Respondent has not produced sufficient evidence to rebut the presumption set out in Section 1(d) of the Act.

Further, the weight of the evidence proves Petitioner's noise exposure and resulting hearing loss was due to his work as a firefighter.

This conclusion is supported by comparing Respondent's evidence submitted in this case with the evidence submitted by the employer in the *Johnston* case. In *Johnston*, the firefighter had suffered a heart attack due to coronary artery disease. The employer's Section 12 physician testified that the firefighter's underlying coronary artery disease was due to a 20-year history of smoking one to one-and-one half packs of cigarettes per day, a family history of heart disease, his obesity, and his underlying diabetes. This evidence gave the Commission ample reason to determine that the rebuttable presumption had been successfully rebutted. *Johnston*, at ¶ 50.

Similar evidence was presented by the employer in another heart attack case, *Simpson v. IWCC*, 2017 IL App (3rd) 160024 WC. Simpson was another firefighter who also suffered from heart disease. The employer in that case produced evidence that the firefighter had three risk factors for heart disease—hypertension, obesity and high cholesterol. The court concluded that this evidence was enough to rebut the presumption. *Simpson*, at ¶*47*.

The evidence submitted by the employers in the *Johnston* and *Simpson* cases each involved chronic medical conditions that had most likely existed for many years, if not decades, were unrelated to the firefighter's job duties and had to do with personal life choices and heredity. In the case at bar, the only contrary evidence was that Petitioner worked as a police officer for 25 years. However, there really is no comparison with the noise exposure Petitioner experienced as a police officer and that which he experienced as a firefighter. All of the evidence shows that the noise exposure for the firefighting job was much higher and much more pervasive.

Furthermore, there is no evidence of any other risk factor for hearing loss. Petitioner does not have a family history of hearing loss, has never suffered from a physical injury to either of his ears, and has never suffered from any other medical condition which affected his hearing.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met his burden of proof on the issue of 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, and issue (O), Petitioner's entitlement to prospective medical treatment, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (C), the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work accident of September 6, 2012. In so concluding, the Arbitrator relies upon the September 3, 2018, report by Adam Tasler of Beltone Hearing Care Center, which was not refuted. The Arbitrator further finds that Petitioner is entitled to prospective medical treatment recommended by Mr. Tasler, including but not limited to, hearing aids.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Section 7 of the Occupational Diseases Act states:

> (a) Loss of hearing for compensation purposes shall be confined to the frequencies of 1,000, 2,000 and 3,000 cycles per second. Loss of hearing ability for frequency tones above 3,000 cycles per second are not to be considered as constituting disability for hearing.
> (b) The percent of hearing loss, for purposes of the determination of compensation claims for occupational deafness, shall be calculated as the average in decibels for the thresholds of hearing for the frequencies of 1,000, 2,000 and 3,000 cycles per second. Pure tone air conduction audiometric instruments, approved by nationally recognized authorities in this field, shall be used for measuring hearing loss. If the losses of hearing average 30 decibels or less in the 3 frequencies, such losses of hearing shall not then constitute any compensable hearing disability. If the losses of hearing average 85 decibels or more in the 3 frequencies, then the same shall constitute and be total or 100 percent compensable hearing loss.
> (c) In measuring hearing impairment, the lowest measured losses in each of the 3 frequencies shall be added together and divided by 3 to determine the average decibel loss. For every decibel of loss exceeding 30 decibels an allowance of 1.82% shall be made up to the maximum of 100 percent which is reached at 85 decibels. 820 ILCS 310/7.

The Arbitrator again relies upon the report and hearing test prepared by Adam Tasler on June 12, 2018. The results of this test, utilizing the air conduction measurements, are as follows:

	1000hz	2000hz	3000hz	TOTAL	AVERAGE
Right	35	30	70	135	45
Left	20	25	60	105	35

In compliance with the formula contained in Section 7 of the Occupational Diseases Act, this hearing test demonstrates, and the Arbitrator finds, that Petitioner has sustained loss of hearing to the extent of 27.3% in the right ear [45 – 30 =15 x 1.82% (0.0182) = 27.3] and 9.1% in the left ear [35 – 30 = 5 x 1.82 (0.182) = 9.1].

The parties stipulated that Petitioner's average weekly wage was $1,624.37. The Arbitrator finds his permanent partial disability rate is $712.55, the statutory maximum rate in effect for his date of accident.

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

BOBBY CRANE,

Petitioner,

19IWCC0460

vs. NO: 14 WC 027673

THE AMERICAN COAL COMPANY,

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 occupational disease, permanent partial disability and Section 1(d) through (f) of the Occupational Diseases 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 August 7, 2018, with the Illinois Workers' Compensation Commission is hereby affirmed and adopted.

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

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

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

DATED: AUG 26 2019
DLS/mav
O: 08/13/19
46

Deborah L. Simpson

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0460

CRANE, BOBBY
Employee/Petitioner

Case# **14WC027673**

THE AMERICAN COAL COMPANY
Employer/Respondent

On 8/7/2018, 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 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5236 CULLEY FEIST KUPPART & JORDAN
ROMAN P KUPPART
3 SOUTH MAIN STREET
HARRISBURG, IL 62946

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

19IWCC0460

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

Bobby Crane
Employee/Petitioner

v.

The American Coal Company
Employer/Respondent

Case # 14 WC 27673

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 William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on July 18, 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 Sections 1(d)-(f) of the Occupational Diseases Act

FINDINGS

On March 1, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

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 $n/a; the average weekly wage was $940.00.

On the date of accident, Petitioner was 67 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Conclusion of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

August 7, 2018
Date

AUG 07 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart. The Application alleged a date of last exposure of March 1, 2014, and that Petitioner sustained the occupational disease as a result of inhalation of coal mine dust including, but not limited to, coal dust, rock dust, fumes and vapors for a period in excess of 30 years (Arbitrator's Exhibit 2).

At the time of trial, Petitioner was 71 years of age. Petitioner has a bachelor degree from Southern Illinois University in early childhood development. Petitioner worked in coal mines for 30 years. In addition to coal dust, Petitioner was exposed to rock dust, gravel dust, fly ash dust, a multitude of chemicals and rock glue resin. Petitioner was also exposed to diesel fumes. He drove a diesel fork truck for 27 or 28 years at the coal mine.

Petitioner's last day working as a coal miner was March 1, 2014. On that date he worked for Respondent at the Galatia mine. He was 67 years of age on that date. His last job classification was yard man or heavy equipment operator/fork truck operator. Petitioner testified that he was exposed to and breathed coal and rock dust on that day. Petitioner testified that he retired on that day. He testified that he retired in part because of the conditions of the coal mine. He was already signed up for Social Security and Medicare. He did not look for work nor did he work anywhere after his retirement.

Petitioner graduated from high school in 1966. He worked for a cabinet factory before being drafted into the Army on November 6, 1966. He served in the Army for 1 year, 11 months and 26 days. During that time, he was stationed in Vietnam. After discharge from the Army, he worked at Babcock and Wilcox building nuclear reactors. He worked for the State of Illinois at the A.L. Bowen Center in Harrisburg from 1971 to 1983. He started out as a child care aid and ended up as a recreational therapist. During that time he went to school to get his bachelor degree. Petitioner went to work for Kerr-McGee as a coal miner in 1984. Kerr-McGee was eventually bought out by Respondent. Petitioner worked there until his retirement. Petitioner worked as a warehouse clerk for Respondent for a year or a year and a half. After that, he became a yardman/heavy equipment operator and held that position for the remainder of his coal mine employment.

Petitioner testified that the yard man/heavy equipment operator would order supplies and send them underground. He would load and unload trucks as they delivered and picked up stuff at the coal mines. In this job he drove a fork truck and a 966 end loader which was used to dump gravel and fly ash down a pipe to the underground coal mine where it was spread on the roads. Loading and unloading supplies required that he physically lift and load the supplies in addition to using a fork truck. The supplies included rock dust, timbers, cribs, glue, bolts and roof bolts. He described the physical exertional requirements as being pretty physical. He would have to lift items ranging from 40 or 50 pounds to a little over 100 pounds. Most of the time he worked 12 hour shifts. The last

couple of years that he was employed in the coal mine, he worked nine hours, six days a week. He testified that he was exposed to coal or rock dust at least 75% of his work day.

The rock dust was delivered in bags which were stacked on pallets. The bags would fall off and bust. When they busted, Petitioner would get rock dust on him trying to get it cleaned up. He testified that he was in the dust a lot when messing with rock dust. They would empty the bags underground and then send the empty bags back to the surface. Petitioner would have to throw those bags over his head into a dumpster. He testified that he would always get dust on him in this process. Petitioner testified that his entire coal mining career was spent above ground. Petitioner testified that there was a slope at the mine where they would send trains underground. When he was preparing the cars to go underground and hooking them to the hoist, the beltline carrying coal would be running nearby, and coal would fall off the belt. As the fork truck ran up and down the concrete, it would grind the coal into a fine dust, which was stirred up by the fork truck. Petitioner testified that his body and clothes were dirty at the end of a workday. He could shake his coveralls and coal dust, rock dust and fly ash would come out of them. In addition to lifting, he also had to stoop, squat and bend.

Petitioner testified that he started having issues with his breathing while performing his job duties eight or ten years before he retired. He testified that when doing physical labor, he would get short of breath and sometimes would cough. He testified that he had a little tightness in his chest and went to see the doctor about that. When he had those problems at work, he would slow down or take a break. As of Arbitration, Petitioner testified he could walk a block or a block and a half at a normal pace. He testified that he could go one flight of stairs fairly easily, but if he had to do more than one flight he would become short of breath. Petitioner testified that from the time his breathing problems started until the time of Arbitration, they had gotten worse.

Petitioner testified that he talked to his physician, Dr. Alexander, about the breathing problems. He testified that he was prescribed breathing medication. Petitioner testified that his breathing problems affect his daily life activities. Petitioner testified that he declines to do certain things because he knows he will not be comfortable doing them. He testified that he has a friend who has asked him to go horseback riding 10 or 15 times in the last year and he has always declined. The friend has also asked him to go walking and Petitioner does not walk with him. He has turned down these opportunities mainly because of his breathing problems. Petitioner testified that he mows his own yard. He testified that he mows about half of it and has to take a break. He testified that he cannot weed eat his whole yard. He testified that hot weather causes him to have trouble breathing. Petitioner testified that at the time he retired, he was taking breaks and would have to slow down because of his breathing. He testified he would have to get help completing his work duties. He testified that if he was loading rollers on a sled to go underground, he would have to get the hoist man to help him because of his shortness of breath.

Petitioner testified that he treated with Dr. Alexander for his breathing problems. He testified that he talked to Dr. Alexander about his coal mining work and the dust. Petitioner testified that he has not done any type of work other than manual labor. He does not have any computer or typing skills.

Petitioner testified that he may have smoked three or four cigarettes as a kid. This is the only smoking history in his whole life. Petitioner testified that he has digestive problems for which he sees Dr. Tibrewala.

Petitioner testified that as of Arbitration he could go back and do the coal mining job that he had on his last day, but it would take him longer to do it. He testified that he could get it all done in his 10 hour day. Petitioner testified that he talked to James Karr, his supervisor, as well as Steve Willis, the head of safety, about his breathing problems. Petitioner testified that he had been to Dr. Alexander about his breathing problems and Dr. Alexander suggested he talk to his supervisor.

Petitioner testified that after he talked with his supervisors about his work duties at Dr. Alexander's suggestion, they brought the street sweeper up about once a week to the cage where he worked and up and down the road where Petitioner ran the fork truck. They would sweep the area where he worked at to clean up the coal and rock dust. He testified that there was less dust. Petitioner testified that after a few weeks the street sweeper broke. When they quit running the street sweeper the dust got bad again. He testified that when he ran the fork truck through the dust, it would fog up like a car going down a gravel road.

Petitioner testified that while working as a miner, from time to time, he underwent screening for NIOSH for black lung. He would undergo x-rays and then NIOSH would write to him and tell him what the x-ray revealed. The Petitioner did not bring any of those letters with him to Arbitration. Petitioner testified that Dr. Goldstein was the original company doctor that he had to see for an annual physical so he just decided to have him as his treating physician. When he retired, Dr. Alexander became the company doctor and Petitioner started seeing him. His primary doctor was Dr. Voss in Marion. The Petitioner testified that Dr. Voss retired 10 to 12 years prior to Arbitration. Petitioner testified that Dr. Alexander continued to be his primary care doctor. Petitioner testified that he saw a doctor in Marion upon the recommendation of Dr. Alexander. The doctor listened to his lungs and checked his oxygen levels. He saw this doctor three or four times. He testified that this referral was made eight or ten years ago.

Petitioner testified that he spends his time visiting friends and taking care of the yard. He used to mess with his horses, but the last one died two or three months prior to Arbitration. He goes to the nursing home every afternoon to visit his mother. Petitioner has 87 acres where he used to have cattle, but now he has someone that cuts hay off of it once a year. He owns another 15 acres that he bush hogs once a year. He testified that he and his wife mow the yard, and he has a small garden.

Dr. Suhail Istanbouly examined Petitioner on August 27, 2014, at the request of his counsel (Petitioner Exhibit 4, p 6). Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine (Petitioner's Exhibit 4, p 4). Dr. Istanbouly testified that roughly 30% of his patient census deals with the care and treatment of coal miners. He conducts black lung examinations for the U.S. Department of Labor. Dr. Istanbouly has been the Medical Director of the Pulmonary Department at Herrin Hospital since approximately 2005 (Petitioner Exhibit 4, p 5).

Dr. Istanbouly noted that Petitioner was a coal miner for 30 years with all that time being above ground. Petitioner never smoked. He complained of daily cough for almost 10 years, more prominent in the morning. The cough was triggered by strenuous activities. Petitioner reported having a cardiac stress test three months prior to Dr. Istanbouly's evaluation which was negative (Petitioner's Exhibit 4, p 7).

Dr. Istanbouly performed spirometry testing which revealed mild non-specified respiratory limitation. Dr. Istanbouly testified that the chest x-ray showed mild interstitial changes consistent with simple pneumoconiosis. Dr. Istanbouly testified that it was significant that Petitioner had never smoked because that would make long term coal dust exposure the number one culprit for his abnormal spirometry tests and chronic symptoms (Petitioner's Exhibit 4, pp 7-8). Dr. Istanbouly testified that the complaint of cough reflects chronic bronchitis. The only risk factor he found in Petitioner's history was long term coal dust inhalation. Dr. Istanbouly also testified that Petitioner's reported exertional dyspnea was consistent with underlying lung disease or lung damage related to coal dust inhalation (Petitioner's Exhibit 4, p 8). Dr. Istanbouly testified that the physical examination of Petitioner's chest was normal (Petitioner's Exhibit 1, p 9). Dr. Istanbouly testified that Petitioner's FEV1 was within normal range, his FVC was mildly reduced and the FEV1/FVC ratio was normal. Dr. Istanbouly found that Petitioner had a non-specific mild abnormality. He testified that it was suggestive of mild restrictive defect, but he could not tell that based on spirometry alone. He would need complete pulmonary function testing with lung volumes (Petitioner's Exhibit 4, pp 10-11). Dr. Istanbouly testified that the cause of Petitioner's mild non-specific ventilatory limitation was long term coal dust inhalation (Petitioner's Exhibit 4, p 11)

Dr. Istanbouly testified that he personally reviewed and interpreted Petitioner's chest x-ray of April 17, 2014. He testified that he customarily relies on his own interpretation of x-rays to diagnose, care and treat his patients, but in the situation where there is a legal concern, he relies on his interpretation as well as the B-reader report (Petitioner's Exhibit 4, p 12). Dr. Istanbouly testified that his review of the chest x-ray revealed mild interstitial changes including small round opacities bilaterally consistent with coal workers' pneumoconiosis (Petitioner's Exhibit 4, p 13). Dr. Istanbouly testified that the cause of Petitioner's coal workers' pneumoconiosis was long term coal dust inhalation (Petitioner's Exhibit 4, p 14).

Dr. Istanbouly testified that pulmonary function testing is one part of the evidence that he uses to confirm the diagnosis of pneumoconiosis (Petitioner's Exhibit 4, pp 14-15). Dr. Istanbouly testified that the fine particles of coal dust are inhaled and reach the deep parts of the airways ending in the alveoli creating a local irritation or inflammation that ends up with a tiny scar which are the small round opacities seen on the chest x-ray. He testified that eventually these tiny scars will replace normal lung tissue and affect the gas exchange through the vascular parenchymal barrier. That scar tissue is sometimes referred to as fibrosis (Petitioner Exhibit 4, p 15). Dr. Istanbouly testified that by definition, if one has coal workers' pneumoconiosis, he has an impairment in the function of the lung at least at the site of the scar or fibrosis (Petitioner's Exhibit 4, p 16).

Dr. Istanbouly testified that Petitioner had significant pulmonary impairment based on his cough, shortness of breath and wheezing. He testified that the main culprit for this impairment was Petitioner's long term coal dust inhalation. Dr. Istanbouly testified that Petitioner was precluded from safely returning to work in the coal mine because of his diagnoses. He testified that additional coal dust exposure could endanger Petitioner's health (Petitioner's Exhibit 4, p 17).

Dr. Istanbouly saw Petitioner one time for the purpose of evaluation for his state black lung claim. He performs five to seven such examines per month. All of the exams are performed at the request of attorneys representing claimants (Petitioner's Exhibit 4, pp 19-20). Petitioner did not relate to Dr. Istanbouly a past history of respiratory disease. The only trigger that Petitioner identified for his cough was exertion. The complaint of dyspnea on exertion can be due to causes other than pulmonary disease (Petitioner's Exhibit 1, p 19). Petitioner was not taking any breathing medication at the time of Dr. Istanbouly's examination and he did not relate to Dr. Istanbouly that he had ever taken breathing medication in the past (Petitioner's Exhibit 4, p 20). Dr. Istanbouly did not review any treatment records regarding Petitioner other than the B-reading by Dr. Alexander and his medication list (Petitioner's Exhibit 4, pp 20-21). Petitioner did not tell Dr. Istanbouly that he left the mine at the time he did due to respiratory problems or that he was unable to do the job duties required of him in his last job at the mine (Petitioner's Exhibit 4, p 21).

Dr. Istanbouly is not an A-reader or a B-reader. He does not provide profusion ratings on the films that he interprets for black lung. He determines if the film is positive or negative. If it is positive, his classification system is one in which he describes the disease present as mild, moderate or severe. In Petitioner's case, he classified the disease as mild based on the x-ray findings. Dr. Istanbouly testified that one needs a good quality film to make an accurate diagnosis. Poor quality will not show the details of the lung tissue and the anatomy. He testified that it is important to note the film quality to know whether the reader took same into consideration in his interpretation (Petitioner's Exhibit 4, pp 22-23).

Dr. Michael S. Alexander interpreted the chest x-ray for Petitioner dated April 17, 2014. Dr. Alexander interpreted the film as positive for pneumoconiosis, profusion 1/1 with P/P opacities in all lung zones (Petitioner's Exhibit 1) Dr. Alexander interpreted the chest x-ray of March 14, 2011, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones (Petitioner's Exhibit No. 2). Dr. Alexander is a board certified radiologist and B-reader (Petitioner's Exhibit No. 3).

Records of NIOSH were admitted into evidence. A chest x-ray of October 6, 1986, was interpreted by an A-reader and B-reader as being completely negative (Respondent's Exhibit 3, pp 2-3). A chest x-ray of September 4, 1987, was interpreted by an A-reader and B-reader as being completely negative (Respondent's Exhibit 3, pp 4-5). A chest x-ray of October 25, 1991, was interpreted by an A-reader and B-reader as being completely negative (Respondent's Exhibit 3, pp 6-7). A chest x-ray of December 19, 2006, was interpreted by an A-reader and B-reader as having no parenchymal abnormalities consistent with pneumoconiosis (Respondent's Exhibit 3, pp 8-11). A chest x-ray of March 14, 2011, was interpreted by an A-reader and B-reader as having no parenchymal abnormalities consistent with pneumoconiosis (Respondent's Exhibit 3, pp 12-15). A chest x-ray of April 3, 2013, was interpreted by two B-readers as having no abnormalities consistent with pneumoconiosis (Respondent's Exhibit 3, pp 16-19).

Dr. Cristopher Meyer reviewed PA chest x-ray that was a digital scan of an analog film from Harrisburg Medical Center dated March 14, 2011. He also reviewed a PA and lateral chest x-ray from Ferrell Hospital that was a digital exam dated April 17, 2014. Dr. Meyer found both x-rays to be of diagnostic quality. The March, 2011, film was quality 3 because of underexposure and poor contrast. The examination of April 2014, was quality 3 due to underinflation and mottle (Respondent's Exhibit 1, pp 41-42). Dr. Meyer testified that there were no findings of coal workers' pneumoconiosis on those chest x-rays (Respondent's Exhibit 1, p 42).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p 8). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1, p 21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader program (Respondent's Exhibit 1, pp 22-23). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty is typically experienced senior level B-readers (Respondent's Exhibit 1, pp 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation 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 1, pp 35-36).

Dr. Meyer testified that the B-reader looks at the lungs 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 1, p 24). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities (Respondent's Exhibit 1, pp 29-30). The distribution of the 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. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion (Respondent's Exhibit 1, p 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung (Respondent's Exhibit 1, pp 31-32).

Dr. Meyer testified that chest x-rays that are underexposed are extremely white and have a tendency to artificially increase the look of opacities in the lung parenchyma (Respondent's Exhibit 1, p 28). The underexposure of the film tends to accentuate the pulmonary vasculature (Respondent's Exhibit 1, p 29). Dr. Meyer testified that if there is mottle on the examination, it can make the film look grainy. He testified that mottle can also simulate small opacities (Respondent's Exhibit 1, pp 28-29).

Dr. Meyer testified that to become a B-reader one takes the weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples with mentors overseeing the practice examples. At the end of the weekend there is an exam (Respondent's Exhibit 1, pp 33-34). The certifying exam is six hours long with 120 chest x-rays to be categorized (Respondent's Exhibit 1, p 35).

Dr. Jeffery Selby examined Petitioner at the request of Respondent's counsel on September 10, 2015 (Respondent's Exhibit 2, p 7). Dr. Selby is board certified in internal medicine and pulmonology. He has been a B-reader since 1985 (Respondent's Exhibit 2, p 3). Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient. He does all manner of consultation work as far as chest, lungs or breathing disorders. His practice also encompasses occupational lung disease including individuals with coal workers' pneumoconiosis (Respondent's Exhibit 2, pp 4-5).

Petitioner reported to Dr. Selby 30 years of coal mine employment with 100% of that being on the surface. He worked in the warehouse for two years and then drove heavy equipment. Petitioner retired on March 3, 2014. He reported to Dr. Selby that he mows grass and takes care of one horse and fifteen acres (Respondent's Exhibit 2, p 8). Petitioner reported to Dr. Selby that he had never had any ER visits or hospitalizations due to breathing problems. He had seen a pulmonologist four to five years prior to Dr.

Selby's examination who had given him several different inhalers. He took the inhalers for about two months. One made him sick, and he did not notice any difference with his breathing. He told Dr. Selby that one year prior he had seen another pulmonologist who did an office spirometry and diagnosed him with black lung. He underwent a treadmill test with arterial blood gas in Harrisburg and was told these were within normal limits (Respondent's Exhibit 2, p 9). Petitioner's chief complaints were shortness of breath and fatigue. He reported being short of breath for five to six years. He coughed every day which was productive of clear, milky secretions. He wheezed on exertion. He reported he could walk 1,000 feet before stopping to rest due to shortness of breath. He reported that he has gotten so short of breath that he has vomited. He had seasonal allergies as a child. Petitioner reported that he had a positive sleep study and was now on CPAP (Respondent's Exhibit 2, pp 9-10).

Dr. Selby testified Petitioner's chest exam was normal with good airflow and clear breath sounds. His resting oxygen saturation on room air was 97%. Petitioner had normal spirometry without significant improvement post bronchodilator, normal lung volumes and normal diffusion capacity (Respondent's Exhibit 2, pp 11-12). The diffusion capacity measures the ability of oxygen molecules to get across the air sacs into the capillaries or bloodstream. Petitioner's diffusion capacity was 111% of predicted which meant his lungs were working better than normal, and he would have no respiratory limitation to exertion (Respondent's Exhibit 2, pp 12-13). Dr. Selby testified that based upon a total lung capacity of 83%, Petitioner had no restriction present. Dr. Selby testified that his testing met the ATS reproducibility criteria (Respondent's Exhibit 2, p 13). For spirometry to be used for diagnostic purposes, it should meet the ATS reproducibility criteria. Dr. Selby testified that spirometry performed at his office did not reveal any evidence of obstruction (Respondent's Exhibit 2, p 14).

Dr. Selby testified that a proper reading of a chest x-ray requires the reader to note the opacity type, to indicate lung zone involvement and to indicate what the profusion of the film is. He testified that profusion is important because it gives an idea of just how much disease is present. Dr. Selby reviewed two digital films and compared them to the NIOSH analog exemplars (Respondent's Exhibit 2, p 14). Dr. Selby testified that if a non B-reader characterizes a film as positive and evidences either early or mild pneumoconiosis, without a profusion rating, one does not have any way of knowing whether the film has a profusion of 1/0 or 0/1. Dr. Selby testified that that distinction is important. He testified that the distinction between a 1/0 film and a 0/1 film, in terms of whether it is positive for pneumoconiosis is that there has to be a line in the sand which has been drawn by NIOSH as to the difference between a positive or negative film for pneumoconiosis (Respondent's Exhibit 2, pp 15-16). Dr. Selby testified that the distinction between a 1/0 film and a 0/1 film is one of the points of emphasis in the B-reader course and exam (Respondent's Exhibit 2, p 16). Dr. Selby testified that the films he interpreted for Petitioner were dated March 14, 2011, and April 17, 2014. He testified that neither film was positive for pneumoconiosis (Respondent's Exhibit 2, p 16).

Dr. Selby testified that he is familiar with the *Guides to the Evaluation of Permanent Impairment, Sixth Edition.* He testified that when Table 5-4, Pulmonary Dysfunction, is applied to the results from the pulmonary function testing performed in Dr. Selby's office, Petitioner falls in a Class 0 impairment (Respondent's Exhibit 2, p 16). Dr. Selby testified that the key factors used in Table 5-4 for Class 0 impairment are spirometry and diffusion capacity. Table 5-5 relates to asthma. When the results of Dr. Selby's pulmonary function testing are applied to Table 5-5 of the *Guides*, Petitioner also falls into Class 0 impairment. Dr. Selby testified that based on his examination and testing of Petitioner, he was capable of heavy manual labor from a pulmonary standpoint. Dr. Selby agrees with the position of 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. Selby testified that there is almost a zero percent chance for simple pneumoconiosis to progress once the exposure ceases (Respondent's Exhibit 2, p 17).

Dr. Selby concluded that Petitioner did not suffer from respiratory or pulmonary abnormalities as a result of coal mine dust inhalation or coal mine employment. Petitioner does not suffer from coal workers' pneumoconiosis. Dr. Selby testified that Petitioner had a likely diagnosis of asthma or other kind of bronchospasm based on his history of exertional dyspnea, wheeze and sensitivity to triggers. Any bronchospasm he now suffers is not the result of coal mine dust inhalation but is due to genetics and prior viral infections. Dr. Selby testified that Petitioner had obstructive sleep apnea that could lead indirectly to dyspnea. Dr. Selby testified that Petitioner had the respiratory or pulmonary capacity to perform any and all of his prior coal mine duties, including his last job driving heavy equipment (Respondent's Exhibit 2, p 18).

Dr. Selby also reviewed treatment records for Petitioner which covered the timeframe of June 15, 1993, through February 14, 2014. He did not see the diagnosis of chronic bronchitis by his treating physician. Dr. Selby testified that he did not see any pathologic evidence of the lungs in the medical that he reviewed (Respondent's Exhibit 2, p 19). Dr. Selby testified that there was nothing in Dr. James Alexander's office note of January 30, 2014, which would indicate what he based the diagnosis of coal workers' pneumoconiosis on. Dr. Selby testified that most likely Dr. Alexander was simply parroting someone else (Respondent's Exhibit 2, p 37).

Dr. Selby testified that for a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in his lungs, he must have a reaction to that dust. That tissue reaction is called scarring or fibrosis (Respondent's Exhibit 2, p 21). Dr. Selby testified that by definition, a person with pneumoconiosis would have impairment in the function of his lung, at least at the site of the scarring and fibrosis whether it could be measured by spirometry or not (Respondent's Exhibit 2, p 22).

Dr. Selby testified that in regard to the application of *Guides to the Evaluation of Permanent Impairment* Table 5-4, the *Guides* state that the spirometry that is being used has to be valid in order to apply the table. The study of April 3, 2013, did not meet the ATS guidelines for reproducibility so pursuant to the *Guides* it is not to be used in determining impairment. Dr. Selby testified that the American Thoracic Society requires that there be three reproducible studies for the spirometry to be considered valid (Respondent's Exhibit 2, p 39). Dr. Selby testified that the August 27, 2014, testing by Dr. Istanbouly did not meet the ATS guidelines because there were not three reproducible studies. Dr. Selby used Knudson predictions for his testing. He testified that if the NHANES predicted values had been used, Petitioner still fell in Class 0 impairment and his pulmonary function was normal (Respondent's Exhibit 2, pp 41-42).

Medical records of Dr. James Alexander from the Harrisburg Medical Clinic were admitted into evidence. Petitioner was seen on January 18, 2011, with chief complaint of vomiting and diarrhea. His chest was normal to percussion and clear to auscultation. He had no wheezing or rhonchi. Under active problems asthma and sinusitis were listed (Respondent's Exhibit 4, pp 179-181). A chest x-ray was taken on March 14, 2011. Same was interpreted as negative. The lungs were clear (Respondent's Exhibit 4, p 178). Petitioner was seen on May 3, 2011, with chief complaint of head congestion. He complained of dyspnea, cough, coughing up sputum and wheezing. Symptoms had been present for one week. The assessment was sinusitis, allergic rhinitis and asthma (Respondent's Exhibit 4, pp 175-177). Petitioner was seen on September 26, 2011, for medications. His history of present illness was positive for dyspnea. His review of systems was positive for dyspnea and wheezing. On examination the chest was normal to percussion. He had normal breath sounds. No wheezing, rhonchi or rales/crackles were heard. The assessment included asthma (Respondent's Exhibit 4, pp 170-173).

Petitioner was seen on November 8, 2012, for throat pain and sinus pain. He had no sneezing, dyspnea or wheezing. He had cough and nasal discharge. On physical examination his lungs were clear to auscultation with no rales or crackles. The assessment was acute sinusitis and acute pharyngitis (Respondent's Exhibit 4, pp 163-166). Petitioner was seen on November 26, 2012. Active problems included extrinsic asthma NOS. It was noted that Petitioner had a history of dyspnea. Review of systems was negative for cough. His review of systems pulmonary was positive for dyspnea and wheezing. Physical examination revealed no wheezing, rhonchi or rales/crackles. The assessment included mild persistent asthma (Respondent's Exhibit 4, pp 157-162).

Petitioner was seen on February 18, 2013, with chief complaint of sinus problems. He had no dyspnea, coughing up sputum or wheezing at that time. He did have nasal discharge and cough. On physical examination his lungs were clear to auscultation and there were no rales/crackles. The assessment was acute sinusitis, chronic sinusitis and allergic rhinitis due to pollen (Respondent's Exhibit 4, pp 149-152). Pulmonary function test results were provided from testing performed by NIOSH on April 3, 2013. On the report the interpretation stated "Although the test results are below the normal limit, the

test results are not reproducible and cannot be accurately interpreted." (Respondent's Exhibit 4, p 148). Petitioner underwent a sleep study on October 11, 2013. The results of the study suggested that Petitioner had obstructive sleep apnea syndrome of moderate severity (Respondent's Exhibit 4, pp 146-147). On November 15, 2013, Petitioner was seen regarding some issues with his CPAP face mask. At that time review of systems was positive for dyspnea and cough as well as wheezing. Physical examination of the lungs showed normal breath sounds with no wheezing, rhonchi or rales (Respondent's Exhibit 4, pp 141-145).

Petitioner was seen for recheck on January 30, 2014. Under functional it was charted, "physical disability, but able to perform usual physical activities for age, physical disability does not affect ability to work, self-reliant in usual daily activities and no difficulty of activities of daily living." On review of systems pulmonary, he had dyspnea and wheezing but no cough. On physical examination the lungs showed normal breath sounds. Dr. James Alexander noted that rales/crackles were heard on the right at the base. No wheezing or rhonchi were heard. On this date Dr. Alexander's assessment included coal workers' pneumoconiosis (Respondent's Exhibit 4, pp 131-136). Petitioner was seen on November 5, 2014, with chief complaint of low back pain. Review of systems pulmonary revealed no dyspnea. Physical examination of the chest revealed normal breath sounds without wheeze, rhonchi or rales (Respondent's Exhibit 4, pp 123-126). Petitioner had no dyspnea or cough and the chest examination remained normal without wheeze or rale on November 26, 2014, December 1, 2014, and December 10, 2014 (Respondent's Exhibit 4, pp 104-115).

Petitioner was seen on July 28, 2015, with complaint of head congestion which started two days prior with cough and sinus congestion. Physical examination of the chest revealed the lungs were clear without wheeze, rhonchi or rale. The assessment was cough, sinusitis and allergic rhinitis (Respondent's Exhibit 4, pp 88-91). Petitioner returned on October 19, 2015, for yearly physical. Active problems included exercise induced asthma. Petitioner related dyspnea during exertion, but no chronic cough and no wheezing. He related being out of breath easily. He reported that he had seen a lung doctor a few months ago. He related that he was tired all the time. His review of systems pulmonary revealed dyspnea but no cough or wheezing. Physical examination of the chest revealed decreased breath sounds with rales bilaterally at the bases. No wheezing and no rhonchi were heard. The assessment included exercise induced asthma (Respondent's Exhibit 4, pp 76-81).

Petitioner was seen on January 15, 2016, with complaint of stomach problems. Review of systems pulmonary revealed dyspnea, but no cough. Physical examination of the chest revealed rales (Respondent's Exhibit 4, pp 69-72). Petitioner was seen for a recheck on January 29, 2016. Review of systems pulmonary revealed shortness of breath but no cough. Physical examination of the chest revealed the lungs to be clear to auscultation without rales or crackles (Respondent's Exhibit 4, pp 65-68). Petitioner was seen on March 16, 2016. Review of systems pulmonary revealed no dyspnea. Examination of

the chest revealed normal breath sounds without rales or crackles (Respondent's Exhibit 4, pp 56-58). Petitioner was seen on April 4, 2016. His review of systems pulmonary revealed no dyspnea. Physical examination of the chest revealed normal breath sounds without rales or crackles (Respondent's Exhibit 4, pp 53-55).

Petitioner was seen on October 3, 2016. Active problems included exercise induced asthma and non-organic sleep apnea with a CPAP. Potential issue at that visit was possible UTI. Petitioner reported that he was a never smoker. He reported having severe breathing difficulty. Family history was significant for respiratory disorder on his paternal side. Review of systems pulmonary showed no dyspnea or cough. On physical examination the lungs were clear to auscultation (Respondent's Exhibit 1, pp 37-40). Petitioner was seen on November 17, 2016, with a cat scratch on the left hand. Review of systems pulmonary was negative for dyspnea, cough or wheezing. Physical examination of the lungs showed normal breath sounds with no wheezing, rhonchi or rales heard (Respondent's Exhibit 4, pp 29-32). Petitioner was seen on December 27, 2016, with post nasal drip and cough. He was also complaining of chest congestion. On physical examination of the lungs there were no rales, rhonchi or wheezing heard. Assessment was acute sinusitis, allergic rhinitis and acute bronchitis (Respondent's Exhibit 4, pp 20-23).

Petitioner returned on January 12, 2017, with cough. This was a follow up for his sinusitis. He reported that he had gotten better initially, but the cough had returned and worsened. The cough was non-productive. Physical examination of the lungs was clear. Assessment was acute sinusitis and acute bronchitis (Respondent's Exhibit 4, pp 16-19). Petitioner was seen on June 16, 2017, for a tick bite and stomach problems. Review of systems pulmonary was negative for any dyspnea or cough. Physical examination of the lungs remained clear to auscultation (Respondent's Exhibit 4, pp 12-15). Petitioner was seen on August 23, 2017, for recheck of the abdominal pain as well as spots on his liver and lung. It was noted that he had recently had two CT scans of his abdomen which revealed a small cyst in his liver and a 4mm nodule in his right lower lung. Review of systems pulmonary showed no dyspnea, cough or wheezing. Physical examination of the lungs showed the chest was normal to percussion. He had normal breath sounds and no wheezing, rhonchi or rales (Respondent's Exhibit 4, pp 2-5).

Petitioner was seen on November 8, 2017, to discuss medications. His active problems continued to include exercise induced asthma and coal workers' pneumoconiosis. Under social history Dr. James Alexander noted Petitioner had severe breathing difficulty. On examination of his lungs, the chest was normal to percussion. His Nexium medication was adjusted (Petitioner's Exhibit No. 6). Petitioner was seen on December 18, 2017, for annual Medicare wellness examination. Petitioner reported dyspnea with exertion. He had no chronic cough or wheezing. On examination decreased breath sounds were heard. Rales/crackles were heard bilaterally at the bases. No wheezing or rhonchi were heard. The assessment was coal workers' pneumoconiosis, nonorganic sleep apnea and Barrett's esophagus (Petitioner's Exhibit No. 6).

Medical records of Dr. Suhail Kumar Tibrewala were admitted into evidence. Petitioner was seen on July 25, 2017, for abdominal pain and heartburn. His review of systems respiratory was negative for cough and dyspnea. On examination his lungs were clear to auscultation and percussion. The assessment was generalized abdominal pain, heartburn and history of colonic polyps (Respondent's Exhibit 5, pp 8-11). A CT scan of the abdomen and pelvis was performed on July 26, 2017. Same revealed a few atelectatic/fibrotic bands were seen in the right middle lobe and lingular segments (Respondent's Exhibit 5, p 4).

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did not sustain an occupational disease arising out of and in the course of his employment by Respondent.

In support of this conclusion the Arbitrator notes the following:

Dr. Istanbouly testified that Petitioner had a mild non-specific ventilatory limitation. He based this opinion on the pulmonary function testing performed on August 27, 2014. The spirometry report, however, stated the ATS reproducibility criteria were not met. Dr. Selby testified that the study of April 3, 2013, did not meet the ATS guidelines for reproducibility. Dr. Selby testified that for spirometry to be used for diagnostic purposes, it should meet the ATS reproducibility criteria. Dr. Selby testified that the testing performed as part of his examination on September 10, 2015, met the ATS reproducibility criteria. This spirometry did not reveal any evidence of obstruction or restriction in Petitioner. Dr. Selby concluded that Petitioner did not suffer from respiratory or pulmonary abnormalities as the result of coal mine dust inhalation or coal mine employment.

Dr. Michael Alexander, a board certified radiologist and B-Reader, interpreted chest x-rays for Petitioner dated March 14, 2011, and April 17, 2014, as positive for coal workers' pneumoconiosis. The chest x-ray of March 14, 2011, was interpreted by an A-reader and a B-reader of NIOSH as having no parenchymal abnormalities consistent with pneumoconiosis. Dr. Istanbouly is not an A-Reader or a B-Reader so he does not have the special training for interpreting chest x-rays for occupational lung disease that was described by Dr. Meyer. Dr. Meyer, a B-Reader and board certified radiologist, testified that there were no findings of coal workers' pneumoconiosis on the chest x-rays of March 14, 2011, and April 17, 2014. Dr. Selby, a board certified pulmonologist and B-Reader, interpreted films dated March 14, 2011, and April 17, 2014, as negative for pneumoconiosis.

The Arbitrator finds the opinions of Dr. Selby and Dr. Meyer to be more persuasive than those of Dr. Istanbouly and Dr. Michael Alexander.

Petitioner testified that he first noticed breathing problems eight or ten years before he retired. He testified that when doing physical labor he would get short of breath and would cough sometimes. He testified that his breathing problems have gotten worse over the years. Petitioner testified that he has turned down offers to go horseback riding and walking with a friend due to his breathing. He further testified that as of the date of trial, he could go back and do his last coal mining job of yardman/heavy equipment operator.

Dr. Selby testified that Petitioner's medical records from June, 1993, through February 2014, did not reveal a diagnosis of chronic bronchitis by his treating physician. Dr. Selby testified that Petitioner likely had asthma or another kind of bronchospasm but any bronchospasm he is now suffering would not be the result of coal mine dust inhalation, but rather due to genetics and prior viral infections. While Dr. James Alexander's records contain coal workers' pneumoconiosis on Petitioner's list of active problems, there is nothing in Dr. Alexander's treatment records on which he could have based a diagnosis of coal workers' pneumoconiosis. Dr. Selby testified that there was nothing in the January 30, 2014, office note of Dr. Alexander to base a diagnosis of coal workers' pneumoconiosis and that Dr. Alexander was likely parroting someone else.

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

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES WOOLSEY,

Petitioner,

19IWCC0461

vs. No: 15 WC 17712

GLOBAL BRASS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident (exposure to excessive noise), causal connection (to hearing loss), and permanent partial disability and being advised in the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained his burden of proving that he was exposed to excessive noise at the workplace which contributed to his hearing loss.

Testimony

Petitioner testified that in June 2014 he worked for Respondent and had since June 16, 2000. He retired on January 31, 2015. In the last two or three years of his employment he worked in the cupping department on a "government press." He identified where he worked in that capacity on a map and circled it. He also identified the hearing protection he wore, which he described as "little spongy ones." They were approved by Respondent and it was stipulated by the parties that they had a hearing protection rating of 33. He wore the hearing protection the whole time of his workday. If a worker did not wear the hearing protection, they would be written up.

Petitioner also testified he worked 8-16 hour shifts. The majority of his shifts were over 12 hours. When asked if he had hearing loss prior to his employment with Respondent, Petitioner responded "I took my physical and everything and if I had much of a hearing loss I wouldn't have passed my physical, let's put it that way." His hearing seemed to get worse during his employment with Respondent.

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Petitioner explained that the cupping area had 22 presses in which they stamped out shell casings and produced bullet jackets. It was not unusual for the ear plugs to come out and he would have to wipe his hands of lubricant and replace the plugs. He wants the Commission to award hearing aids so that he "can hear what everybody is saying" and be able to watch television without it blaring.

On cross examination, Petitioner agreed that he took a hearing test when he was first hired by Respondent. He would not dispute the results of that test but he asserted that when he was hired, he could "hear fine in conversations and stuff like that." Prior to working for Respondent he worked at an auto body shop for 23 years, where he was also required to wear hearing protection. In that job he used tools such as grinders and hammers. In his job with Respondent, when his ear plugs came out, they would remain out for only a short period of time. He believed his hearing remained the same since his retirement.

On redirect examination, Petitioner testified the auto body shop was not as loud as Respondent's plant. After leaving the auto body shop, his hearing was "about the same" as when he started there.

Mr. Joe Wickenhauser was called by Respondent for which he worked as safety director and was in charge of safety and health in Respondent's six plants in North America. He had been with Respondent for 30 years. He was in charge of hearing preservation and helped establish the guidelines for the hearing preservation protocol. He worked with audiologists and "of course" followed all OSHA and ANSI guidelines and standards. OSHA had reviewed their procedures twice "and were well pleased with what they reviewed." Mr. Wickenhauser was not familiar with Petitioner but he was familiar with the area in which he worked. He produced three differed type of plugs that Respondent provides. OSHA requires hearing testing annually.

On cross examination, Mr. Wickenhauser testified he had been safety director for about seven years. OSHA gets their information from NIOSH. He agreed that the OSHA guidelines for noise had not changed since 1983. He was not aware that NIOSH had recommended adjustment of the guidelines in 1996, nor was he familiar with the fact that "based on the OSHA guidelines pertaining to occupational noise exposure they directly address the difference between field attenuation and lab attenuation as it pertains to a noise reduction rating." The audiologist calculates the noise reduction/protection rating. Mr. Wickenhauser assumed, but was not certain, the audiologist followed the OSHA calculation in finding the filed attenuation for the noise reduction rating. He was not aware of the most recent recommendation of NIOSH regarding calculation of the field attenuation for noise reduction ratings.

On redirect examination, Mr. Wickenhauser testified that Respondent had civil and environmental engineers which perform studies which the audiologists use to determine the hearing protection that is necessary. He defers to the experts to create the standards and that they remain within OSHA standards.

On re-cross examination, Mr. Wickenhauser testified he did not know whether the audiologists use the OSHA standards from 1983 or the NIOSH recommendations from 1996.

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Noise/hearing protection data from December 31, 2010

The noise level at Respondent's facility ranged generally between 65 decibels and 95 decibels, with the majority appearing to fall in the 80s to 90s range. A 2006 noise survey noted 12 job categories with decibels exposure between 83 decibel and 98 decibels, with the OSHA noise PEL at 85 decibels. There is also a document which indicates that an area where Petitioner worked had an exposure of 103.4 decibels.

Doctors' depositions

Dr. Fletcher was deposed on June 21, 2017. He is board-certified in occupational environmental medicine and part of his training in occupational medicine was hearing preservation. He also had extensive training in hearing conservation in the military. Hearing is a major component of his practice in occupational medicine and his office tests hearing every day.

At the request of Petitioner's lawyer he saw Petitioner to offer an opinion on the nature and extent of his hearing loss and whether it was work-related. He administered an audiogram and reviewed prior audiograms; they all showed severe hearing loss of both speech-range and high frequency levels. Dr. Fletcher opined that Petitioner did suffer occupational hearing loss. His opinion was "based on the fact that he participated in a hearing conservation program for his employer." Dr. Fletcher was "provided some limited noise exposure surveys, information that provides some decibel determination of his exposure in the workplace." However, he noted that he did not have dosimeter records of Petitioner, which would trace the peaks and valleys of his exposure to noise, and which is the most accurate measure.

Dr. Fletcher explained that the toxicology of hearing loss is from both decibel levels and duration. The higher the decibels the lower duration of exposure is necessary to cause hearing loss. Using hearing protection is helpful in reducing the potential for hearing loss, but it's not foolproof. It has to be worn continuously, it has to be well-fitted, and the consensus in the occupational medical field is that the protection "offered by hearing protection is about 1/3 of what the manufacturer gives as far as noise reduction rates." So the hearing protection that Petitioner used at 33 would actually result in a reduction of 8-10 decibels.

Dr. Fletcher also testified that exposure of 85 decibels causes harm and "anything 95 and above, [he believed], would definitely cause work-related noise exposure." Dr. Fletcher acknowledged that Petitioner had some hearing loss prior to his employment with Respondent. However, it worsened at a rate higher than it would have been based on aging alone. He also took a detailed history of other potential contributors to hearing loss and Dr. Fletcher concluded that Petitioner's work-place exposure contributed to his hearing loss.

On cross examination, Dr. Fletcher agreed that he saw Petitioner only once, did not treat him, and did not recommend a particular hearing aid. Typically, he does not prescribe or fit hearing aids; he refers patients to an audiologist. He did not have information about the hearing protection devices at the time of his examination, but received it subsequently.

Dr. Fletcher was not aware of the specific hearing protection Petitioner used. He had not received any dosimeter readings but only "level spot checks on the floor plan." He did not have any information about Respondent's hearing conservation program. He did not know whether OSHA employed the formula that hearing protection provided about 1/3 of what the manufacturers claim.

On redirect examination, Dr. Fletcher clarified that he believed Petitioner would benefit from hearing aids and recommended bilateral hearing aids. He felt he had sufficient information to arrive at his opinions, which he stood by. Dr. Fletcher cited studies in which the real field attenuation was compared to brand label claims. Hearing protection does not always work, they oftentimes do not provide adequate protection, and sometimes employees do not use it properly.

On re-cross examination, Dr. Fletcher agreed that hearing protection provides some benefit, but they are not perfect and people can still develop noise-induced hearing loss when using hearing protection.

Dr. Mikulec was deposed on March 18, 2018. He is a board-certified otolaryngologist (ENT) as well as being board-certified in Neurotology, Otology, and skull surgery. He is a tenured professor at St. Louis University in the field. More than 90% of his practice involves treatment of the ear.

At the request of Respondent's lawyer, he performed a Section 12 medical examination on Petitioner on December 8, 2017. Petitioner "had a little difficulty locating the exact place where he worked, but he did identify something called the FW press as one of the main presses he worked on. He also spoke of something called a government press, which we were not able to locate in the paperwork." Dr. Mikulec noted that the "FW presses were listed as 100 decibels A-weighted, and the other locations were less."

Petitioner identified the hearing protection he used, which Dr. Mikulec discovered had a noise reduction rating of 33. Hypothetically, the use of the protection would result in a total exposure of 67, "if you just subtracted the NRR, but there is some debate regarding what is the correct correction factor used with NRR," which he summarized in his report. Using the correction factor most favorable to form a C-weighted sound measurement to an A conversion, would result in an NRR of 26. If one reduced that 50% to 13, that would reduce the 100 decibel exposure to 87 decibels, "which is still less than the 90 allowed by law" under the Illinois Workers' Compensation Act. According to Dr. Mikulec, even allowing for a 12-hour shift for three days a week, Petitioner's exposure was still lower than that allowable under law.

Dr. Mikulec noted that prior to his employment with Respondent Petitioner had "fairly significant" hearing loss; his 2000 audiogram showed a 33.3% hearing loss in the right ear. He also noted that Dr. Fletcher's testing on October 5, 2016 showed a 78% hearing loss in the right ear and 75% in the left ear. The testing done in Dr. Mikulec's office on December 8, 2017 showed 94% loss of hearing in the right ear and 91% in the left ear, which he believed was a significant progression in a year and two months, even though he retired in 2015. He also noted Dr. Fletcher's statement that because of his retirement, his occupational-related hearing loss would not get any worse, a statement with which Dr. Mikulec completely agreed.

Dr. Mikulec opined that Petitioner did not sustain occupational hearing loss working for Respondent. He based that on the significant progression of hearing loss after retirement, his significant hearing loss prior to his employment, and that even with the most aggressive correction of noise reduction rate, he was not exposed to noise in excess of Illinois law.

On cross examination, Dr. Mikulec testified that Petitioner mentioned that he worked in building 488 which was circled on the map and he identified the FW press. He agreed that the decibel reading from building 488 was between 91.4 to 101.7 decibels. However, Petitioner could not identify exactly where he worked in building 488, so he used the decibel levels in the FW press, which was "the most specific and loudest area that he could identify as definitively he worked in." He agreed that duration of exposure is an important factor in determining occupational hearing loss. But even assuming 12.1 hours of exposure, 87 decibels would be allowed. The table of allowable exposure is not adjusted for age.

Dr. Mikulec explained that because he does Section 12-type medical examinations, he keeps up with the "field versus actual attenuation" of the hearing protection devices. He relied in the OSHA standards and Illinois law in his calculations and considered the formula of using noise reduction of 1/3 of the rating to be speculative; he "would have to see a primary source document." He uses other calculation for Section 12-type examinations in Missouri. He then testified that both Illinois and Missouri defer to federal OSHA rules.

Dr. Mikulec agreed that the ultimate issue is what decibel levels and the duration of exposure Petitioner was exposed to. He indicated that exposure of 87 decibels was allowable for 12.2 hours and 88 decibels for 10.6 hours. However, even if he were exposed to decibel/duration above the allowable limit, that would not automatically translate to his having occupational hearing loss. He based his calculation on the NRR of 33, if it were 26 his calculations would be different.

Dr. Mikulec was not familiar with the "one-third correction factor" and he again would want to see a primary source document before commenting on that. He would be willing to submit an addendum report once provided such source material. Dr. Mikulec has not done independent research on the attenuation rating. Like Dr. Fletcher, he was not provided any dosimeter readings.

Dr. Mikulec reiterated that he used the base of 100 decibels which was the loudest level Petitioner identified. If he changed his calculation to use 103.4 decibels, he could also want to know the exact number and length of breaks. Exposure of 90 decibels for more than eight hours exceeds OSHA standards. Petitioner reported that he wore his ear protection for the entire time he was at work. He did not recall whether he asked Petitioner whether the plugs were properly fitted or shown how to use them.

Dr. Fletcher was deposed again on July 6, 2018. Dr. Mikulec's report did not change his opinions and he noted that Dr. Mikulec did not calculate noise exposure based on decibels greater than 100. He reiterated his believed that real hearing protection was 1/3 of lab results,

though he acknowledged that the actual attenuation rate was debatable. Dr. Fletcher again opined that Petitioner sustained occupational hearing loss.

Conclusions of Law

On the issue of accident, or exposure to noise, the Occupational Disease Act provides that an exposure of 90 decibels per day for an eight-hour period is the threshold for establishing a claim for hearing loss. In addition, the scale for establishing a cause of action adjusts whereby a higher level of decibel-exposure requires a shorter period of exposure. For example an exposure of 1 & ½ hours per day of 102 decibels is sufficient to be compensable. (See 820 ILCS 810/7(f)).

In looking at the entire record before us, the Commission finds that Petitioner sustained his burden of establishing that he was exposed to both eight hours a day of exposure to 90 decibels as well as occasional exposure to 103.4 decibels. We base that conclusion primarily on the noise data of Respondent's plant and Petitioner's unrebutted testimony that he worked in the area in which 103.4 decibels were recorded. Therefore, the Commission concludes that Petitioner has proved compensable exposure to excessive noise at his workplace.

The Arbitrator denied the claim based upon the evidence, or lack thereof, to support the Petitioner's argument that the hearing protection he used provided an actual noise reduction rating much lower than that contained on the ear plugs packaging. The manufacturer asserted that the rating was 33 decibels. If that were correct, then obviously the Petitioner would not have been exposed to noise levels deemed excessive by our statute.

The Commission disagrees with the Arbitrator. There was ample evidence to support the Petitioner's argument. Dr. Fletcher testified that in practice the manufacturer's rating was not considered to be the actual attenuation achieved in the workplace. Dr. Mikulec agreed and provided a formula based upon OSHA guidelines. Under the formula, the actual noise reduction provided by the ear plugs used by the Petitioner was 13 decibels. The Commission finds both doctors' testimony persuasive on this issue. As the Petitioner proved exposure to noise levels of 103.4 decibels, a reduction of 13 decibels by the ear plugs meant exposure above the levels set forth in our statute.

On the issue of causation, the Commission is aware that Petitioner had pre-existing hearing loss and that it worsened with age. Nevertheless, the Commission finds that Petitioner's exposure to excessive noise contributed to his current hearing loss, despite the use of hearing protection, (*See, Wagner Casing Co., v Industrial Commission*, 241 Ill. App. 3d 584 (4th Dist. IC Div., 1993), and despite conflicting testimony of expert witnesses, (*See, United State Steel Corp., v Industrial Commission*, 132 Ill. App. 3d 101 (1st Disc. IC div., (1985)). In this regard, we find the testimony of Dr. Fletcher persuasive. He opined that Petitioner's hearing loss accelerated at a rate higher than one would expect simply by the natural aging process. The record supports Dr. Fletcher's conclusions. Petitioner's 2000 audiogram showed a 33.3% hearing loss in the right ear. Petitioner worked for Respondent for the next 15 years and gave unrebutted testimony regarding the high levels of noise exposure. The next audiogram taken in 2016, approximately 1 & 1/2 years after his retirement, reflects a 78% hearing loss in the right ear and 75% hearing loss

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in the left ear. In addition, Respondent's Section 12 medical examiner, Dr. Mikulec, did not calculate his findings based on any exposure of over 100 decibels and noted that if he used the 103.4 decibel level in his calculations, he would want additional information concerning duration of exposure and breaks.

It is axiomatic in Illinois, under the Workers' Compensation and Occupational Diseases Acts, a claimant must prove only that the work-related accident/exposure was a factor in contributing to his/her current condition of ill-being. Therefore, the Commission finds that Petitioner sustained his burden of proving that he was exposed to excessive noise at the workplace which contributed to his hearing loss.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner sustained his burden of proving that he was exposed to excessive noise at the workplace which contributed to his hearing loss and the Decision of the Arbitrator dated December 31, 2018 is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $648.00 for a period of 70.36 weeks because the exposure to excessive noise at the workplace caused occupational hearing loss of 60.6% in the left and 69.7% of the right ear.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for hearing aids prescribed by an audiologist.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 26 2019

D. Douglas McCarthy

BNF-DDM/dw
O-7/15/19
46

Barbara N. Flores

Dissent

I respectfully dissent from the decision of the majority. I would have affirmed the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving that he was exposed to excessive noise resulting in a loss of hearing.

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While clearly not disparaging the general expertise of Dr. Fletcher, I agree with the Arbitrator that Dr. Mikulec, as a board-certified otolaryngologist (ENT) as well as being certified in Neurotology, Otology, and skull surgery, is more qualified to render an opinion on the causes of hearing loss than Dr. Fletcher, who is board-certified in occupational medicine. Dr. Mikulec testified that Petitioner's exposure to noise never exceeded OSHA standards and that his hearing loss was not caused by his work environment. Dr. Mikulec's findings were corroborated by the testimony of Mr. Wickenhauser who testified that Respondent's facility complied with all OSHA specifications and that the facility passed all prior OSHA inspections. In addition, Petitioner testified he always wore his hearing protection; they would be disciplined if they were found not wearing it.

Furthermore, in his calculations, Dr. Fletcher assumed that actual, real-world, hearing protection provided by protective devices is only 1/3 of the manufactures' lab results. Dr. Fletcher did not explain any basis for that assumption, except asserting that it was the "consensus" in the field of occupational medicine. While Dr. Mikulec acknowledged that OSHA accepts that protective devices provide only ½ of lab results, he had no knowledge of the correction to 1/3 of the lab results and wanted to see "a primary source document" to support such attenuation. Dr. Mikulec also persuasively testified that because he performs numerous Section 12-type examinations, he keeps himself informed on the latest developments on otology and standards within the industry.

Finally, in my opinion perhaps the most important factor in assessing the merit of this claim is that Petitioner's hearing got progressively and significantly worse after his retirement and therefore after his exposure to the allegedly offending noise stopped. Dr. Fletcher acknowledged that Petitioner's work-related hearing loss stopped when his exposure to work-related noise ceased. Dr. Mikulec wholeheartedly agreed with that statement. As illustration, Petitioner's audiograms showed a 33.3% hearing loss in his right ear in 2000. In October 2016 his hearing loss was 78%, which translates to a hearing loss of 45% loss over 15 years, or 3% loss per year. In contrast, in the year after his retirement, he went from 78% hearing loss to 94% hearing loss in the right ear and from 75% hearing loss to 91% hearing loss in the left ear. That translates to a 16% loss in each ear in a single year after his exposure to the noise in the work environment ended. The facts that Petitioner had significant pre-existing hearing loss, that Petitioner's hearing seriously deteriorated after his retirement and after his exposure of work-related noise ceased, support the finding that his hearing loss is caused by factors other than his work environment.

For the reasons stated above, I would have affirmed the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving that he was exposed to excessive noise resulting in a loss of hearing. Therefore, I respectfully dissent from the decision of the majority.

DLS/dw
O-7/15/19

Deborah L. Simpson

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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIRA CORTEZ,

Petitioner,

19IWCC0462

vs.

NO: 15 WC 37268

ARAMARK,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner sustained a stipulated compensable accident on October 9, 2015 when she tripped while carrying a tray of food. She claimed injury to her head, back, left knee, and right arm/shoulder. The Arbitrator found that Petitioner proved that the accident resulted in conditions of ill-being of her left knee, right shoulder, and lumbar spine. However, he found Petitioner not to be a credible witness and found she suffered only contusions and sprains in her accident. Based on that determination, the Arbitrator awarded $8,906.83 in medical expenses. He also denied medical expenses of $66,566.09 which he found were incurred after she had been declared at maximum medical improvement for all her conditions of ill-being and which were outside the allowable chain of referrals. The Arbitrator also awarded Petitioner 30.75 weeks of permanent partial disability benefits representing loss of 5% of the left leg for her knee injury and 4% of the person-as-a-whole for her lumbar and shoulder injuries.

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The Commission affirms the Arbitrator's findings that Petitioner suffered only sprains and contusions in her accident, his award and denial of various medical expenses, and his award of permanent partial disability benefits. In so doing, the Commission notes that Petitioner had no medical treatment other than physical therapy and actually declined a steroid injection offered for her back. In addition, Dr. Markarian, whose bill comprises the vast majority of the medical expenses denied by the Arbitrator, diagnosed and treated pathology not found by any of Petitioner's other treating doctors, Respondent's Section 12 medical examiners, or found in the imaging interpreted by the radiologists or the other treating doctors. Finally, in this case Petitioner's claim is predicated largely on her subjective complaints. The Arbitrator was in the best position to assess her veracity and credibility. The Commission sees no reason to disturb the decision of the Arbitrator on the issue of Petitioner's credibility. His determination of her lack of credibility is supported by her inconsistent complaints and her two functional capacity evaluations ("FCE"). The first FCE was deemed invalid due to inconsistent effort. Her second FCE was considered valid even though she was found to have exhibited seven out of a possible 16 positive Waddell signs.

The Arbitrator denied any temporary total disability benefits because he found that she had not proven that she was entitled to any based on the minimal nature of her injuries, her questionable performance in the FCEs, and her lack of any good-faith job search. The Commission generally agrees with the analysis of the Arbitrator in this claim. Nevertheless, the Commission acknowledges that Petitioner did suffer work-related injuries which resulted in a period of time in which she was not able to work. Petitioner testified that she last worked on November 13, 2015. That testimony was not rebutted. The doctor treating her lumbar spine, Dr. Chunduri, found her at maximum medical improvement in April 2016, but released her from treatment on May 18, 2016. Petitioner had been previously declared at maximum medical improvement and released from treatment for her other conditions of ill-being. The Commission finds an award of temporary total disability benefits from November 13, 2015 to May 18, 2016, for a total of 26&6/7, weeks is appropriate in this claim and modifies the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $317.65 per week for a period of 26&6/7 weeks, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that pursuant to §8(a) Respondent pay medical expenses of $454.00 to Dreyer Occupational Clinic, $562.82 to Illinois Orthopedic Network, $745.00 to G&T Orthopedics, $1,600.00 to Premier Therapy, and $5,545.00 to 4Pro Physical Therapy, subject to the applicable medical fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that pursuant to §8(d)2 Respondent pay Petitioner $285.88 a week for 30.75 weeks because the injuries sustained caused the loss of the use of 5% of the left leg and 4% of the person-as-a-whole.

19IWCC0462

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,000.00. 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 26 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-8/15/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0462

CORTEZ, KIRA
Employee/Petitioner

Case# **15WC037268**

ARAMARK
Employer/Respondent

On 7/18/2018, 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 2.14% 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:

1920 BRISKMAN BRISKMAN & GREENBERG
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

19IWCC0462

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

Kira Cortez
Employee/Petitioner

v.

Aramark
Employer/Respondent

Case # **15** WC **37268**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **March 20, 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 **October 9, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**4,288.20**; the average weekly wage was $**476.47**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**2,766.73** for other benefits, for a total credit of $**2,766.33**.

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 $454.00 to Dreyer Occupational Clinic, $562.82 to Illinois Orthopedic Network, $745.00 to G & T Orthopedics, $1,600.00 to Premier Therapy, and $5,545.00 to 4Pro Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $285.88/week for 10.75 weeks, because the injuries sustained caused the 5% loss of the Left Leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $285.88/week for 20 weeks, because the injuries sustained caused the 4% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall be given credit for $2,766.33 for benefits paid under the Act.

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

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

Signature of Arbitrator

July 13, 2018
Date

JUL 18 2018

Statement of Facts

Petitioner Kira Cortez testified that on October 9, 2015, she was a middle school manager for the lunch program for Respondent. She was responsible for the kitchen including shipping and ordering. She testified ~~that on October 9, 2015, she was carrying a tray of tuna when she caught her foot on a raised electrical socket~~ and tripped and fell to the ground. She testified that her extended right arm went thru a cart and that she fell on both knees to the ground. She testified she felt pain in her right shoulder, both knees and back.

Petitioner was taken to Delnor Hospital emergency department on the day of the accident. Petitioner gave a history of tripping over an object. She said she fell down onto both knees and struck the top of her head on a rolling cart. She complained of bilateral knee pain, worse on the right, and low back pain. She refused any pain medication. Physical examination was limited to the back and right knee. The exam notes that Petitioner's weight was 356 pounds. X-rays of the back and right knee were negative. Petitioner was diagnosed with a right knee contusion and lumbar sprain. She was given work restrictions until cleared by the company doctor (RX 5).

Petitioner treated at Dreyer Medical Center beginning October 13, 2015 (PX 1). Her handwritten statement of injury reported a fall after tripping over an electrical box hitting head and face on a metal/hard plastic cart and knees and hands to the ground. Petitioner stated her pain was located in the bilateral; knees. Left is worse with pain mostly to the lateral part of the left knee. She complained of right arm pain from the right shoulder extending to the elbow, and right-hand pain. She complained of right lumbar back pain. Examination was positive for tenderness to the right lumbar paraspinals; a slightly antalgic gait; tenderness at the posterior right shoulder and upper arm; limited range of certain motions of the shoulder; pain with impingement testing; bilateral patellar tenderness; and left lateral knee pain with McMurray testing. The diagnosis was strain of the right upper arm, contusion of the knee, and lumbar strain. She was prescribed physical therapy, prescribed Flexeril, and limited to no climbing, bending, or stooping; a 10-pound lifting limit; and no over the shoulder lifting (PX 1). Petitioner testified she did return to light duty work.

Petitioner began physical therapy on October 21, 2015. She reported no improvement in her back and right arm. Her right knee had improved and her left knee had worsened. Physical therapy was performed to the low back, right shoulder, and left knee. On October 27, 2015, Petitioner reported that her left knee was improved but her back pain and right shoulder and arm pain had not improved. She reported she is doing desk work but after 5 hours, is in a lot of pain from sitting in her chair. She was continued in physical therapy and kept on work restrictions. On November 10, 2015, Petitioner reported she is still not doing much better. Her right shoulder pain is better, but the left knee pain is still there and her back pain has not changed and is still severe. Physical examination did not demonstrate any numbness or tingling in her legs. Straight leg raising was negative for leg pain. Strength and reflexes were normal. There was no obvious swelling or effusion of the left knee. There was limited range of motion. Petitioner was advised to use ice several times per day and heat as needed. She was advised to increase activity as possible. She was continued on restricted work duty and scheduled for a follow up on December 1, 2015 (PX 1). Petitioner did not return. She testified that she worked restricted duty to November 12, 2015 but stopped because she was not able to do it.

Petitioner next sought care from Dr. Phillip Gattas, D.C. at 4Pro Physical Therapy on November 12, 2015 (PX 4A). His record notes no referral, direct access. Petitioner reported she decided to seek care elsewhere. Petitioner complained of pain in the back along the waistline, left knee and right shoulder. His physical examination noted no limitation in range of motion in the shoulder, knee and lumbar spine and normal

reflexes. Muscle strength could not be assessed due to complaints of pain. Dr. Gattas referred Petitioner for physical therapy at 4Pro beginning November 13, 2015 through November 30, 2015. Petitioner reported varying improvement and increases in her pain in the knees, right shoulder and back. On November 16, 2015, she noted primarily back pain. The right shoulder only hurts when moving or weight bearing. She reported improvement in her back pain on November 19, 2015. On November 23, 2015, she reported no shoulder pain and minimal low back pain (PX 4A).

Petitioner sought treatment from Dr. Samir Sharma at Pain & Spine Institute on November 23, 2015 (PX 3). His intake paperwork does not reflect any referring physician. The Petitioner's pain diagram reflects left knee pain, pain in the right shoulder and upper arm, and pain in the back without radiation into the legs. He notes the history of accident and treatment with Delnor Hospital, Dreyer Clinic, physical therapy and chiropractic. Petitioner noted her back pain does not radiate. His assessment was lower back pain, osteoarthritis of the knee, shoulder pain and upper back pain. He scheduled a lumbar MRI (PX 3, PX 2). The December 22, 2015 lumbar MRI showed 2mm central disc protrusions indenting the thecal sac at L2-3, L4-5, and L5-S1 (PX 2).

Dr. Sharma referred Petitioner to Dr. Krishna Chunduri (PX 3). Petitioner saw Dr. Chunduri on January 18, 2016. She complained of left knee pain and right shoulder pain, but most of all low back pain and into the back of her thighs. Dr. Chunduri diagnosed lumbar spondylosis, right shoulder pain, and left knee pain. He ordered continued physical therapy (PX 2). Dr. Chunduri ordered an MRI of the right shoulder and left knee. Petitioner underwent these MRIs on February 6, 2016. The radiologist read the right shoulder MRI as showing a partial tear of the supraspinatus tendon, a subchondral bone cyst, and small subacromial/subdeltoid effusion. The MRI of the left knee showed degenerative arthritis, swelling, cystic lesions, Baker's cyst, and knee joint effusion. A February 8, 2016 EMG of the lower extremities was possibly positive for right radiculopathy (PX 2).

Petitioner was seen by Dr. Kevin Tu at Dr. Chunduri's request to evaluate her right shoulder and left knee complaints (RX 1). She complained of difficulty in overhead reaching. She notes burning and decreased range of motion as well as partial giving way episodes in her knee. Dr. Tu noted the right shoulder MRI was negative for a full-thickness rotator cuff tear. There is a small partial thickness rotator cuff tear present. The left knee MRI is negative for meniscus tear. There are some early degenerative changes. He diagnosed right shoulder impingement and a left knee contusion. He recommended continued physical therapy. He released Petitioner to return to work with restrictions (PX 9, RX 1). Petitioner continued therapy at 4Pro (PX 4B). On March 17, 2016, Dr. Tu noted Petitioner has had significant improvement. She has no difficulty with her knee and shoulder. His physical examination of the shoulder and knee are completely negative with full range of motion, no effusion, no tenderness. He released Petitioner to return to full duty with respect to the knee and shoulder. He discharged her from his care (PX 9, RX 1).

Dr. Chunduri saw Petitioner on March 9, 2016. She complained of lower back pain and numbness radiating into her legs. He noted the EMG is consistent with L5 radiculopathy. He diagnosed lumbar spondylosis with bilateral radiculopathy and recommended L5 epidural steroid injections. On April 20, 2016, He noted Petitioner did not wish to proceed with any further invasive treatment including injections. He placed her at MMI and scheduled a functional capacity evaluation (PX 2). The FCE performed at Premier Physical Therapy on April 29, 2016 was considered valid and placed Petitioner at the sedentary physical demand category. Petitioner had 7 positive non-organic signs. To be an invalid result requires 9 positive signs. She was noted to have scored greater that 50% on the pain questionnaire (PX 10). On May 18, 2016, Dr. Chunduri released Petitioner to return to work per the FCE and found her at MMI (PX 2).

Petitioner testified that she was not happy with Dr. Tu's care. She chose to seek treatment from Dr. Gregory Markarian on March 22, 2016. Petitioner provided a consistent history of her accident. She reported that she experienced an acute onset of right shoulder, bilateral knee and back pain. Petitioner stated that Dr. Tu discharged her despite the fact that she has continued pain in her right shoulder and both knees, and swelling in both knees. Dr. Markarian found the prior MRI studies of insufficient quality. He diagnosed a right knee medial meniscus tear, a left knee possible ACL tear with medial meniscus tear and a partial thickness tear of the rotator cuff with tendinitis in the right shoulder. He ordered new MRI studies of both knees and MRI arthrogram of the right shoulder (PX 12). Petitioner began physical therapy on March 28, 2016. On May 24, 2016, Dr. Markarian noted improvement in the right knee and right shoulder range of motion with less pain. He took Petitioner off work. He noted that she continued to improve on June 14, 2016 and July 26, 2016. He continued to keep Petitioner off work (PX 12).

On August 30, 2016, Dr. Markarian noted that Petitioner's right knee is not bothering her any more. Her right shoulder is improving. He was just focusing on the left knee. He released Petitioner for sedentary work. On October 25, 2016, he noted tenderness along the medial joint line with positive McMurray and Steinman's tests. He continued therapy and took Petitioner off work (PX 12). An MRI of the left knee performed at his request on October 28, 2016 was read as showing an intact ACL and PCL. There was a mild infra substance signal within the medial and lateral meniscus without evidence of a tear. There was some joint effusion and a Baker's cyst (PX 12). Dr. Markarian stated that he thought she may have a partial tear near the femoral insertion. He continued treatment with therapy and anti-inflammatories and kept Petitioner off work (PX 12).

Dr. Markarian testified by evidence deposition taken January 19, 2017 (PX 13). He testified to his treatment and his initial diagnosis. He testified that on the history provided, his preliminary opinion was that the accident could have caused or aggravated the conditions diagnosed. He noted that the right knee and right shoulder improved with physical therapy. He noted risks of surgery due to Petitioner's obesity. He opined that his diagnosis on the left knee was a partial ACL tear and meniscus tear. As of the date of the deposition, he felt Petitioner could do sedentary work. Dr. Markarian testified Petitioner reported immediate onset of right shoulder pain. He testified that if the onset was not immediate, that would not change his opinion. He did not review Dr. Tu's records. He did not note any left knee symptoms in his May 24, 2016 or June 14, 2016 office notes. He disagreed with the radiologist findings on the October 28, 2016 left knee MRI (PX 13).

On February 21, 2017, Dr. Markarian stated that Petitioner was at maximum medical improvement and scheduled an FCE (PX 12). The March 9, 2017 FCE performed at ATI was invalid. The therapist noted inconsistencies in grip and resistant dynamometer readings, heart rates and pain behavior reports (PX 11). Petitioner testified that the examiner required her to crawl, squat and kneel, which resulted in intense pain in her right shoulder and both knees. On March 21, 2017, Dr. Markarian reviewed the FCE and noted that it was determined to be invalid. He stated he was not sure what that was based off of but felt it was inappropriate for the FCE examiner to require Petitioner to attempt kneeling and crawling due to her pathology. Dr. Markarian overruled the FCE and placed permanent light duty restrictions on Petitioner as a result of the work accident. He placed Petitioner at MMI (PX 12).

Petitioner attended a Section 12 examination with Dr. Lawrence Lieber on January 13, 2016. She complained of low back pain, left knee symptoms with bending and using stairs, and her right shoulder caused difficulty with overhead activity and stiffness. She had no complaints regarding the right knee. After examining Petitioner, and reviewing records and MRI films, Dr. Lieber diagnosed status post contusion of the right shoulder, low back strain, right knee contusion, and left knee strain causally related to the accident based on

Petitioner's history (RX 2, Ex. 2). Dr. Lieber testified by evidence deposition taken January 10, 2017 (RX 2). He testified to his findings in Petitioner's right shoulder. He testified that overall, she had a shoulder that bothered her with activity. There was no isolated abnormality other than shoulder pain with activity and some weakness due to pain. His examination of the right knee was normal. The left knee was normal other than subjective complaints of pain. He noted the lumbar spine MRI showed degenerative disc disease. He did not find any nerve root impingement. He opined that Petitioner's subjective complaints were related to pre-existing degenerative abnormalities. No future treatment was necessary. Petitioner had achieved maximum medical improvement and was able to return to full duty. Dr. Lieber testified he has not reviewed Dr. Markarian's records. The right shoulder symptoms he noted would be consistent with a partial tear of the supraspinatus. The left knee symptoms would not be consistent with a partial tear of the ACL (RX 2).

Petitioner was examined by Dr. Nikhil Verma at the request of the Respondent on June 1, 2016. Dr. Verma testified by evidence deposition taken July 26, 2017 (PX 3). Dr. Verma testified to Petitioner's prior history of anxiety and depression. Petitioner complained of bilateral knee pain and right shoulder pain. On physical examination Dr. Verma notes she was 5' 5" inches tall and weighed 360 pounds. He noted a normal gait. The only finding was tenderness of the left knee. She had a normal examination of her right shoulder. He testified that the right shoulder MRI showed typical age related degenerative rotator cuff changes. The left knee MRI was normal with the exception of mild degenerative change in the patellofemoral compartment. He reviewed records from the date of accident until the April 29, 2016 FCE. Dr. Verma concluded Petitioner's diagnosis was bilateral knee contusions with mild preexisting arthritis and right shoulder contusion. He opined that Petitioner's condition had resolved. Petitioner's knee complaints were consistent with osteoarthritis related to her morbid obesity. The treatment that he reviewed was reasonable and related to the accident. No additional treatment was necessary. Petitioner was able to return to full duty (RX 3).

Dr. Verma testified that he reviewed additional records thereafter including Dr. Tu's March 17, 2016 notes, Dr. Markarian's records through December 6, 2016 and the MRI films. He maintained his opinions from the June 1, 2016 examination. He testified that an O'Brien's sign is not relevant if there is no indication of a SLAP tear. He disagreed with Dr. Markarian that the MRI of the left knee showed any evidence of partial tear. His interpretation of the MRI is consistent with both radiologist's interpretations and with Dr. Tu. He did not perform a McMurray or Steinman test because there was no sign of a meniscus injury (RX 3).

Petitioner was examined by Dr. Carl Graf, a spine surgeon, on July 8, 2016 at the request of the Respondent. Dr. Graf testified by evidence deposition taken January 8, 2018 (RX 4). He testified to his review of records per his report (RX 4, Ex. 2). Petitioner complained of low and mid back pain at 8-9/10 with medication and both legs go numb. Dr. Graf examined Petitioner. He recorded her weight as 370.5 pounds. He documented seven non-organic findings. He noted various inconsistencies on examination. Petitioner rated her disability as extreme. This is inconsistent with a person able to walk in and out of an examining room. After examining Petitioner and reviewing records, Dr. Graf opined Petitioner was malingering. There was a lack of objective findings to support her complaints. Her complaints were not related to the accident. Any treatment for the spine other than two to three weeks of physical therapy was not reasonable. No additional treatment was necessary. Petitioner was able to return to full duty work. Dr. Graf testified that his examination was limited to the spine. His opinions, including his opinions regarding malingering, were limited to the spine. His reading of the MRI was essentially the same as the radiologist's. The 2-millimeter disc protrusion would be more of a degenerative finding, not an acute disc herniation. He opined that there was no aggravation of the lumbar degeneration. Petitioner had a strain (RX 4).

Petitioner testified that she has been off work since November 13, 2015. When she received Dr. Markarian's March 21, 2017 restrictions. She started looking for work. She applied at Organic Life and at Sodexo. She testified that she contacted Respondent and was told they could not meet her restrictions. She has had no other contact with potential employers, but her resume is on Indeed.com. She has applied for SSDI. She has had no prior or subsequent injuries to her low back, knees, or right shoulder. She agreed that she had labored breathing after walking from the back of the hearing room to the witness stand. She testified that this did not have anything to do with her application for SSDI. She testified that physical therapy provided temporary relief.

Petitioner testified that she weighed 250 pounds at the accident and has gained 150 pounds since then. She testified that she has pain every day in her back, both knees and her right shoulder. Her symptoms come and go. Currently, her right knee is worse than her left knee. Her legs are swollen. She notices pain with showering, dressing, putting on shoes, standing, walking, lifting, using the bathroom, and playing with her nieces and nephews. She takes Tramadol, Soma, and Ibuprofen. She gets prescriptions through Dr. Markarian or her family doctor. She also takes over the counter Tylenol.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). Petitioner sustained an undisputed accident on October 9, 2015, when she caught her foot on a raised electrical socket and tripped and fell. The dispute is as to what body parts were injured and what conditions of ill-being were caused or aggravated by the accident.

Body Parts Injured:

Petitioner has provided a consistent history of falling over the raised electrical socket while carrying a tray. At the Delnor Hospital emergency department on the day of the accident. She said she fell onto both knees and struck the top of her head on a rolling cart. She complained of bilateral knee pain, worse on the right, and low back pain. Her first complaints of right shoulder pain were at Dreyer Medical Center beginning October 13, 2015. Petitioner stated her pain was located in the bilateral; knees. Left is worse with pain mostly to the lateral part of the left knee. She complained of right arm pain from the right shoulder extending to the elbow, and right-hand pain. Thereafter, Petitioner has complained of pain to various degrees in her back, both knees and right shoulder. While there is further dispute as to the nature of the Petitioner's condition of ill being in the knees and back, Petitioner's treaters have found some condition of ill being in the back and knees. Respondent's experts have opined that Petitioner suffered at least a lumbar sprain and contusions or strains to both knees. The medical evidence is in agreement that Petitioner sustained at least some condition of ill-being to the, low back and both knees.

Petitioner has advanced ongoing right shoulder complaints since her October 13, 2015 visit to Dreyer Clinic, and to Dr. Gattas, Dr. Sharma, Dr. Chunduri, Dr. Tu and Dr. Markarian. She has undergone an MRI and has been treated with medication and physical therapy. Dr. Verma has also diagnosed a right shoulder sprain. Dr. Lieber, while disputing Petitioner's shoulder condition was causally related to the accident, diagnosed a right

shoulder sprain causally connected to the accident based upon Petitioner's history and agreed that Petitioner's symptoms could be consistent with the partial tear of the supraspinatus. Dr. Markarian noted that the delay in reporting the right shoulder symptoms would not change his opinion on causation. The Arbitrator finds that, given the mechanism of injury, Petitioner's claim of injury to the right shoulder is persuasive. The short delay in advancing her symptoms are not inconsistent with the accident sustained.

Conditions of Ill-Being and MMI Findings:

The nature of Petitioner's conditions was addressed by the treating medical providers and Respondent's evaluating physicians. 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, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). 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 evaluating the opinions, diagnoses and treatment of the various experts, the Arbitrator notes that an important component in their decisions was the evaluation of Petitioner's subjective complaints advanced. Therefore, the Arbitrator's assessment of the credibility of the Petitioner's subjective presentation is an important factor in determining the weight to be given to the various medical opinions. The Arbitrator notes that Petitioner's presentation has been inconsistent and varied during her testimony and the course of her care. Her representation of the nature and intensity of her pain has not been consistent. As noted above, she did not initially complain of her right shoulder. She consistently notes improvement with treatment to the right shoulder, and is released by both Dr. Tu and Dr. Markarian. Yet she now advances multiple complaints.

Her knee symptoms also vary. Her initial knee complaints were greater on the right. By October 21, 2015, her right knee is improved and treatment is to the left knee only through her release by Dr. Tu. She advanced no right knee complaints to Dr. Lieber or Dr. Verma. Yet she complains and gets treatment from Dr. Markarian to the right knee which he states is improved by August 30, 2017 and at trial she testified the right knee is worse that the left despite the lack of any objective findings on examination or MRI. Dr. Tu noted no complaints and his physical examination noted no swelling and full range of motion. Yet Petitioner presented to Dr. Markarian with a history of ongoing pain and swelling.

The Arbitrator notes that her claim to have gained weight after the accident is impeached by the medical records. While her 2012 driver's license lists her weight as 225 pounds. She was noted to be 356 pounds at the emergency room. Dr. Verma notes a weight of 360 pounds and Dr. Graf notes her weight in July 2016 only months after the accident is 370.5 pounds. The Arbitrator also notes that Petitioner denied any radiating pain

in both her complaints to Dr. Sharma and the pain diagram that she prepared in November 2015. Complaints in her buttock did not arise until January 2016. The Arbitrator also notes the March 17, 2016 note of Dr. Tu documenting both the lack of objective findings and Petitioner's lack of any complaints in his release to full duty at that time.

The Arbitrator notes that the diagnostic studies found a paucity of pathology. Petitioner's 2017 FCE was invalid for multiple inconsistent responses. The April 2016 FCE, while stating it was valid, also noted 7 inconsistent responses, only two fewer that the standard for finding the FCE invalid.

Given the extensive inconsistency in Petitioner's testimony and medical records, the Arbitrator finds ample support of Dr. Tu's release of Petitioner to full duty at MMI for the shoulder and left knee and Dr. Chunduri's MMI finding in May 2016. The opinions of Dr. Lieber, Dr. Verma and Dr. Graf that Petitioner's subjective complaints are out of proportion to her objective findings support the MMI finding. While the Arbitrator finds that Dr. Lieber's January 2016 MMI finding is slightly premature based on his finding of ongoing shoulder symptoms with activity and the treatment recommendation of Dr. Tu and Dr. Chunduri which resulted in improvement of the symptoms, it is ultimately supported by the subsequent opinions of Dr. Tu, Dr. Chunduri, Dr. Verma and Dr. Graf.

The Arbitrator also finds persuasive the testimony of Dr. Lieber, Dr. Verma and Dr. Graf that the diagnostic studies did not demonstrate any acute pathology other that age appropriate degeneration. The Arbitrator finds the opinions advanced by Dr. Markarian unpersuasive and contradicted not only by the multiple evaluating experts but also the prior treaters including the radiologists who read the MRI studies, Dr. Tu and Dr. Chunduri.

Based upon the record as a whole, the Arbitrator finds that, as a result of the accidental injury sustained on October 9, 2015, Petitioner sustained the following conditions of ill being:

1. A right knee contusion which reached MMI as of October 21, 2015
2. A left knee contusion and sprain which reached MMI as of Dr. Tu's release to full duty on March 17, 2016.
3. A right shoulder sprain and temporary aggravation of a degenerative partial tear of the supraspinatus which reached MMI as of Dr. Tu's release to full duty on March 17, 2016.
4. A lumbar sprain which reached MMI as of Dr. Chunduri's finding of MMI on May 18, 2016

The Arbitrator finds that any other claimed condition of ill-being to the multiple body parts involved or any condition treated after the dates said conditions reached MMI are not causally related to the accident.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). In weighing the reasonableness and necessity of treatment, the Commission considered the medical opinions presented. Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts.

Madison Mining Company v. Industrial Commission, 309 Ill. 591, 138 N.E. 211 (1923). In determining the reasonableness and necessity of treatment, the Commission also has considered whether the records demonstrate subjective or objective improvement or whether the treatment failed to provide demonstrable benefit. *Hugo Alvarez v AMI Bearings, 16 IWCC 0408; Nelson Centeno v. Minute Men, 13 IWCC 0914, affirmed Centeno v. Illinois Workers' Compensation Commission, 2016 IL App (2d) 150575WC-U; 2016 Ill. App. Unpub. LEXIS 1261.*

Based upon the Arbitrator's finding with respect to Causal Connection, all treatment following the findings of MMI would not be related to the accident. The Arbitrator also finds the treatment by Dr. Markarian was not reasonable or necessary based upon the persuasive opinions of Dr. Lieber, Dr. Verma and Dr. Graf as well as the MMI opinions of Dr. Tu and Dr. Chunduri.

Further, Petitioner's choices of medical providers are limited in number pursuant to the provisions of Section 8(a) of the Act. The Arbitrator notes that Petitioner initially sought treatment through the employer at Delnor Hospital and Dreyer Clinic. She then on her own sought chiropractic treatment with Dr. Gattas. She then chose treatment without referral by Dr. Sharma. Dr. Sharma referred her to Dr. Chunduri who referred her to Dr. Tu for her shoulder and left knee. These constitute her two choices of medical. She thereafter chose to treat with Dr. Markarian as a third choice. The employer is not responsible for bills for this third choice by Petitioner.

The Arbitrator has reviewed the billing submitted by Petitioner contained in PX 3, PX 4B, and PX 5-12 and the medical records admitted detailing the treatment received. The Arbitrator finds that the bills detailed in PX 7(EQMD for $1,830.73), PX 8 (Windy City RX for $$1,250.00), PX 11 (ATI for $3,024.36), and PX 12 (Orthopedic Associates of Naperville for $60,461.00) are for services after the MMI dates, are not reasonable, necessary, causally related or within an allowable chain of referrals and are denied.

The Arbitrator finds that the bills detailed in PX 2 (Illinois Orthopedic Network for $562.82), PX 5 (Dreyer Occupational Clinic for $454.00), PX 9 (G & T Orthopedics for $745.00), and PX 10 (Premier Therapy for $1,600.00) were for causally connected treatment and based upon the records of Dr. Chunduri and Dr. Tu and the opinion of Dr. Verma that treatment before his examination was reasonable and necessary, the Arbitrator finds this treatment reasonable and necessary.

PX 4B contains the billing from 4Pro Physical therapy for treatment from December 2, 2015 through March 21, 2016 totaling $6,046.00. The Arbitrator notes that the therapy was ordered by Dr. Tu and would be reasonable and necessary up to his release of Petitioner at MMI. The records only contain visit notes through March 8, 2016. The visits on March 17, 2016 and March 21, 2016 are not contained in the records and would be after Dr. Tu's discharge. The $510.00 charged for these two visits is denied.

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $454.00 to Dreyer Occupational Clinic, $562.82 to Illinois Orthopedic Network, $745.00 to G & T Orthopedics, $1,600.00 to Premier Therapy, and $5,545.00 to 4Pro Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Benefits under the Act may be suspended or terminated if an employee refuses work falling within the physical restrictions prescribed by his doctor. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n, 236 Ill. 2d 132, 146, 923 N.E.2d 266, 337 Ill. Dec. 707 (2010).*

Petitioner was initially released to desk work by Dreyer Clinic. Work within her restrictions was provided by Respondent and Petitioner performed these duties. On November 10, 2015 Petitioner was advised at Dreyer Clinic to continue light duty so as not to aggravate her discomfort through December 1, 2015, the next scheduled visit. Instead, she was seen by Dr. Gattas on November 12, 2015 who took her off work until examined by the pain management doctor. No clear medical reason was given other than to prevent further injury. The Arbitrator does not find a valid basis for believing that desk work could cause further injury. The Arbitrator also finds significant that Dr. Sharma did not provide a further off work slip after his November 23, 2015 visit.

As more fully addressed in the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds Petitioner's subjective complaints to be unpersuasive. The Arbitrator finds that the off-work decisions by Dr. Chunduri are in large part based upon these subjective complaints of pain and the ordering of additional diagnostic testing based upon the complaints. The Arbitrator has previously noted the paucity of objective acute finding on those tests. The Arbitrator finds that the Petitioner was able at all times to perform the offered restricted work duties through reaching MMI for her related conditions of ill-being and is therefore not entitled to temporary total disability.

As more fully discussed in the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds the opinions of Dr. Markarian unpersuasive and contrary to the remainder of the treating medical evidence and Respondent's examining physicians. The release to full duty work by Dr. Tu for the shoulder and knees is supported by Dr. Verma and Dr. Lieber. The opinion of Dr. Chunduri that Petitioner is restricted to sedentary duty for her low back is based upon the FCE which the Arbitrator previously noted is only 2 factors short of being invalid. The FCE findings are based in large part on Petitioner's effort and presentation and the Arbitrator does not find the FCE or Dr. Chunduri's opinion that the Petitioner needs restrictions persuasive in light of the opinions of Dr. Lieber and Dr. Graf. The Arbitrator adopts the findings of Dr. Graf that Petitioner is capable of performing her full duty job as of the date of Dr. Chunduri's MMI finding.

The Arbitrator also recognizes that Petitioner has made little effort to find employment since March 2017 when even Dr. Markarian released her to return to work and found her at MMI. The efforts described of three contacts would not constitute a good faith job search. The Arbitrator has considered the subsequent invalid FCE as a further indication of Petitioner's lack of credible subjective presentation.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she is entitled to any temporary total compensation.

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 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 school kitchen manager at the time of the accident and that, based upon the opinions of Dr. Tu, Dr. Lieber, Dr. Verma and Dr. Graf, she is able to return to work in her prior capacity as a result of said injury. The Arbitrator notes that Petitioner has advanced numerous subjective complaints and protestations of disability which the Arbitrator finds are not supported by the persuasive weight of the medical evidence and that she has made little effort to find employment despite her release from care over a year ago. Because of these facts, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 33 years old at the time of the accident. Petitioner would be considered a younger worker and would be expected to experience the effects of her disability over a longer period of time. However, as noted above, the Arbitrator does not find the Petitioner's presentation and subjective complaints persuasive or causally connected to the accident. The related conditions and disabilities as noted above would not be expected to cause Petitioner the level of difficulty with which she presented. Because of this, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that, based upon the findings above with respect to Causal Connection, Medical and Temporary Compensation, the Petitioner is able to return to her regular work with respect to the causally connection conditions of ill-being. She has not returned to work and has made little effort to find employment despite her release to return to work by every treating doctor. Because of this, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the Petitioner's subjective complaints of disability are not persuasive. Nor are the opinions of Dr. Markarian which are contradicted by the opinions of every treating physician, diagnostic test, the opinions of Dr. Lieber, and the persuasive opinions of Dr. Verma and Dr. Graf. The diagnostic tests document limited degenerative finding in the lumbar spine, osteoarthritis in the left knee and some degenerative findings in the right knee. The MRI of the right shoulder noted a partial tear of the supraspinatus tendon. Based upon the persuasive opinions of Dr. Tu, Dr. Verma and Dr. Graf, Petitioner sustained a right knee contusion, a left knee contusion and sprain, a right shoulder sprain and temporary aggravation of a pre-existing degenerative partial tear of the supraspinatus and a lumbar sprain. Because of these facts, 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 5% loss of use of Left Leg pursuant to §8(e)12 of the Act for the injury to the left knee, 2% loss of use of person as a whole pursuant to §8(d)2 of the Act for the injury to the right shoulder, and an additional 2% loss of use of person as a whole pursuant to §8(d)2 of the Act for the injury to the lumbar spine. Petitioner failed to prove any permanent partial disability to the right knee.

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

CHERYL QUINN,

Petitioner,

vs. NO: 13 WC 42330

GREYHOUND BUS LINES,

Respondent.

19IWCC0463

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, prospective medical, temporary total disability, maintenance, and future vocational benefits, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 26, 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.

19IWCC0463

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 $18,200.00. 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 26 2019

D. Douglas McCarthy

DDM/tdm
O: 8/20/19
052

L. Elizabeth Coppoletti

Stephen Mathis

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

QUINN, CHERYL LINETTE
Employee/Petitioner

Case# **13WC042330**

GREYHOUND LINES INC
Employer/Respondent

19IWCC0463

On 11/26/2018, 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 2.45% 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:

4463 GALANTI LAW OFFICE PC
DAVID GALANTI
RTE 111 & AIRLINE DR PO BOX 99
E ALTON, IL 62024

0180 EVANS & DIXON LLC
DAVID J REYNOLDS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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)

Cheryl Linette Quinn
Employee/Petitioner

v.

Greyhound Liines, Inc.
Employer/Respondent

Case # **13** WC **42330**

Consolidated cases: **N/A**

19IWCC0463

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 21, 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. ☐ 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 **Future Vocational Benefits**

FINDINGS

On the date of accident, **12/10/13**, 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 $**44,561.40**; the average weekly wage was $**856.95**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**6,855.60** for other benefits, for a total credit of $**6,855.60**.

Respondent is entitled to a general credit of $**0** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule, of $1,165.00 to Psych Care Consultants, $3,300.00 to Blash Counseling, $3,153.09 to IWP, and $68.58 for out-of-pocket expenses, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any awarded medical bills that it has previously paid.

Respondent shall pay Petitioner maintenance benefits of **$571.30/week** for **30 2/7 weeks** commencing **February 22, 2018** through **September 21, 2018** as provided in section 8(a) of the Act.

Respondent shall provide vocational rehabilitation services to Petitioner, including the formulation of a vocational rehabilitation plan within the requirements of the Commission Rules and National Tea.

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

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

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

Signature of Arbitrator

November 19, 2018
Date

ICArbDec19(b)

NOV 26 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

The parties stipulated that Petitioner sustained an accident on December 10, 2013 that arose out of and in the course of her employment with Respondent. (AX 1) On December 10, 2013, Petitioner was employed by Respondent as a bus driver. Petitioner had been employed by Respondent in that capacity since 2005. On that date, Petitioner was driving from St. Louis, Missouri to Nashville, Tennessee. Approximately 30 minutes into the trip, a passenger burst into the driver's cabin and started physically striking Petitioner. Petitioner was trying to maintain the bus on the road, but her head was against the window and the assailant's hand was covering her right eye. Petitioner screamed for help, and passengers came to her assistance. Because she couldn't push the steering wheel to the right the vehicle was going off into the median of the highway. Three passengers subdued Petitioner's assailant, and Petitioner then pulled the bus over to the right shoulder. The passengers threw Petitioner's assailant out of the bus. Petitioner then told the passengers to get back on the bus because she was unaware of what the assailant was going to do next. One of the passengers called the police. Both the police and paramedics responded to the scene. The police eventually apprehended Petitioner's assailant and, after positively identifying the suspect, she decided to return the bus back to the Greyhound terminal in St. Louis rather than continuing to Nashville.

Petitioner testified that she initially had some physical injuries for which she treated at Concentra, the Pain and Injury Center, her family doctor, and a chiropractor, Dr. Woods. These records reveal that Petitioner was treated for multiple contusions to the neck, head, and face, as well as to the TMJ joint (Generally PX 4, 9A, 9B) (PX 11A, 11B, 12A-12C) These records also show Petitioner improved with medical treatment. (Id.) In fact, Petitioner testified at trial that all of her physical injuries have healed, and she is not having any physical problems associated with this incident.

Petitioner further testified that on the day of the assault, she began to have mental difficulties. For these problems, she has treated with Alternative Options Counseling & Wellness Center where she was provided biweekly therapy by Janet Isbell. This treatment began December 19, 2013. (RX 1) Petitioner was also referred to Dr. Qasim. He has treated Petitioner from April 3, 2014 through the date of arbitration. He is a practicing psychiatrist. (PX 4, pp. 4-5)

While treating with Dr. Qasim Petitioner has been referred Petitioner for counseling with Blash Counseling and Imani Counseling. Petitioner attended counseling with Blash Counseling Services between August 2, 2015 and November 18, 2015 and with Imani Counseling between June 11, 2014 and October 30, 2014 and then from December 30, 2014 through May 16, 2015. These records indicate that Petitioner was complaining of extreme anxiety, panic attacks, extreme depression, sleep disturbance, frequent nightmares, and fear of leaving the house after dark. (RX 2 at 1). Specifically, it was noted that the severity of Petitioner's reported symptoms had limited her daily functions and precluded her ability to return to work.

On March 25, 2014, and at the request of Respondent, Petitioner was examined by Dr. Wayne Stillings, a psychiatrist. Petitioner's current complaints at that time included weak back muscles, dreams of her attack and anxiety. At the time of the exam, Petitioner had been working light duty for a couple of weeks providing

customer service to passengers. Dr. Stillings saw no evidence of over-reporting regarding her subjective complaints and he diagnosed Petitioner with post-traumatic stress disorder and personality disorder not otherwise specified. He suggested a full duty return to work after two four weeks and ongoing work with a counselor. He further recommended psychotropic medication by a psychiatrist particularly as she underwent a desensitization program. (RX 15, ex. 2)

At the request of Respondent, Petitioner was examined by Dr. Fucetola on September 23, 2016. (Dr. Stillings had passed away and, therefore, could not examine Petitioner). He issued a report thereafter. (RX 5A; RX 15, dep. ex. 2;RX 13A)

Petitioner has continued to treat with Dr. Qasim. She has also been engaged in vocational rehabilitation services through England & Associates.

On January 16, 2017 Respondent's former attorneys wrote to England & Company regarding the initiation of vocational rehabilitation efforts for Petitioner. As Respondent's counsel noted in his letter, the more significant component of Petitioner's injuries has been "psychological, with a diagnosis of post-traumatic stress disorder." Petitioner had been seen by Dr. Stillings, a psychiatrist, on March 25, 2014 and he had diagnosed Petitioner with post-traumatic stress disorder and "predicted – accurately, that treatment would be rather prolonged." (RX 5A) Dr. Stillings subsequently passed away and arrangements had been made for Petitioner to be examined by Dr. Fucetola, another psychiatrist[1]. Dr. Fucetola felt Petitioner could use some further, albeit limited treatment, and that Petitioner reported a high level of functioning and minimal psychological distress. Counsel further noted that, at times, the parties had been very close to getting Petitioner back to work as a bus driver. She got to a point she could ride on the bus. However, "at this point, all parties have agreed that perhaps it is best the claimant not return to work as a bus driver. Hence, our agreement to provide vocational rehabilitation." (RX 5A) Mr. Kaver met with Petitioner and her attorney on February 16, 2017. (RX 5A)

Mr. Kaver authored a vocational evaluation report on March 5, 2017 after meeting with Petitioner and reviewing pertinent information provided to him. In reviewing her medical records, he noted that Petitioner's sole permanent restriction was from driving a commercial bus with passengers. He added that, when seen by Dr. Andrew Wayne on August 18, 2014, Dr. Wayne did not feel Petitioner needed any permanent restrictions due to any physical injuries she had sustained in the work accident. Mr. Kaver further noted that Petitioner, herself, felt she had recovered from her physical injuries although she felt weaker. Psychologically, Petitioner reported that she felt well except for the inability to return to work for Respondent as a driver. She had made three attempts at returning to work as a driver on trial runs and she experienced much anxiety (anxiety, tension, shaking, rapid heartbeat, fear). Mr. Kaver wrote, "She believes her mental health professionals opined that she is experiencing PTSD whenever she attempts to drive a passenger bus." She was seeing a psychiatrist every three months, a therapist once a month, and taking prescription medication for anxiety and depression along with a sleep aid. Petitioner's education and prior employment was reviewed and discussed. Mr. Kaver felt Petitioner could return to work and had career options. He noted it was "unclear if [Petitioner] could return to work as a professional driver if she operated a vehicle with no passengers." As they discussed the possibility, Petitioner seemed uncertain as to her abilities to operate a commercial vehicle if passengers were not the cargo. Training was considered a possibility. Mr. Kaver wished to know if training was a possibility or if the focus should be job placement based upon her current skill set. (RX 5A)

[1] That is an incorrect description as Dr. Fucetola is a psychologist (see RX 15)

Petitioner was deemed employable with career options, including work as a CNA/CMT. (Id.) Vocational efforts then ensued. As part of the vocational efforts, Petitioner authored a cover letter to accompany her resume. She discussed her experience in customer serve and caregiving, describing herself as a caring and compassionate personality and someone who truly enjoyed working with people. She was committed to providing quality care and assistance to the young and old, the disabled, disadvantaged, or anyone in need of help. She described herself as hardworking, enthusiastic, and results-oriented. Her career/job objectives included a position as a classroom student aide, tutor, home health aide, interviewer/intake specialist, or accounting clerk. (RX 5A)

According to vocational notes, Petitioner was placed at a job at One to Grow On, Inc. on May 8, 2017 but quit the following day, stating the cleaning duties were too physically demanding. (Id.)

According to vocational notes, Petitioner was also placed at a second job at Client Services Inc. on June 8, 2017. (Id.) However, she quit that job because she found it too stressful. (RX 5B)

On November 16, 2017 Mr. Kaver issued a Status Report. He indicated that he and Petitioner had a conversation on October 23, 2017 concerning Petitioner's vocational rehabilitation program. Petitioner reported that her job with Client Service Inc. did not work out for as it was too stressful for her and she could not keep up with her duties as a clerk. Mr. Kaver further noted that Petitioner "might" be interested in becoming training and employed as a professional truck driver. She was prepared to fully commit to a truck driving job goal, but she was uncertain whether she could psychologically handle the job and advised that she might not know if she could perform as a truck driver until she actually initiated the training required to obtain the CDL. There were two ways Petitioner could become trained and qualified to work as a professional truck driver. She could train at a truck driving school, earn her CDL and find a job as a truck driver or she could get hired by a trucking company and the firm would sponsor the required training. (RX 5B)

On February 14, 2018 Mr. Kaver issued another status report noting that the vocational rehabilitation plan had been approved for sponsorship by a carrier and Petitioner would be initiating truck driving training at MTC Truck Driving School on February 18, 2018. He stated that on February 13, 2018 Petitioner informed England & Company that her doctor would not provide medical approval for her to become trained and employed as a truck driver. MTC required a medical release from her doctor before she began her first day of training. She had seemed excited about the training and it was disappointing that she would be unable to participate in it. Dr. Qasim's restriction was included in the file. (RX 5B)

Petitioner's TTD benefits were terminated as of February 22, 2018. (AX 1)

On April 23, 2018 Mr. Kaver issued another Status Report requesting instruction as to whether or not England & Company should be proceeding with additional vocational rehabilitation services on Petitioner's behalf. (RX 5B)

Nothing more has transpired with England & Company.

On May 22, 2018, and at the request of Respondent, Petitioner was re-examined by Dr. Fucetola. A written report issued. (RX 15, dep. ex. 3) In his report Dr. Fucetola noted that Petitioner candidly told him she had tried one day of work at a "One to Grow On" and said it was not a good fit as she felt "just thrown" there without knowing what to do and the facility was very disorganized with a high employee turnover. She also worked as a clerk for a collection agency (CSI) in the summer of 2017 but it only lasted for 1 ½ months because she was in training, stressed, and unable to keep up with the paperwork. She worked in a locked room that

created anxiety and that was compounded by working in a small cubicle. Her manager told her she was to slow; however, the event that led to the end of the job was the day when she was "startled" by a supervisor who approached her with criticism and made her feel like she would be attacked, thereby reminding her of the 2013 events. Thereafter, she had trouble eating and sleeping and she spoke to a higher supervisor and her primary care doctor who gave her a couple of days to "regroup" but Petitioner was on guard so much so she quit. She also started having nightmares again and was told by her psychotherapist that the event might have restarted her PTSD symptoms. Petitioner further advised the doctor that in 2018 she had been offered training to drive a truck although she thought it was "a bad idea". She talked to her attorney who told her to try and she reluctantly agreed; however, she became panicked and the training restarted anxiety symptoms. During the training she mentioned the attack and what had happened and she was asked for a letter of release from her doctor to drive; however, Dr. Qasim said she was not released to commercial driving. Petitioner had not worked since. Dr. Fucetola ran some tests and concluded Petitioner did not have PTSD. His original diagnosis of unspecified anxiety disorder remained unchanged. He felt it was still possible that the condition was related to the original accident but he noted that Petitioner had hinted about another upsetting event and medical procedure she had experienced since the last evaluation but which she did not wish to discuss thereby making it difficult for the doctor to determine if the new event was the contributor or primary contributor to some of the anxiety she was now experiencing. He also noted that Petitioner expressed the desire to work as a teacher with children in the future but currently lacks the educational and training experience required. He did feel she should have a permanent restriction against driving a commercial bus with passengers. (RX 15, dep. ex. 3)

Deposition of Dr. Qasim

The deposition of Dr. Qasim was taken on June 19, 2018. (PX 4)

Dr. Qasim testified that Petitioner is no longer participating in talk therapy but is continuing to follow-up with Dr. Qasim and is being prescribed both Effexor and Xanax for Post-Traumatic Stress Disorder or "PTSD" (PX 4 at 9).

Dr. Qasim diagnosed the Petitioner with PTSD. (PX 4 at 9) Dr. Qasim testified that she met the criteria for that diagnosis as she was "experiencing a traumatic event which was effecting her day-to-day life, having nightmares, hypervigilance, increased anxiety, fears, dreams, inability to function in a premorbid state. (Id. at 9). He has continued to treat her with medications in an effort to subdue anxiety and emotional effect. (Id. at 10). Dr. Qasim has, at times, varied her medications due to her intolerance of these medications. (Id.) Dr. Qasim does not feel that she can drive any commercial driver and in fact cannot experience any loud environment as he is worried about regression of her PTSD symptoms. (Id. at 11). Dr. Qasim felt the Petitioner's PTSD was causally related to the assault (Id. at 13).

Dr. Qasim testified that he is a board-eligible but not a board-certified psychiatrist. (Id. at 4) He reiterated his opinion Petitioner could not drive any commercial vehicle and that Petitioner had PTSD. (Id. at 7-9) Dr. Qasim admitted he never spoke to Petitioner's counselors regarding her progress and only obtained updates from Petitioner herself. (Id. at 15-16) Dr. Qasim acknowledged his notes indicated a period of time where Petitioner no longer had recurring nightmares and admitted this did not meet one of the criteria for PTSD, but nevertheless testified Petitioner did have PTSD. (Id. at 9, 25-26, 37) Dr. Qasim also admitted it would surprise him if a patient with PTSD could also effectively represent herself in a workers' compensation case for a year. (Id. at 29-30) Regarding the February 19, 2018 note restricting Petitioner from commercial driving, Dr. Qasim testified Petitioner contacted him about a letter authorizing truck driving. (Id. at 32-33) However, Dr. Qasim admitted he wrote the letter based solely on prior examinations of Petitioner. (Id. at 33) Dr. Qasim testified the restrictions on

Petitioner were based on her subjective complaints as he had not performed any objective psychological testing of Petitioner. (Id. at 34-35)

Dr. Qasim testified that Petitioner cannot drive a commercial vehicle where there is a loud environment or hostile environment. If there is somebody yelling or screaming, she cannot tolerate that. (PX 4, p. 11) On cross-examination Respondent's counsel asked the doctor why she couldn't drive a commercial vehicle when she could drive a personal vehicle and, while there was some difficulty letting the doctor answer the question, he stated, "So driving a commercial vehicle, you know, and stopping at – wherever they stop and the things, it's very – she cannot do that." The doctor was then told there would be limited interaction and just driving a commercial truck from Point A to Point B, and he replied, "Again, it's a large vehicle. It can bring back the memories and she was being pushed to do that, pushed to drive an 18-wheeler." (PX 4, p. 34) The doctor was asked if she was possibly exaggerating her subjective complaints and he replied, "No." (PX 4, p. 34)

Deposition of Dr. Fucetola

The deposition of Dr. Fucetola was taken on August 9, 2018. Dr. Fucetola is a board certified and clinical neuropsychologist at the Washington University School of Medicine (RX 14 at 5). The doctor testified that on September 23, 2016, he took a history, reviewed the vast majority of her medical records, and conducted a mental status examination. (RX 13A at 1-9). Dr. Fucetola specially noted that Petitioner was a good historian, who was able to provide a clear personal history, including one for the events of the December 10, 2013 attack. (Id. at 9). Dr. Fucetola administered an MMPI-2 (Id.) Dr. Fucetola concluded his psychological testing indicated mild anxiety, but no serious psychological pathology. Trauma specific testing indicated generalized anxiety but was not indicative of active PTSD. Dr. Fucetola concluded that Petitioner was suffering from an unspecified anxiety disorder, secondary to the accident which caused a clinically significant anxiety disorder, which did not rise to a level of PTSD. (Id. at 11). Dr. Fucetola felt that the treatment was causally related to the innocent of December 10, 2013 specifically because there were no records of pre-existing anxiety in Petitioner. (Id. at 11). He recommended continued in vivo exposures, as well as psychoactive medications prescribed by her treating psychiatrist.

Dr. Fucetola testified that he re-examined Petitioner on May 22, 2018 and took an interim history of Petitioner attempting to go to truck driver training, even though she thought it was "a bad idea". (RX 13B at 2). Dr. Fucetola noted that Petitioner was asked for a letter of release from her treating physician for this training, but that Dr. Qasim had not released her to engage in commercial truck driving (Id.) Dr. Fucetola reviewed additional medical records which occurred after he had first seen her as well as reviewing some vocational records. (Id. at 3) He also administered a Mini Mental State Examination, a Trauma Symptom Inventory-2nd Edition, a Minnesota Multiphasic Personality Inventory-2nd Edition, and a Victoria Symptom Validity test. (Id.) Petitioner indicated to Dr. Fucetola that after his last psychological evaluation she had tried exposure therapy and was unable to tolerate the treatment. (Id. at 5). Additionally, Petitioner reported to Dr. Qasim very mild and generalized mood and anxiety symptoms prior to attempting to return to truck driver training which dissipated after she disengaged with these activities. (Id.) She did feel she was capable of working in certain areas that would not trigger her anxiety symptoms. (Id.) Dr. Fucetola concluded his diagnosis of an unspecified anxiety disorder was unchanged and that it may be partly related to the original December 10, 2013 incident. (Id. at 6). Dr. Fucetola also felt the Petitioner was at maximum medical improvement and that she should be restricted from performing her pre-accident job as a bus driver; however, he felt she could work as a commercial truck driver without passengers.

Dr. Fucetola testified Petitioner had been driving her own car, riding her bicycle, going to church, engaging in the community, exercising, and generally living independently, and appeared "normal" aside from not working. (Id. at 24) Dr. Fucetola reaffirmed his diagnosis of anxiety disorder, that Petitioner did not meet the threshold criteria for PTSD, and that she was at MMI as of 05/22/18. (Id. at 28-30, 33)

Dr. Fucetola took issue with Dr. Qasim's diagnosis of PTSD. (Id. At 32) Dr. Fucetola testified of the importance of not relying solely on a patient's self-report of symptoms, but also objective testing when diagnosing PTSD. (Id.) He noted Dr. Qasim did not have access to actual objective psychological testing. (Id.) Dr. Fucetola felt truck driving training was a reasonable next step for Petitioner and, based on the objective testing, he could not identify a rationale for Dr. Qasim's restriction of no commercial driving. (Id. at 35)

Dr. Fucetola admitted on cross-examination that Petitioner's current condition was, at least, in part caused by the trauma of the assault on the bus. (RX 15 at 37). Dr. Fucetola felt Petitioner was trying to be honest with him and was not exaggerating or manipulating her condition. (Id.). Dr. Fucetola does not personally make the diagnosis of PTSD or an unspecified anxiety disorder in the absence of administering the testing that he performed. (Id. at 43). However, Dr. Fucetola admitted that those diagnoses can be made without that testing. (Id. at 43).

The Arbitration Hearing

Petitioner's case proceeded to arbitration on September 21, 2018. Petitioner was the sole witness testifying at the hearing. The disputed issues were causal connection, medical bills, maintenance, and vocational rehabilitation. (AX 1)

Petitioner testified regarding the details of her accident that occurred on December 10, 2013. Her testimony regarding the details of the accident are corroborated within the medical records and need not be recounted again. Petitioner testified that, as a result of the accident, she sustained both physical and mental/emotional problems and that the former have resolved but not the latter. Petitioner denied any prior psychological issues or need for treatment.

Petitioner testified that she has been treating with Dr. Qasim primarily and he has treated her with medication and counseling. She is currently restricted from driving a commercial vehicle of any sort as doing so makes her anxious and she becomes tense. She gets nervous and returns to a "feeling of fear" and she starts getting sad. She would not feel safe operating a commercial vehicle.

Petitioner testified that she worked with England & Associates regarding vocational assistance and that the company was selected by the insurance company; however, it is no longer assisting her. She reached out to find out why and was told it hadn't heard back from the insurance company. Petitioner further testified that since services have been terminated she has looked for work on her own to no avail and she would like additional assistance.

Petitioner testified that after England & Associates placed her into a commercial truck driving school she went there and spoke with the recruiter who asked her questions about "prior and everything." She further testified that then the situation with Respondent came up and the recruiter was concerned. The recruiter asked her if she wanted to do it and she explained that the insurance company was providing it and paying for it. She then had to contact Dr. Qasim.

On cross-examination Petitioner testified that she applied for Social Security benefits in 2017 but was also looking for work during that time. She has had a hearing but hasn't heard anything. She confirmed that her physical injuries from the work accident have resolved.

Petitioner further testified that she represented herself for a period of time in 2015 in this case, including filing 19(b) petitions and otherwise representing herself. Her current attorney is her second one. Petitioner testified she drives her car regularly and goes out into the community, including the mall, without any trouble despite the numbers of people around her in those crowded places. She denied any issues with people.

Petitioner testified that she graduated from high school and has some college credits but never graduated. She also worked as a CNA several years before going to work for Respondent. Her CNA license and phlebotomist licenses have expired. She is computer literate. Her Commercial B license has expired. She has a regular driver's license.

Petitioner was asked about her unrelated medical event as mentioned to Dr. Fucetola. She explained that she had breast cancer in 2016 and 2017.

Petitioner acknowledged that she was placed in a couple of jobs in March and August of 2017 but she quit both places because one was too physical and the second one was stressful and she started having issues with the supervisor and it provoked her symptoms to reoccur. Thereafter, she was offered the truck driving school option. Petitioner disagreed with her vocational counselor's portrayal of her excitement at being offered the truck driver training, testifying instead that she was not excited about it. When asked if she went to Dr. Qasim asking him to provide her with a note so she wouldn't have to go to the driving school, she replied that the school requested the release from the doctor. Consequently, she did not go through with the training. Nevertheless, Petitioner admitted to agreeing to attend truck driver training in October 2017 until concerns were raised mere days before she was actually scheduled to begin training.

Petitioner presented her job search sheets from July 9, 2017 through July 26, 2018. (PX 2). Petitioner has also indicated that she tried to reach back out to England Company to continue rehabilitation service in an area outside of commercial truck driving, but they would not assist her as the insurance company has not contacted them for approval. Petitioner would like to continue to work with England Company Rehabilitation Services to become a teacher. She is scheduled in the fall to begin volunteer work as a math tutor towards this end.

Regarding her job search, Petitioner testified she has not looked for work since July 26, 2018. She testified she could not supply any supporting documentation including the application, her resume, or receipt confirmations apart from the list of job searches consisting of the name of the employer, job title, and date applied. Petitioner testified she did not have the names of any points of contact with the employers on her job search list. Petitioner admitted that she lacked relevant background for many of the positions to which she applied, including teaching positions, preschool jobs, and accounting jobs. Petitioner testified she lacked educational certification, preschool certification, or accounting certification. She acknowledged hearing back from some of the schools. She further testified that she didn't bring additional information that she had because she didn't think she needed it for the hearing. In June and July of 2018 Petitioner was looking for teacher-type positions. She has some background in volunteer-type teaching. The positions she was applying for didn't require certificates or experience.

Petitioner explains that she does volunteer tutoring. She hadn't done it in awhile but had something scheduled for the next week. She will be as she is to begin training in the next week at an elementary school in

St. Louis. After the training, she will be tutoring. She acknowledged that she had been "hired" as a teacher's assistant at Peabody Elementary in 2017; however, she did not have enough credit hours to be able to keep the job. She would like to be an elementary school teacher.

Petitioner testified that she is able to cook and go to lectures.

Petitioner's medical bills are found in PX 5:

Psych Care Consultants: $1,165.00
Blash Counseling: $3,300.00
IWP: $3,153.09
Out-of-Pocket: $68.58

Proofs were closed.

The Arbitrator concludes:

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

Petitioner's current mental/psychological condition of ill-being is causally related to her work accident of December 10, 2013. This conclusion is based upon the testimony of both the treating and examining physicians – Dr. Stillings, Dr. Fucetola, and Dr. Qasim. While Respondent contends causation is lacking because Petitioner does not suffer from Post-Traumatic Stress Disorder (PTSD) that's really missing the mark. Whether Petitioner has PTSD or a generalized anxiety disorder is not the question. Either way, the condition is causally related to her accident of December 10, 2013 and none of the doctors disagree that she needs to avoid driving a commercial passenger vehicle which is the job she held at the time of her accident. Therefore, at a minimum, Petitioner has sustained a mental/psychological injury as a result of a traumatic injury that has resulted in a permanent restriction that prohibits her from returning back to the job she held at the time of the undisputed accident. Petitioner's current condition of ill-being is causally related to her work accident.

Indeed, the parties seemed to have agreed upon that when vocational assistance was initiated in November of 2017. The real problem at this point in time is that there is no specific vocational plan in place and there is a question as to whether or not Petitioner can engage in any commercial driving, including over-the-road truck driving, or whether she is limited to refraining from driving commercial vehicles carrying passengers.

Issue (J) – Medical Bills.

Respondent's dispute as to liability for the medical bills was based upon causation. Consistent with the Arbitrator's causation determination, Respondent will pay the following medical bills:

Psych Care Consultants: $1,165.00
Blash Counseling: $3,300.00
IWP: $3,153.09
Out of Pocket: $68.58

Issue (L) Maintenance.

Petitioner is entitled to maintenance benefits from February 22, 2018 through September 21, 2018, a period of 30 2/7 weeks.

The parties stipulated that Petitioner was temporarily totally disabled between December 13. 2013 and February 26, 2014 and again from March 12, 2014 through May 12, 2014. Between May 16, 2014 and March 4, 2017 various periods of TTD/TPD were paid and, by stipulation of the parties, no additional TTD or TPD benefits should be paid during this period. The parties also agreed that maintenance benefits were owed from March 5, 2017 until February 21, 2018, and that no additional amounts are due in this period of time. Thus, the only dispute is as to maintenance benefits between February 22, 2018 and September 21, 2018 a period of 30 2/7 weeks.

Respondent terminated TTD benefits as of February 21, 2018 without explanation. At that time Petitioner was engaged in vocational job placement services. She had presented for training as a commercial non-passenger truck driver and the training recruitor requested a medical release from Petitioner's treating doctor before she could proceed. Petitioner was unable to get this. She was unable to proceed with training and further vocational services ended. Petitioner, on her own, proceeded to look for work within her restrictions. While she may not have had all of the supporting documentation with her at the time of trial she was, at least, attempting to do more than Respondent was doing. While she had not done any job searches for the two months preceding the hearing, she remained unable to return to work in the job she had at the time of the accident. Furthermore, her own efforts had led to a possibility of a tutorship in the near future. The Arbitrator finds that Petitioner is awarded maintenance benefits during this period of time. Pursuant to the agreement of the parties, Respondent shall receive a credit of $6,855.60 for monies advanced to Petitioner during this period of time.

Issue (O) – Vocational Rehabilitation.

Petitioner is entitled to ongoing vocational assistance.

The Arbitrator is aware that Petitioner is able to drive her own vehicle, go places, cook, tutor, and engage in most, if not all, aspects of ordinary life. As Dr. Fucetola noted, she appears "normal." None of that undermines the fact that, as a result, of the accident herein, Petitioner is unable to return to work as a commercial bus driver.

Respondent has also suggested, through questioning of Petitioner at trial, that she is trying to undermine vocational efforts in that she sought a slip from Dr. Qasim that would keep her from having to go to truck driving school and that she waited until the very last minute to do this. The Arbitrator disagrees. Records from England & Associates (RX 5 A and B) contain references throughout the status reports suggesting Petitioner had fears and concerns about truck driving. However, she was reluctantly agreeing to give it a try because (1) her attorney told her to and (2) the insurance company was paying for it and providing it. These are reasonable reasons to "give it a try." At this point it should be noted that the Arbitrator found Petitioner to be a very credible witness and, at 36, still quite young. She came across as intelligent. The Arbitrator also found Petitioner's testimony regarding the circumstances of her returning to Dr. Qasim and requesting a release for truck driving school to be very credible. That is, the Arbitrator does not believe that she went to the doctor and asked for a note so she could avoid the school; rather, she believes that the "recruiter" requested a release. If Respondent had any concerns regarding these circumstances, it could have subpoenaed the recruiter to testify in rebuttal. It didn't.

Regarding Petitioner's current diagnosis, Dr. Fucetola, a psychologist, does not believe Petitioner is suffering from PTSD. Dr. Qasim believes Petitioner is suffering from PTSD. He is a psychiatrist although Respondent has pointed out, he is not board-certified. Dr. Stillings also examined Petitioner (and at Respondent's request). He was a psychiatrist and felt she had PTSD. Two psychiatrists seem to feel she has it and, as such, the Arbitrator would be inclined to defer to them over a psychologist.

Again, however, diagnosis aside, the real issue is what restrictions Petitioner needs as a result of her work accident. While Dr. Fucetola could not find any rationale as to why Dr. Qasim extended Petitioner's restriction to no commercial driving whatsoever, Dr. Fucetola did not review Dr. Qasim's deposition. Dr. Qasim testified that Petitioner cannot drive a commercial vehicle where there is a loud environment or hostile environment. If there is somebody yelling or screaming, she cannot tolerate that. (PX 4, p. 11) On cross-examination Respondent's counsel asked the doctor why she couldn't drive a commercial vehicle when she could drive a personal vehicle and, while there was some difficulty letting the doctor answer the question, he stated, "So driving a commercial vehicle, you know, and stopping at – wherever they stop and the things, it's very – she cannot do that." The doctor was then told there would be limited interaction and just driving a commercial truck from Point A to Point B, and he replied, "Again, it's a large vehicle. It can bring back the memories and she was being pushed to do that, pushed to drive an 18-wheeler." (PX 4, p. 34) The doctor was asked if she was possibly exaggerating her subjective complaints and he replied, "No." (PX 4, p. 34) Furthermore, during the arbitration hearing, Respondent's counsel wished to ask Petitioner some questions about her job searches. Counsel asked Petitioner's attorney if Petitioner could look at his copy of the job searches indicating he could stand over Petitioner and they could look at the same one but "your client doesn't want me to do that."

Dr. Qasim, Petitioner's treating physician for the last 4 and a half years has concluded that Petitioner has PTSD secondary to her accident. Dr. Fucetola has only seen her twice. When England & Associates found Petitioner a job as a clerk Petitioner had an encounter with her supervisor that also brought back memories and symptoms. Petitioner also had problems when working light duty behind the Greyhound counter when passengers became upset. Thus, it would appear that it's not just the driving of passenger commercial vehicle that is a trigger for Petitioner, but, additionally, surprising and/or hostile (or perceived to be possibly hostile) encounters with people. Given the nature of the assault Petitioner experienced, this seems understandable and Dr. Qasim seems concerned about this. While Petitioner might be able to drive a commercial vehicle without passengers, most commercial truck drivers have to stop at weigh stations or truck stops from time to time. It would seem quite possible that Petitioner might encounter "hostile environments" of one sort or another at these places. No one has identified any other type of commercial truck driving that Petitioner might be able to engage in that wouldn't involve passengers or a potential "hostile" or confrontational environment. If one could be identified, perhaps that would work. At this point in time, however, commercial truck driving may simply not be a good match for Petitioner.

As reflected in the vocational records, Petitioner has consistently expressed an interest in working with children. This may be the direction they need to go in. The parties are to be encouraged to go back to the drawing board, if necessary, and come up with a vocational plan that meets the requirements of National Tea Co. v. Industrial Commission, 97 Ill. 2d 424, 454 N.E. 2d 672 (1983). It may be possible to identify and place Petitioner in a job based upon her current skill level and education. She may also require some training. As it stands, the current push to get her into commercial non-passenger driving may not be the best fit, given the effects of her accident. Petitioner has no permanent restrictions as a result of any physical injuries she sustained. She does have a restriction due to her psychological injuries. The Arbitrator points this out given Petitioner's

perceived reluctance to proceed with some jobs because they involved physical activities she did not feel she could perform (cleaning activities associated with child care jobs) (RX 5A, p. 9 of 44).

Therefore, Respondent shall authorize future vocational efforts through England & Associates, or such other provider that the parties might agree upon, in an effort to get Petitioner back to a wage level she was making before this injury. The parties need to cooperate in the formulation of a plan within the parameters of National Tea to determine/asses in what direction Petitioner's vocational rehabilitation should proceed at this time and move forward with that plan.

****

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SUSAN PRINCE,

Petitioner,

vs. NO: 17 WC 29875

STATE OF ILLINOIS,
ILLINOIS YOUTH CENTER - HARRISBURG,

Respondent.

19IWCC0464

DECISION AND OPINION ON REVIEW

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

The Commission finds that the Petitioner failed to prove that her visit with Dr. Nathan Mall on November 29, 2017 was causally related to the September 5, 2017 work-related accident. During the November 29, 2017 visit, Petitioner informed Dr. Mall that she was carrying a lot of keys the night before and developed some wrist soreness. Dr. Mall diagnosed Petitioner with left wrist tendinitis and prescribed anti-inflammatory medication. Per the medical record, it was noted that Dr. Mall advised the Petitioner that this was now a different process from the work-related injury, and she would have to report it as a new injury if her condition were to continue.

Accordingly, the Commission modifies the Decision of the Arbitrator and finds that the Petitioner failed to prove that her treatment with Dr. Mall on November 29, 2017 was causally related to her work accident. Therefore, she is not entitled to the $180.00 bill incurred therefrom.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the

19IWCC0464

Arbitrator filed on November 13, 2018, 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 $790.64 per week for a period of 10.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the five (5) percent loss-of-use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,744.48 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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

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

DATED: AUG 27 2019

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth.Coppoletti

DDM/tdm
O: 7/3/19
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRINCE, SUSAN
Employee/Petitioner

Case# **17WC029875**

STATE OF IL/IYC HARRISBURG
Employer/Respondent

19IWCC0464

On 11/13/2018, 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 2.45% 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
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT 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 13 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

Susan Prince
Employee/Petitioner

v.

State of IL/IYC Harrisburg
Employer/Respondent

Case # 17 WC 29875

Consolidated cases: _____

19IWCC0464

An *Application for Adjustment 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 October 12, 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 September 5, 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 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 $86,604.00; the average weekly wage was $1,665.46.

On the date of accident, Petitioner was 49 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services provided to Petitioner as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $790.64 per week for 10.25 weeks because the injury sustained caused the five percent (5%) loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

November 9, 2018
Date

NOV 13 2018

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment by Respondent on September 5, 2017. According to the Application, Petitioner sustained an injury to her left hand, wrist and arm as a result of "Twisting wrist" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Juvenile Justice Specialist Supervisor. On September 5, 2017, Petitioner received a call on the radio regarding an uncooperative inmate in Unit 12. When Petitioner responded to the call, she had to unlock and open a door located in Unit 10. When Petitioner operated the key in the door, Petitioner stated she felt a "pop" in her left wrist and experienced an onset of pain. Petitioner testified the doors in the facility were made of heavy steel and each one of them had to be unlocked with a key because it was a secured facility.

Petitioner reported the accident to Respondent in a timely manner. On September 6, 2017, Petitioner completed and signed a Notice of Injury which noted Petitioner had sustained an injury to her left hand while using a key to unlock/open a door in Unit 10 (Petitioner's Exhibit 7).

On September 6, 2017, a First Report of Injury, Supervisor's Report of Injury and an Incident Report were prepared. All of the preceding were consistent with Petitioner having sustained a left hand injury while using a key to unlock/open a door (Respondent's Exhibit 2).

On September 7, 2017, Petitioner was evaluated by Marcia Scott, a Physician Assistant. At that time, Petitioner informed PA Scott she had sustained an injury to her left hand/wrist on September 5, 2017, while unlocking a steel door. On examination, Petitioner's range of motion of her left wrist was limited because of pain. PA Scott prescribed a wrist splint and Petitioner informed her she wanted to be seen by an orthopedic surgeon (Petitioner's Exhibit 3).

On September 12, 2017, Petitioner was seen by Dr. Nathan Mall, an orthopedic surgeon who had previously treated Petitioner for a knee condition. At that time, Petitioner informed Dr. Mall she injured her left hand/wrist when she attempted to unlock/open a door. Dr. Mall opined Petitioner had sustained a left wrist strain/wrist extensor strain. He ordered physical therapy, prescribed medication and a brace and also noted that if Petitioner continued to complain of pain, he would order MRI scans of the left wrist and left elbow (Petitioner's Exhibit 4).

Petitioner was subsequently seen by Kelly Williams, a Nurse Practitioner associated with Dr. Mall, on October 24, 2017. At that time, Petitioner continued to complain of left wrist pain. NP Williams ordered MRI scans of Petitioner's left wrist and elbow (Petitioner's Exhibit 4).

The MRI scans of Petitioner's left wrist and elbow were performed on November 1, 2017. According to the radiologist, the MRI of the left wrist revealed cystic changes in the proximal/ulnar aspect of the lunate, likely degenerative changes, but no evidence of a tear or tendinopathy. According to the radiologist, the MRI of Petitioner's left elbow revealed mild lateral epicondylitis and extensor tendinitis, but no tendon tear (Petitioner's Exhibit 5).

Dr. Mall evaluated Petitioner on November 1, 2017, and reviewed the MRI scans. He opined the MRI of Petitioner's left wrist revealed cystic formation within the lunate consistent with Kienbock's disease, but no tearing. He opined the MRI of Petitioner's left elbow revealed very minimal inflammation. He authorized Petitioner to return to work without restrictions, but indicated he wanted to see her in four weeks (Petitioner's Exhibit 4).

Dr. Mall last saw Petitioner on November 29, 2017. At that time, Petitioner's condition had improved. Petitioner's pain symptoms had largely resolved and she only had some mild pain over the first and second dorsal compartments. Dr. Mall opined Petitioner was at MMI, but he recommended Petitioner continue to take anti-inflammatory medications and wear a soft wrist brace while at work (Petitioner's Exhibit 4).

Dennis Ferrell testified for Respondent at trial. Ferrell was the facility's chief engineer. He testified that there were no reports of any maintenance issues with the door used by Petitioner on the date of the accident. On cross-examination, Ferrell agreed that the doors were made of steel and were heavy.

Respondent also tendered into evidence a CD with two videos obtained on September 5, 2017. The first video was taken outdoors, outside of Unit 10. At 16:13, a person approaches an outside door and enters the building. However, the video was taken from a considerable distance and the quality was poor, it was not clear whether the person seen in the video was, in fact, the Petitioner. Further, it was not possible to determine what amount of force was required to unlock/open the door. The second video was taken in the hallway of Unit 10, and Petitioner was observed walking down the hallway with someone who appeared to be a coworker. The Petitioner was merely walking down a hallway and did not use her left hand to unlock/open a door. The Arbitrator does note the Petitioner did not appear to have any visible sign that she was having pain/discomfort in her left hand/wrist (Respondent's Exhibit 3).

At trial, Petitioner testified she had no prior injuries/symptoms in regard to her left hand/wrist. Petitioner agreed her condition had improved; however, Petitioner stated she still has occasional pain and discomfort as well as some diminished strength in the left hand/wrist, primarily associated with active use.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of her employment by Respondent on September 5, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner reported the accident to Respondent in a timely manner. Further, the various reports tendered into evidence all noted Petitioner sustained a left hand/wrist injury on September 5, 2017, when she was using a key to unlock/open a door in Unit 10.

Petitioner gave a consistent history of how she sustained the injury to her medical providers.

Dennis Ferrell, Respondent's Chief Engineer, credibly testified that there were no reports of any maintenance issues with the door used by Petitioner on the day of the accident. However, he agreed the doors were made of steel and were heavy.

In regard to the videos tendered by Respondent, the first video was taken outdoors, outside of Unit 10. A person approached and entered a door to Unit 10. As was noted herein, it was not possible to determine if the person in the video was, in fact, the Petitioner. Further, it is also not possible to determine what amount of force was required to unlock/open the door. Additionally, the video was taken at a considerable distance and was of poor quality. Accordingly, the Arbitrator finds this video to be or no probative value.

The second video was taken in the hallway of Unit 10, and Petitioner was observed walking down the hallway with someone who appeared to be a coworker. The Petitioner was merely walking down a hallway and did not use her left hand to unlock/open a door. The Arbitrator does note the Petitioner did not appear to have any visible sign that she was having pain/discomfort in her left hand/wrist. However, the Arbitrator notes that simply because Petitioner did not exhibit any visible sign of pain/discomfort in her left hand/wrist does not mandate the conclusion that she had not sustained a strain type injury to her left hand/wrist. Accordingly, the Arbitrator finds this video to be of minimal probative value.

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

The Arbitrator concludes Petitioner's current condition of ill-being in regard to her left hand/wrist is related to the accident of September 5, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony she had no prior injuries/symptoms in her left hand/wrist was unrebutted.

Petitioner sought medical treatment shortly after the accident and was diagnosed with having sustained a left hand/wrist strain injury.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the left hand.

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 worked as a Juvenile Justice Specialist Supervisor in a secured facility that had metal doors which were heavy, all of which required the use of the key to unlock/open. The Arbitrator gives this factor moderate weight.

Petitioner was 49 years old at the time of the accident. She will have to live with the effects of this injury for the remainder of her working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

As a result of the accident, Petitioner sustained a left hand/wrist strain. While most of Petitioner's symptoms resolved, she continued to have some pain/discomfort in the left hand/wrist, primarily with active use. Dr. Mall, Petitioner's primary treating physician authorized Petitioner to return to work, but recommended she continued to take anti-inflammatory medications and wear a soft wrist brace while at work. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dave Meziere,
Petitioner,

vs. NO: 13 WC 40507

City of Chicago, Department of Water Management,
Respondent.

19IWCC0465

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 11, 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 28 2019
o081519
BNF/mw
045

Barbara N. Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEZIERE, DAVE
Employee/Petitioner

Case# **13WC040507**

CITY OF CHICAGO DEPT OF WATER MANAGEMENT
Employer/Respondent

19IWCC0465

On 1/11/2018, 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:

1993 ROMANUCCI & BLANDIN LLC
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

0010 CITY OF CHICAGO LAW DEPT
NICHOLSON J PERRONE
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

DAVE MEZIERE
Employee/Petitioner

v.

CITY OF CHICAGO, DEPT. OF WATER MANAGEMENT
Employer/Respondent

Case # **13** WC **40507**

Consolidated cases: **n/a**

19IWCC0465

An *Application for Adjustment 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 **NOVEMBER 1, 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: **PROSPECTIVE MEDICAL**

FINDINGS

On **NOVEMBER 14, 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 $**95,069.00**; the average weekly wage was $**1,828.25**.

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

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

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

Respondent shall be given a credit of $**51,367.51** for TTD, $**0.00** for TPD, $**12,537.15** for maintenance, and $**0.00** for other benefits, for a total credit of $**63,904.66**.

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

ORDER

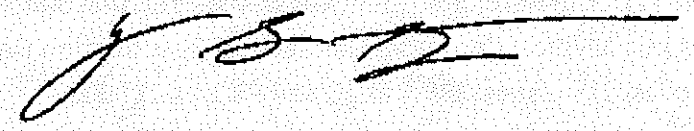
As detailed in the attached memorandum discussing the *Findings of Fact and Conclusions of Law*:

1) The Respondent shall pay the Petitioner the sum of **$721.66 per week** for a further period of **162.50 weeks**, as provided in **Section 8(e)12** of the Act, because the injury to the Petitioner's left leg caused a **75.58% loss of use of the left leg**;

2) The Petitioner's medical rights under Section 8 of the Act **shall remain open for life** and the Respondent shall be required to pay any and all reasonable and necessary medical services causally related to the Petitioner's November 14, 2013 left leg accident, pursuant to the medical fee schedule, as provided in Section 8(a) and Section 8.2 of the Act.

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

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



Signature of Arbitrator

JANUARY 11, 2018
Date

JAN 11 2018

DAVE MEZIERE v. CITY OF CHICAGO, DEPT. OF WATER MANAGEMENT

13 WC 40507

FINDINGS OF FACT AND CONCLUSIONS OF LAW

INTRODUCTION

This matter was tried before Arbitrator Steffenson on November 1, 2017. The issues in dispute were causal connection, the nature and extent of the injury, and prospective medical care. (*Arbitrator's Exhibit* 1). The parties requested a written decision, including findings of fact and conclusions of law, pursuant to Section 19(b) of the Act, and agreed to receipt of this Arbitration Decision via e-mail. (*Arbitrator's Exhibit* (hereinafter, *AX*) 1).

FINDINGS OF FACT

The Petitioner, a 40-year-old married man with two dependents under the age of 18, testified credibly he was a full-time union Plumber, who was hired by the Respondent on May 28, 2013 as a full-time employee, where he eventually earned approximately $1,828.25 per week. He testified that his job duties as a Plumber consisted of the following: heavy level labor job, which involves installing water mains, frequently lifting, pushing, pulling with both upper extremities, frequent overheard reaching and lifting, and frequent use of tools.

The Petitioner testified while at work on November 14, 2013, he was installing a water main at Cicero and Shubert when the trench collapsed and a cement block or part of a curb crushed his left leg. (*Petitioner's Exhibit* 1 at 12). He testified a coworker immediately reported the injury to his supervisor, Bob Johnson, and an ambulance was called to the scene. He was then taken via ambulance to Our Lady of Resurrection Medical Center. At that facility, x-rays were performed of the left leg, left knee, left foot, and left ankle, and revealed a nondisplaced acute fracture involving the proximal metaphysis and diaphysis of the tibia. (*Petitioner's Exhibit* (hereinafter, *PX*) 1 at 15-16). In addition, there was concern with decreased pulses in the left foot and his inability to move his toes on that foot. Accordingly, an Ultrasound Arterial Duplex of the left lower extremity and a CT Angio of the left lower extremity were performed, revealing a left popliteal artery occlusion. (*PX* 1 at 17). The Petitioner then was transferred that same day via ambulance to Advocate Illinois Masonic Medical Center as Our Lady of Resurrection Center was not equipped to handle such cardiovascular issues. (*PX* 1 at 13 and *PX* 2 at 271-72).

Upon arrival at the emergency room at Advocate Illinois Masonic Medical Center, x-rays of the chest and left leg were performed, as well as another left lower extremity Arterial Duplex Ultrasound. (*PX* 2 at 50-52, 281, 525, and 528). The Petitioner was diagnosed with a crush injury to the left lower extremity, a hairline fracture of the tibia, and acute occlusion of the popliteal artery. (*PX* 2 at 52). He then was sent for an emergency vascular surgeon consult by Dr. Ashok Doshi, who opined that an emergency surgery was necessary (*PX* 2 at 331-332). Later that same day, Dr. Doshi performed an emergency exploration of left lower extremity for severe limb-threatening ischemia; left popliteal above knee to posterior tibial artery, saphenous vein bypass graft; left popliteal angiogram with distal runoff up to the foot (intraoperative contrast injection, radiologic supervision and intraoperative interpretation); exploration and thromboembolectomy of left distal anterior tibial artery; posterior compartment fasciotomy; and anterior compartment fasciotomy (*PX* 2 at 342-346).

The Petitioner then was admitted to Advocate IL Masonic Medical Center following surgery, where he was examined by Dr. Rajeev Garapati, an orthopedic surgeon, on November 15, 2013. (*PX* 2 at 332-334). Diagnostic studies of the left leg and left knee were performed and Dr. Garapati prescribed a knee immobilizer for the left knee. (*PX* 2 at 334, 525-527). Thereafter, on November 18, 2013, an initial physical therapy evaluation was performed in the hospital and the Petitioner continued with daily physical therapy through his discharge from the hospital on November 26, 2013. (*PX* 2 at 312-330).

However, prior to that discharge[1], on November 20, 2013, Dr. Richard Fantus, a trauma surgeon, performed another surgery consisting of preparation of recipient site; application of acellular xenograft 3 x 2.5cm distal anterior tibia, 6 x 24 cm left medial fasciotomy wound; vacuum-assisted wound closure placement greater than 50 cm with modifier 22 for complex procedure due to the nature of the wound; and dressing change under anesthesia. (PX 2 at 346-348). Dr. Fantus again saw the Petitioner for surgery on November 25, 2013, when he performed a delayed primary closure of left lateral fasciotomy wound 16 cm and delayed primary closure of left medial fasciotomy wound 25.5 cm. (*PX* 2 at 58-59). As previously discussed, the Petitioner then was discharged from Advocate IL Masonic Medical Center on November 26, 2013, was prescribed Lovenox and Coumadin, was advised to remain off work, and was scheduled for another surgery on December 4, 2013. (*PX* 2 at 232-270).

The Petitioner returned to Dr. Doshi on December 2, 2013, for anticoagulation therapy management prior to his next surgery and he was prescribed aspirin as an antiplatelet agent

[1] The Petitioner began receiving TTD benefits from the Respondent on November 15, 2013, the day after his accident date. (*Respondent's Exhibit* 1).

and Norco for the pain. (*PX* 3 at 113-114). On December 4, 2013, Dr. Fantus' December 4, 2013 surgical procedure consisted of a delayed primary closure of anterior distal open wound left lower extremity 8.5cm. (*PX* 2 at 60-61).

Thereafter, on December 9, 2013, Dr. Doshi performed a bilateral lower extremity arterial blood flow study, a study of bilateral brachial segmental systolic pressures, and a bilateral brachial arterial Doppler tracings. (*PX* 3 at 120-123). He also refilled the Petitioner's prescriptions of Norco, Lovenox, and Coumadin, prescribed venous compression stockings to be worn daily, and prescribed a CT angiogram of the left lower extremity. (*Id.*) That same day, the Petitioner also saw Dr. Juan Santiago-Gonzalez, another trauma surgeon in Dr. Fantus' group, to check the status of his wounds. (*PX* 2 at 496-499).

On December 13, 2013[2], Dr. Garapati ordered x-rays of the left leg, performed some dressing changes for the fasciotomy, and placed him on Keflex until he could follow-up with his trauma surgeon. (*PX* 4 at 150, 154). Dr. Garapati also recommended the Petitioner remain non-weightbearing, work on his left knee range of motion, and to use his knee immobilizer. (PX 4 at 150). That same day, Dr. Doshi met with the Petitioner due to a fever and drainage from the incision, and Dr. Doshi again prescribed a CT angiogram. (*PX* 3 at 115-116).

On December 16, 2013, Dr. Santiago-Gonzalez, a trauma surgeon at Advocate, saw the Petitioner and removed some of his sutures. (*PX* 2 at 501-504). The Petitioner then underwent a CT angiogram of the left lower extremity on December 18, 2013. (*PX* 2 at 15-19). On December 23, 2013, he saw Dr. Michele Mellett, another trauma surgeon at Advocate, who removed additional sutures. (*PX* 2 at 505-508). Immediately after that session, the Petitioner returned to Dr. Doshi due to bleeding over leg after suture removal and anticoagulation therapy management. (*PX* 3 at 117-119).

On January 6, 2014, Dr. Garapati ordered new x-rays of the left leg and prescribed physical therapy for the left knee and left ankle (*PX* 4 at 149, 153). The Petitioner then returned to Dr. Doshi on January 10, 2014, to discuss long term treatment with antiplatelet agents of aspirin and Plavix, low intensity anticoagulation and statin therapy as well as the need for long term vascular monitoring for bypass evaluation. (*PX* 4 at 124-125). The next day, he began a course of left knee physical therapy Illinois Bone & Joint Institute. (*PX* 4 at 137-139).

The Petitioner continued to meet with and be examined by trauma surgeons at Advocate on January 16, January 20, January 30, and February 6, 2014. (*PX* 2 at 484-495). He

[2] The Petitioner testified on or about December 13, 2013, the Respondent hired and assigned a telephonic nurse care manager from Coventry, Ms. Elizabeth Toppmeyer, to his case, but she did not attend his appointments and, instead, only called him to obtain medical updates and assist with needed medical authorizations.

also returned to Dr. Garapati on February 7, 2014, where updated x-rays of the left lower extremity were obtained and he was authorized to return to light duty work.[3] (*PX* 4 at 148, 152). On March 7, 2014, Dr. Garapati obtained additional left knee x-rays and recommended compression bandages to address swelling while continuing with and aggressive physical therapy regime. (*PX* 4 at 40, 147, 151).

Dr. Doshi then prescribed, on March 10, compression stockings to the calf and additional Coumadin.[4] (*PX* 3 at 126-127). At that same time, he also obtained further bilateral lower extremity arterial blood flow studies, bilateral brachial segmental systolic pressures, and bilateral brachial arterial Doppler tracings. (*PX* 3 at 87-91).

On May 9, 2014, Dr. Garapati performed x-rays of the left knee, recommended an injection for the left knee[5], and prescribed a supportive knee sleeve. (*PX* 4 at 37-39, 44). The Petitioner returned to Dr. Doshi on June 5, 2014, for an evaluation where Dr. Doshi recommended the Petitioner: 1) would need to wear venous compression stockings daily; 2) would require for the remainder of his life statin therapy, a long term dual agent antiplatelet therapy of Plavix and aspirin, and long term vascular bypass evaluations; and 3) deal with the risk for artherosclerosis. (PX 3 at 84-86).

On June 9, 2014, while Dr. Doshi imposed light duty work restrictions[6], Dr. Fantus released the Petitioner at maximum medical improvement (MMI), indicating he was capable of performing full duty while wearing protective covering over his distal leg wound, his knee protection, and still being subject to the restrictions of "Ortho, Vascular, PT, and OT as well". (*PX* 3 at 82). The Petitioner then finished his physical therapy program on June 17, 2014. (*PX* 4 at 119-122).

Subsequently, on June 25, 2014, Dr. Garapati prescribed a work conditioning program running 5 times per week for 4 weeks that began on July 15, 2014. (*PX* 4 at 116-118). Dr. Garapati then obtained updated x-rays of the left knee on July 18 and prescribed custom orthotics for the Petitioner's bilateral feet due to an altered gait as the Petitioner was found to be favoring his left leg (*PX* 4 at 34-36, 43, and 47). On July 21, 2014, Dr. Doshi again obtained

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[3] The Petitioner testified that, due to ongoing work restrictions imposed by Dr. Fantus and Dr. Doshi, he continued to receive TTD benefits from the Respondent at that time. (*Respondent's Exhibit* (hereinafter, *RX*) 1).

[4] Dr. Doshi also repeatedly recommended the Petitioner obtain a neurology evaluation for his left leg numbness, but the Petitioner reported he never saw a neurologist after discussing that option with Dr. Fantus and his other trauma surgeons. (*PX* 3 at 89, 125, 127).

[5] The Petitioner declined this treatment option at that time.

[6] *PX* 3 at 83.

updated bilateral lower extremity arterial blood flow studies, bilateral brachial segmental systolic pressures, and bilateral brachial arterial Doppler tracings.[7] (*PX* 3 at 77-81). He revised the Petitioner's light duty work restrictions on July 24 (*PX* 3 at 76) before the Petitioner completed his work conditioning program on August 19, 2014. (*PX* 4 at 107-110). Thereafter, on August 25, 2014, Dr. Garapati obtained new x-rays of the left knee and released the Petitioner at MMI with permanent restrictions as recommended by his work conditioning program and consisting of limited kneeling, limited standing, limited walking, and repetitive lower extremity work for a total of four hours per day. (*PX* 4 at 31-33, 42). On or about September 6, 2014, the Respondent began paying maintenance benefits. (*RX* 1).

On November 13, 2014, the Petitioner, at the Respondent's request, attended a vocational rehabilitation meeting. (*PX* 6). After that session, maintenance benefits ceased as of November 16, 2014. (*RX* 1). The Petitioner then was placed in a position as a full time/full duty Plumber on November 17 that allowed his permanent restrictions to be reasonably accommodated and allowed him to earn his same rate of pay as prior to his date of accident (*RX* 1). The Petitioner confirmed he still works in that position.

The Petitioner testified he last saw Dr. Fantus on June 9, 2014 and Dr. Garapati on August 25, 2014. (*PX* 3 at 82 and *PX* 4 at 31-33). However, he continued to treat with Dr. Doshi on January 26 and July 20 of 2015 and January 21, July 18, and July 31 of 2017. He confirmed Dr. Doshi would administer during these visits bilateral lower extremity arterial blood flow studies, bilateral brachial segmental systolic pressures investigations, and bilateral brachial arterial Doppler tracings. The Petitioner also noted Dr. Doshi has reiterated his recommendations that he wear venous compression stockings daily for the rest of his life, take statin therapy for life, participate in long term dual agent antiplatelet therapy of Plavix and aspirin for life, receive long term vascular bypass evaluations for life, and cope with the risk for artherosclerosis. (*PX* 3 at 1-5, 20-29, 56-60, and 67-70). On September 21, 2016, the Petitioner also underwent another CT angiogram per Dr. Doshi's orders and reviewed those results with Dr. Doshi on October 3, 2016 (*PX* 3 at 7-15). The Petitioner also testified Dr. Doshi has urged him to return for yearly follow-up appointments for updated extensive diagnostic testing, a review of his multiple medication programs, yearly physical evaluations, and determinations as to whether he would require further surgical interventions, including vascular bypass or the amputation of his left leg. (*PX* 3 at 1-5).

[7] On October 20, 2014, Dr. Doshi performed an additional round of bilateral lower extremity arterial blood flow studies, bilateral brachial segmental systolic pressures, and bilateral brachial arterial Doppler tracings. (*PX* 3 at 71-75).

The Petitioner indicated he did not have any injuries to his left leg prior to or after his November 14, 2013 work accident. Instead, prior to that date, he had been working full duty with restrictions. Presently, he still has difficulty being on his feet for long periods of time and kneeling for long periods of time whether at work or when performing daily activities. He has appreciated some weakness, soreness, a squeezing sensation, and a loss of range of motion in his left leg and left knee. However, after introducing his custom orthotics for his shoes, he no longer has issues with his left foot. Over the left leg itself, the Petitioner still senses pain, soreness, and tenderness in his left leg after work or daily activities and rates his pain level at 5-6 on a 10-point scale. He continues with his medications, including Tylenol for pain, and uses heat and ice to further address his pain symptoms.

The Petitioner also testified he continues to work for the Respondent in the same position and at the same pay rate, where he has been able to work within and around his permanent restrictions. He also agreed the Respondent has paid all reasonable, necessary and related medical expenses regarding this matter. (*AX* 1).

CONCLUSIONS OF LAW

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

Issue F: *Causal connection*

It is axiomatic that, in order to prevail on a claim under the Act, an injury must arise out of and in the course of employment. See Baggett v. Industrial Commission, 201 Ill. 2d 187, 194 (2002). To this end, a claimant must show, inter alia, that some aspect of his or her employment was a causal factor that resulted in the complaint of injury. Teska v. Industrial Commission, 266 Ill.App. 3d 740, 742 (1994). It is not, however, necessary that the employee demonstrate that the injury was "the sole or principal positive factor, as long as it was a causative factor in the resulting condition of ill-being." Land and Lakes Company v. Industrial Commission, 359 Ill.App. 3d 582, 592 (2005). Whether a causal connection exists between a claimant's injury and his or her employment presents a question of fact. Land and Lakes Company, 359 Ill.App. 3d at 692. It is the role of the Commission to resolve conflicts in evidence and this is particularly true with regard to medical opinion evidence. Navistar International Transportation Corp. v. Industrial Commission, 331 Ill.App. 3d 405, 415 (2002). It is also the duty of the Commission to assess the credibility of witnesses and assign weight to their testimony. Paganelis v. Industrial Commission, 132 Ill.2d 468, 483-484 (1989).

The medical records of Our Lady of Resurrection Medical Center, Advocate Illinois Masonic Medical Center, Dr. Doshi, Dr. Fantus, and Dr. Garapati all causally relate the Petitioner's left leg and vascular injuries and the need for current permanent restrictions to the work-related accident of November 14, 2013 (*PX* 1, *PX* 2, *PX* 3, and *PX* 4). Furthermore, the Respondent offered no contrary testimony, opinions, or medical evidence.

As such, the Arbitrator finds the Petitioner's current condition of ill-being is causally related to his November 14, 2013, accident. The Petitioner credibly testified as to the accident, his medical care, and his present symptoms. The medical records offered into evidence are consistent with the Petitioner's testimony and the mechanism of injury is consistent with his left lower extremity difficulties. Furthermore, there is no evidence the Petitioner suffered any other recent injuries to his left leg in the past or subsequent to this injury.

Issue L: *Nature and extent of injury*

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

(a) A physician licensed to practice medicine in all its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment from (a) above;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

(See 820 ILCS 305/8.1b)

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

i. The Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence by either party. As such, the Arbitrator therefore gives ***no weight*** to this factor.

19IWCC0465

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

ii. The Arbitrator finds the Petitioner worked for the Respondent as a full-time union Plumber overseeing the Respondent's water distribution system, installing and repairing water mains, and performing other various heavy level labor work. The Petitioner testified he has returned to this position and is able to work within or around his permanent work restrictions at his same rate of pay. As such, the Arbitrator therefore gives ***moderate weight*** to this factor.

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

iii. The Arbitrator notes that the Petitioner was 40-years-old at the time of the accident (*AX* 1), but no specific evidence as to how the Petitioner's age might affect his disability was offered by either party. As the Petitioner must cope with his left leg symptoms for several years in the future, the Arbitrator therefore gives ***moderate weight*** to this factor.

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

iv. The Arbitrator notes that the Petitioner testified he has returned to his prior position as a union Plumber for the Respondent and earns the same rate of pay that he did prior to his November 14, 2013 accident. Furthermore, the Petitioner specifically indicated he does not believe his future earning capacity has been diminished by this accident. (*T.* at 38). As such, the Arbitrator therefore gives ***no weight*** to this factor.

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

v. The Petitioner's treating medical records show he eventually was diagnosed with a crush injury to the left lower extremity, a hairline fracture of the tibia, and acute occlusion of the popliteal artery. (PX 2 at 52). The Petitioner underwent multiple surgical procedures, numerous diagnostic tests, and physical therapy and work conditioning programs before returning to work with permanent restrictions. He continues to see Dr. Doshi for regular follow-up appointments for diagnostic testing and to consider treatment revision options.

The Petitioner testified he continues to experience left leg difficulties after long periods of being on his feet or kneeling. He also has ongoing pain symptoms and experiences weakness, soreness, a squeezing sensation, and a loss of range of motion in his left leg and knee. He uses Tylenol, along with ice and/or heat, to

address his pain symptoms and continues to take other medications for his vascular issues. As such, the Arbitrator therefore gives ***significant 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 a **75.58%** loss of use of the **left leg** pursuant to Section 8(e)12 and Section 8.1b.

Issue O: *Prospective medical*

The Petitioner's medical records and testimony confirm Dr. Doshi is recommending the Petitioner, for the remainder of his life, return for at least annual follow-up visits to monitor his statin therapy program, to conduct updated diagnostic vascular testing, to perform physical examinations of his vascular system, to review his medication prescriptions, and to consider revisions to his medical care plan, including future surgeries up to the amputation of the Petitioner's left leg. (*PX* 3 at 1-5).

As such, the Petitioner's medical rights under Section 8 of the Act shall remain open for life and the Respondent shall be required to pay any and all reasonable and necessary medical services causally related to the Petitioner's November 14, 2013, left leg accident, pursuant to the medical fee schedule, as provided in Section 8(a) and Section 8.2 of the Act.

Signature of Arbitrator

JANUARY 11, 2018
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Francisco Labra,

Petitioner,

vs. NO: 15 WC 36719

R & M Trucking,

Respondent.

19IWCC0466

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, disease, temporary disability, permanent disability, wages, benefit rates, medical expenses, employee relationship, jurisdiction, 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 July 27, 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.

19IWCC0466

The party commencing 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 28 2019
o071719
BNF/mw
045

Barbara N. Flores

Marc Parker

Deborah Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LABRA, FRANCISCO
Employee/Petitioner

Case# **15WC036719**

R&M TRUCKING
Employer/Respondent

19IWCC0466

On 7/27/2018, 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 2.14% 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:

4262 ROMANEK & ROMANEK
DARON ROMANEK
ONE N LASALLE ST SUITE 425
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
BRIAN T RATERMAN
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

FRANCISCO LABRA,
Employee/Petitioner

Case # **15 WC 36719**

v.

Consolidated cases:

R&M TRUCKING,
Employer/Respondent

19IWCC0466

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **May 10, 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 19IWCC0466

On **10/7/2015**, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent. Because Petitioner failed to prove accident, the other issues as to causal connection, whether Petitioner has received all reasonable and necessary medical services and whether Respondent has paid all appropriate charges for same is hereby rendered moot.

In the year preceding the injury, Petitioner earned $**39,633.12**; the average weekly wage was $**762.18**.

On the date of accident, Petitioner was 32 years of age, ***married*** with 2 dependent children.

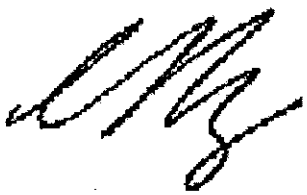
Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0. Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Because Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent, all benefits are denied.

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

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



Signature of Arbitrator

7-26-18
Date

JUL 27 2018

FINDINGS OF FACT

Petitioner testified that on October 7, 2015 he was working for Respondent as a dock worker. He testified that he and his co-worker, Margarito Noriega, were filling an order for shipment when Petitioner said to Mr. Noriega "are you going to help me out or what?" Petitioner testified that he then walked past Mr. Noriega, who then grabbed him (Petitioner) from behind by in a "bear hug." Petitioner testified that Mr. Noriega shook him back and forth while Petitioner struggled to get away, but did not fight back, and tried to stop the encounter by putting his hands up. Petitioner testified that he felt his left knee pop with extreme pain while in the bear hug, then he and Mr. Noriega fell to the ground together. Mr. Noriega did not testify at trial.

Petitioner testified that, that he thought "Mike," another R&M Trucking employee, approached Mr. Noriega and him approximately 5-10 minutes later while they were still on the floor. Petitioner testified that he was in too much pain to report what happened to him.

Petitioner testified he was helped from the ground by a coworker and they walked together so he could sit in a chair off the warehouse floor. Petitioner testified that Mike then drove him to U.S. Healthworks for medical care. Petitioner testified that he did not tell Mike during the drive to U.S. Healthworks that he was fooling or playing around Mr. Noriega at the time of this incident. Petitioner testified that when he arrived at U.S. Healthworks that Mike checked him in before leaving. Petitioner testified that he was seen by Dr. Garala but denied telling the doctor that he was "play fighting" with a co-worker. Petitioner testified that Mike returned to US Healthworks when his visit concluded and drove him back to Respondent's facility.

Petitioner testified that he met with Nicole Adamson when he was back at Respondent's facility. He testified that he did not tell Ms. Adamson during this meeting that he was engaged in horseplay with Mr. Noriega when he was injured. He further testified that he did not tell Ms. Adamson he and Mr. Noriega wrestled together before they were injured. He testified that he was ultimately terminated from employment by Respondent.

Petitioner testified that he next sought medical care with his primary care physician, Dr. Purchit Laquesta, initially on October 22, 2015. Petitioner testified that Dr. Laquesta referred him to an orthopedic surgeon for examination of his left knee, Dr. Richard Hayek at Northwest Orthopedics and Sports Medicine. Petitioner testified that he saw Dr. Hayek on November 5, 2015. Petitioner testified he wasn't happy with Dr. Hayek and did not return. Petitioner testified that Dr. Laquesta ordered an MRI of his left knee. Petitioner testified that he had said MRI on October 29, 2015. Petitioner then testified that he came under the care of Dr. Ronald Silver on November 7, 2015.

Petitioner testified that Dr. Silver performed surgery to his left knee on January 12, 2016. Petitioner testified that following surgery he was returned to full duty work as of May 6, 2016. Petitioner testified that the last time he saw Dr. Silver was on September 28, 2016 and reported that his left knee was continuing to give him trouble. Petitioner testified that a new MRI scan of the left knee was ordered, but he did not proceed with it to avoid going further into debt.

Petitioner testified that in approximately April 2016 he started to work for Dr. Pepper as a machinist, but only worked for one month. Petitioner testified that he quit this position because his left knee was bothering him too much. Petitioner testified he then found employment with his brother working as a commercial painter. He testified that this job painting job started in May 2016 and paid him $15.00 per hour, 40 hours per week. He testified that his painter's job doesn't require him to stand very long, but he does have to crouch and kneel.

Petitioner testified that he had no problems with his left knee before October 7, 2015. Petitioner testified that he can't climb ladders any longer, but he can go up and down stairs with occasional difficulty. He testified

that he has stiffness in his left knee at the end of the day and it hurts for him to squat, crouch, and kneel. He stated he could no longer run and jump with his kids because of pain. He testified that his left knee hurts more when he slips on water or ice. Petitioner testified that he is not taking prescription medications and has not sought any treatment for his left knee since September 28, 2016. Petitioner testified that he takes over the counter pain medications occasionally. He testified that no doctor has restricted his personal or work activities because of his left knee.

Petitioner testified on cross-examination that he was attacked by Margarito Noriega. However, he did not know Mr. Noriega's mental state and whether he intended to injure him or whether he was angry. When pressed further on cross-exam, Petitioner testified that he believed that Mr. Noriega was probably just joking around with him during the incident. Petitioner testified that he had worked with Mr. Noriega since 2014 at R&M Trucking and had no previous problems with him during that time. He said that they were friendly at work and would occasionally see each other and be friendly outside of work. Petitioner testified that he did not file a police report following this incident. The Arbitrator notes that the Application for Adjustment of Claim related to this case list Respondent's facility located as 3720 River Road, Franklin Park, IL. A subpoena to Franklin Park Police Department returned a Certification of no records of any arrest reports, case, incident and supplemental reports or other police reports pertaining to Petitioner's incident on October 7, 2015. Respondent's Exhibit #12.

Petitioner testified further on cross-examination that the initial person to approach him and Mr. Noriega while they were on the ground together could have been Jason Krawczyk. He testified he wouldn't disagree if the evidence showed this to be true. He denied though that he ever told Mr. Krawczyk that he and Mr. Noriega were fooling around when he was injured.

Petitioner further testified that the trip with Mike Narvaez from Respondent's facility to US Healthworks took approximately 10-15 minutes. Petitioner further testified on cross-exam that he and Mike Narvaez did not discuss what happened to him even once during this drive. Petitioner stated that there were no employees of Respondent in the room during the time he was examined by Dr. Garala at US Healthworks. Petitioner again testified on cross-exam that he did not discuss the mechanism of his injury with Mr. Narvaez on the return drive from US Healthworks to Respondent's facility.

Petitioner further testified that he met with Nicole Adamson alone when he returned to R&M Trucking on October 7th. Petitioner testified that he did not tell Ms. Adamson that he and Mr. Noriega were fooling around at the time he was injured.

Petitioner admitted that that before October 7th he took part in a meeting conducted by Ms. Adamson that addressed Respondent's policy on horseplay and violence in the workplace. Petitioner testified that he therefore knew that engaging in either horseplay or violence could be grounds for immediate termination of employment.

Petitioner testified that that he felt good enough to return to work in May 2016. Petitioner testified that that he felt physically fit to return to the full duty functions of his job as a dock worker and would have returned but-for his termination from employment. Petitioner first testified on cross-examination that his job is a dock worker was less physically demanding than his position as a commercial painter. Petitioner subsequently testified that the position as a dock worker for Respondent was more physically demanding than his commercial painter position because of a purported 50-pound lifting requirement.

He testified that since this injury, he has slipped on ice or water 2-3 times, impacting his left knee. He testified that these slip and fall incidents had increased his left knee pain each time when compared to immediately before.

Respondent's Witnesses

Jason Krawczyk, Operational and Dispatch Manager for Respondent, testified on its behalf. He testified that he has been employed by Respondent for approximately 22 years, save a brief stint in 2007 when he worked as a Cook County Sheriff. Krawczyk testified that on October 7, 2015 he was walking alongside some freight stacked 8-10 feet high on pallets when he heard somebody on the other side exclaim in pain. Krawczyk stated that he immediately went towards the source of the sound, which took him approximately 5-10 seconds before he arrived to find Petitioner and Margarito Noriega on the ground next to each other. Krawczyk testified he asked both what happened, and they replied in unison that they were just goofing around. Krawczyk testified that Noriega eventually stood up, though Petitioner remained on the ground and visibly appeared to be in pain.

Mike Narvaez, the safety director for Respondent since 2014, next testified on Respondent's behalf. Narvaez testified that his position as safety director made him responsible for safety and OSHA compliance. He stated his primary responsibility was not work-related accidents, but he would assist in the investigation if one were to occur. He stated that on October 7, 2015, somebody notified him that there was an injury on the warehouse floor, and when he arrived at the scene, Petitioner was still on ground. Noriega was standing next to him.

Narvaez testified that he ultimately drove Petitioner to U.S. Healthworks in Schiller Park. Narvaez said that he did not usually drive employees to U.S. Healthworks but made an exception in this case because he felt that an ambulance was not necessary and would have taken more time than if he were to drive himself. Narvaez testified that it was only he and Petitioner in his vehicle for the drive to U.S. Healthworks. Narvaez testified that he asked Petitioner what happened multiple times in multiple ways during this drive, including asking Petitioner whether he was attacked or was he being bullied, etc. Narvaez testified he was repetitive because Noriega was physically larger than Petitioner and because of the potential employment implications based on what Petitioner reported.

Narvaez testified that Petitioner replied that "we were just fucking around." Narvaez testified that he checked Petitioner in at U.S. Healthworks but did not meet with Petitioner and the doctor. Narvaez testified he returned to U.S. Healthworks to drive Petitioner back to R&M Trucking. Narvaez testified that during the return drive from US Healthworks, Petitioner reported that he and Noriega were just playing around at the time of his injury. Narvaez testified Petitioner never indicated that he was innocent and was not involved in the incident with Noriega during the drive to and from US Healthworks.

Narvaez testified that he met with Petitioner and Nicole Adamson together when they returned from US Healthworks. Narvaez testified that Petitioner again reported that he was playing around with Noriega at the time of his injury. Narvaez testified that the Petitioner did not once indicate during this meeting in Ms. Adamson's office that he was an innocent victim, or otherwise had no other involvement.

Finally, Narvaez testified that he assisted Adamson in conducting a full investigation of the incident involving Petitioner and Noriega. He testified that the summary completed by Adamson accurately summarized his contribution to the investigation in which he interviewed Frankie Ocasio, Louie Scott and Petitioner. Px18:7.

Finally, Respondent called Nicole Adamson, director of HR for Respondent to testify. Adamson testified that her responsibilities include employee training, benefits, relations, compensation and investigation and documentation of any workplace accidents. Adamson testified that she learned of the incident with Petitioner and Noriega from Mike Narvaez the same day it occurred.

Adamson testified that she investigated of the incident, which included interviewing Mr. Noriega and Petitioner separately in her office on October 7. Adamson testified that Noriega told her that day that he and Petitioner were just joking around at the time that Petitioner was injured.

Adamson testified that Petitioner told her that he and Mr. Noriega were just joking around at the time of his injuries. Adamson stated that at no point during the meeting with Petitioner did he ever state that he was an innocent victim or that he was attacked by Noriega that day. She further said that Petitioner's report of the incident was consistent with that given by Noriega. Adamson testified that Petitioner was also suspended for one week without pay pending completion of an investigation. Adamson's report is contained in Px18. Adamson testified that these contemporaneous summaries accurately reflected the information and evidence that was provided to her by the various individuals noted on the document. Adamson said prior meetings about horseplay and zero tolerance were previously held and that Petitioner attended those. Rx14-15.

Security Footage of October 7, 2015

Security footage purporting to show the incident involving Petitioner and Mr. Noriega was entered into evidence as Rx17. The only information to be gathered from the video are that two bodies moving together across a warehouse floor, and both end up both on the ground before quickly being reached by a third individual.

Surveillance Video

Surveillance video obtained of Mr. Labra totaling 40 minutes was obtained on March 22, 26, 27, 28, and 31, 2017. Rx4. The video depicts Petitioner largely walking in and out of a private residence and in and out of a vehicle. Petitioner is also seen running errands.

Petitioner's employment file

Petitioner subpoenaed his employment file from Respondent on December 21, 2015. Px18. The incident in question was contained in the file and the investigative summary states that Mr. Noriega reported to Nicole and Mike that he and Petitioner were playing around and pushing each other after completing a shipment. The summary further states that Petitioner reported to Ms. Adamson that he and Margarito Noriega were friends and tended to fool around. The summary also documents that Petitioner told Adamson that he and Noriega wrestled a bit before Petitioner put up his arms to stop.

Medical History

Petitioner initially sought medical attention at U.S. Healthworks Medical Group in Schiller Park at 10:36 a.m. on October 7, 2015. He reported to Dr. Mehul Garala that earlier that day he was "play fighting" with a co-worker. Px1. He further reported that they both fell down and he heard a "pop" from his left knee and immediate pain initially rated at 10/10. He denied previous injury to his left knee. An examination was performed and an x-ray showed an irregularity and mild depression of the lateral tibial plateau on the left with no joint effusion. Dr. Garala assessed Petitioner with a left knee sprain and placed him on modified duty of sitting work only, prescribed Nabumetone 750 mg, instructed him to ice his knee and gave him a medium sized hinged knee brace. He was set to return October 12, 2015. A voicemail was left on October 7 for the company representative, Nicole Adamson.

Petitioner next sought medical attention with Dr. Purchit Laquesta at Primecare Family Physicians on October 22, 2015. Px2. Petitioner reported that he was grabbed by a co-worker who was upset with him and felt a pop in his left knee as he was about to fall. Dr. Laquesta diagnosed Petitioner with knee pain and a left

knee MRI was ordered. A left knee MRI was performed on October 29, 2015 and was interpreted by Dr. Brad Abramson to show an intra-articular impacted fracture involving the lateral tibia plateau with extensive bony edema; a bucket handle tear of the posterior horn of the lateral meniscus; and suspected oblique tear of the posterior horn of the medial meniscus. Dr. Laquesta referred Petitioner to Dr. Hayek on October 30, 2015.

Petitioner saw Dr. Richard J. Hayek of Northwest Orthopaedics and Sports Medicine on November 5, 2015. Px3. Dr. Hayek recommended arthroscopic evaluation of the left knee to address the meniscus if it required a repair versus a partial meniscectomy. Dr. Hayek further discussed possible fixation of the lateral plateau depression if it can be elevated and fixated with cannulated screws. Dr. Hayek took Petitioner off work.

Petitioner then came to be seen by Dr. Ronald Silver on November 7, 2015. Px4. Petitioner reported to Dr. Silver on November 7 that he was attacked by a co-worker who came up from behind him, grabbed in a bear hug and shook him side to side causing him to fall down during this altercation on October 7, 2015. Petitioner reported that he twisted his left knee and felt a crack followed by immediate pain, swelling and stiffness. He reported his knee was symptom free prior to October 7. Dr. Silver noted his review of the left knee MRI and obtained standing AP, lateral and skyline x-rays, which he opined demonstrated a minimally depressed lateral tibial plateau fracture of approximately 3 mm to 4 mm. Dr. Silver recommended treating the lateral tibial plateau fracture conservatively due to the minimal depression, but that he required arthroscopic surgery for the torn menisci. Dr. Silver prescribed Ketoprofen, Meloxicam, Protonix for gastrointestinal protection as, according to Dr. Silver, Petitioner had demonstrated gastrointestinal sensitivity to other nonsteroidal anti-inflammatory medications, Hydrocodone for pain and Ultram for lower levels of discomfort. He kept Petitioner off of work. Dr. Silver again ordered Mobic 15 mg, Protonix 20 mg, Norco 2.5/325 mg, Ultram 150 mg, and a Terocin 1% patch again on December 16, 2015.

Dr. Silver performed an arthroscopic debridement, tricompartmental synovectomy, and lysis of adhesions in Petitioner's left knee on January 12, 2016 at St. Francis Hospital. Px5. Dr. Silver documented intraoperatively that there were suprapatellar adhesions, a tricompartmental synovitis, and Grade 2 fragmentation of the anterior non-weightbearing surface of the medial femoral condyle. The medial meniscus and medial compartment were normal. The lateral compartment was also normal to probing, including without meniscus and articular cartilage.

Petitioner began postoperative physical therapy at Advanced Physical Medicine under the direction of Chiropractor Frank Russo. Px6. The initial therapy date was January 27, 2016. Petitioner performed 24 sessions of therapy at Advanced Physical Medicine in total, completing his care on May 3, 2016. On May 3, Petitioner reported no complaints with good tolerance to all activities of daily living and exercises.

Dr. Silver kept Petitioner off work postoperatively until May 6, 2016. Rx4. On May 6, the doctor noted that Petitioner's knee "looked good today" and had full range of motion without atrophy, meniscal clicks, joint line tenderness patellofemoral clicking, crepitation or apprehension. He was recommended to slowly return to normal activities. Petitioner returned to Dr. Silver on September 28, 2016 where he reported that his left knee continued to trouble him. A new MRI scan was ordered.

Section 12 evaluation of Dr. James Cohen

Petitioner was evaluated for purposes of a Section 12 examination at Respondent's request by Dr. James Cohen on August 18, 2016. Petitioner reported to Dr. Cohen that he told one of his co-workers in a joking manner when trucks were coming in "are you going to help me or what" and walked away, after which time the co-worker grabbed him from behind in a bear hug and shook him. Rx1. He stated the other employee may have been goofing around but he asked him to stop, but he felt a sharp pain and pop in his left knee then fell to the

ground. Petitioner reported that he had mostly medial pain in his knee that was somewhat diffuse and he had occasional popping and swelling on the date of the examination.

Petitioner told Dr. Cohen that he was not working, and he could not work, because of pain with prolonged standing and walking. Dr. Cohen performed an examination and noted full range of motion from 0 to 130 degrees bilaterally, no medial, lateral or AP instability, negative McMurray testing, no tenderness medially or laterally, no popliteal or calf tenderness and he had a normal gait and was able to stair step without difficulty bilaterally. Dr. Cohen causally connected the left knee to the alleged incident of October 7, 2015 and found the treatment performed to date to be reasonable, necessary and related as well. Dr. Cohen recommended an intra-articular steroid and lidocaine injection for subjective pain complaints and opined Petitioner could in a position allowing him to sit periodically, or 30% of the time. He placed Petitioner at maximum medical improvement save the potential injection.

Dr. Cohen drafted an addendum on July 14, 2017 upon review of medical records and surveillance video obtained of Petitioner for March 22, March 26, and March 27, March 28, March 29 and March 31, 2017. Rx2. Dr. Cohen indicated he did not believe that a repeat MRI as recommended by Dr. Silver on September 28, 2016 was necessary. He stated that there was no objective evidence that Petitioner could not be working at a full duty position without any restrictions based on the surveillance showing Petitioner walking briskly, going up and down stairs, carrying objects and a lack of any objective findings on examination from the earlier appointment. Dr. Cohen placed Petitioner at maximum medical improvement.

Medical Bills

Petitioner submitted various bills alleged to be liability of Respondent for this accident. Respondent submitted its fee schedule analysis of various bills.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner testified at trial concerning the facts surrounding his work incident, his reporting the incident to various individuals, his course of medical treatment and as to his current condition of ill-being. The Arbitrator finds Petitioner's testimony was questionable and his credibility must be called into question. Petitioner gave testimony that was self-serving as to whether he was engaged in horseplay and that testimony ultimately was not consistent with his initial treatment record and other witnesses' testimonies. Respondent presented the testimony of several key witnesses to the accident issue. The Arbitrator finds those testimonies to be consistent amongst one another, credible and consistent with Petitioner's initial treatment record. The Arbitrator finds Respondent's witnesses' testimonies to be more credible and adopts those as it relates to the issue of accident.

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

Petitioner is seeking compensation for left knee injuries sustained from an incident on October 7, 2015 in which he testified occurred when his co-worker, Mr. Noriega, had him in a "bear hug" and shook him until he felt his left knee "pop."

The legal standards for compensability of an injury occurring as a result of either an assault, or horseplay, are distinct and one theory must be chosen before going any further with a compensability analysis. Petitioner has characterized this incident as an attack by Margarito Noriega. Petitioner claims the attack was

motivated by Petitioner's question to Mr. Noriega "are you going to help me out or what?" Petitioner later admitted on cross-exam that he thought Mr. Noriega was most likely just joking and had no intent to cause him harm. Furthermore, the credible testimony of Respondent's witnesses and the documented reports from Mr. Noriega indicate that Mr. Noriega was joking around when Petitioner was injured. The Arbitrator finds Petitioner failed to prove he was the non-aggressor of a work-related attack. The Arbitrator concludes that the totality of the credible evidence supports a conclusion that this incident constituted horseplay.

Generally speaking, an injured worker whose injury is the result of "horseplay" is not able to recover workers' compensation benefits, since their accidental injury did not occur within the course of their employment. However, under certain circumstances an active participant in horseplay can recover if they have "disengaged" themselves from the horseplay prior to their accident. *Harvard v. Chicago Park District*, 05 IIC 000288, 01 WC 49478. It is also clear in Illinois that a non-participating victim of horseplay may recover workers' compensation benefits. *Murray v. Indus. Comm'n*, 516 N.E. 2d1039 (3d Dist. 1987).

After reviewing the record as whole, the Arbitrator concludes that it cannot be said that the injuries arose from an assault in the course of a dispute involving the conduct of the work. *Franklin v. Indus. Comm'n*, 274 Ill. Dec. 760, 791 N.E.2d 1171 (1st Dist. 2003). Here, Petitioner testified that his co-worker came from behind essentially surprised him and gave him a bear hug. Petitioner testified that he put his hands up to get his co-worker to cease. At no time did Petitioner provide any testimony that the altercation began as a result of a dispute over work. While the video is of low quality, there is nothing to support Petitioner's version of events. In addition, multiple witness testimonies for Respondent, Petitioner's own admissions in his written statement and his medical records confirms that Petitioner was engaged in horseplay rather than an altercation regarding the conduct of the work. While Adamson's report indicated that Petitioner engaged in horseplay and that after a while he put his hands up, the Arbitrator does not find that to be sufficient evidence of attempting to disengage or that Petitioner was an innocent victim of horseplay. Petitioner also gave different histories to different doctors as to how his accident occurred. In one, Petitioner reported to Dr. Cohen that he asked his co-worker to stop but this fact was not corroborated by Petitioner's own testimony at trial nor is that repeated anywhere else in the record. In another, Petitioner first told Dr. Silver that he was "attacked" by a co-worker, grabbed from behind and shaken. Petitioner failed to mention any horseplay, that he allegedly put his hands up or that he told his co-worker to stop. In another, Petitioner reported to Dr. Laquesta he was grabbed by a co-worker who was upset with him and felt a pop in his left knee as he was about to fall. Again, no horseplay or putting his hands up or telling him to stop was mentioned.

Thus, the injuries suffered in this case were the consequence of a motive personal to the Petitioner (i.e. horseplay) rather than work related. Petitioner failed to prove he was an innocent victim of horseplay and/or that he attempted to disengage. Having found that the altercation was horseplay, the Arbitrator concludes that Petitioner failed to prove his accident arose out of and in the course of his employment with Respondent. All claims for compensation is hereby denied

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Beverly Normand,
Petitioner,
vs. NO: 09 WC 37713

State of Illinois - Department of Human Services,
Respondent.

19IWCC0467

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent disability, wages 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 22, 2019, 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 28 2019
o081519
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NORMAND, BEVERLY Case# **09WC037713**
Employee/Petitioner

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

19IWCC0467

On 1/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% 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:

4282 VITU LAW OFFICES
JOSEPH F VITU JR
30 N LASALLE ST SUITE 1728
CHICAGO, IL 60602

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
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

JAN 22 2019

Brendan O'Rourke, Assistant 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

Beverly Normand
Employee/Petitioner

v.

Illinois Dept. Of Human Services
Employer/Respondent

Case # **09** WC **37713**

Consolidated cases: **n/a**

19IWCC0467

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **March 21, 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: **Petitioner received payment of lost wages from the Court of claims and not entitled to TTD.**

FINDINGS

On **May 1, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**10, 216.96**; the average weekly wage was $**196.48**.

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 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 §8(j) of the Act.

ORDER

Respondent shall pay the unpaid balances of the following medical bills directly to the provider, adjusted in accord with the medical fee schedule provided in §8.02 of the Act:

Jackson Park Hospital (PX #1.1)	$249.00
Advocate Trinity Hospital (PX 1.2)	$1,949.00
Chicago Imaging (PX #1.3)	$193.00 ($6.40 balance)
Windy City Emergency Physicians (PX #1.4)	$407.00 ($79.00 balance)
University of Chicago (PX 1.5)	$1,570.23 ($70.17 balance)
Dr. Gregory Stacy (PX 1.6)	$135.00 ($23.42 balance)
Dr. Ranjit Wahi (PX #1.8)	$500.00

Petitioner's claim for TTD the benefits is denied due to Petitioner's failure to prove that she was directed or recommended to stay off work due to her claimed injuries.

Respondent shall pay Petitioner permanent partial disability benefit of $**196.48/week** for **15 weeks**, because the injuries sustained caused a **3% loss of the person-as-a-whole**, as provided in §8(d)2 of the Act.

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

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

Signature of Arbitrator

January 21, 2019
Date

ICArbDec p. 2

JAN 22 2019

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***G:*** What were Petitioner's earnings?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

Petitioner Beverly Normand holds a Bachelor's degree in Psychology from Roosevelt University, as well as a Master's degree from Chicago State University in Administration. She holds an honorary doctorate from Grant College in Birmingham, Alabama for her work as the founder and president of the Rald Institute. Rald Institute provides free educational services for students with special needs and cultural education for gifted students.

Petitioner testified that she had been a special education teacher for the Chicago Public Schools (CPS), retiring in 2005. However, she continued working as a consultant in 2006, 2007, and 2008. Petitioner testified that she worked as a consultant for CPS in 2009 up to the date of her accident. She identified a CPS 2007 IRS 1099-MISC documenting $21, 337.50 (PX #2). She also testified that she worked for Chicago State University as an adjunct professor in special education. She did not work for Chicago State in 2009 before her accident. She identified a 2008 IRS W-2 documenting $1,839.99 (PX #3).

Petitioner testified that she worked as a Personal Assistant for Respondent State of Illinois Department of Human Services (DHS) for 4 years for her brother, Thomas Ross. Mr. Ross had sustained a traumatic brain injury which resulted in severe disability, including dementia. Her job duties included supervising his medications, transporting him for shopping, monitoring his housekeeping, and taking him to doctor and psychiatric appointments. She also helped translate her brother's limited language and speech to his caregivers. Mr. Ross had been housed in a seniors' facility.

It was agreed that she earned $10,216.96 in the one-year period before her accident.

Before her May 1, 2009 accident Petitioner was informed that she had a new supervisor, James Willis. Petitioner noted that she had had several supervisors before Mr. Willis but could not remember their names. Her supervisor before Mr. Willis was a woman, whose name she could not remember. Petitioner testified that she believed she had discussed her consulting work with CPS and her teaching at Chicago State with her previous supervisor. She further testified that facility supervisor Ida Lambert was present for discussions about her other employment.

On May 1, 2009 Petitioner was instructed to meet Mr. Willis at her brother's residence at the seniors' facility to meet each other and evaluate her brother's case. Ida Lambert, Service Coordinator for the facility where Mr. Ross lived, was to be present also. Mr. Ross was being transferred to a nursing home because his doctors decided he needed a nursing home. Mr. Ross had been transferred a few days before the date of accident, but Mr. Ross had "got away" then and returned to the seniors' facility. Petitioner testified that she had informed her brother of the transfer some days before and that he was OK with the transfer.

Petitioner testified that she arrived at her brother's residence at 9:00 a.m. As she walked into the corridor, her brother came out and began hitting her. She testified that he was punching her in the shoulder and struck her with the door, knocking her to the sidewalk outside causing her to fall on her back, elbows and knees. She testified that he had never struck before that day.

Police were called, who then took Mr. Ross to UIC Medical Center (UIC). Petitioner followed to provide information to hospital personnel concerning him. Petitioner did not receive any medical care at UIC. She testified that she went straight to Jackson Park Hospital from UIC.

Petitioner presented to Jackson Park Hospital ER because she was experiencing discomfort (PX # 1.1). The chart noted her registration at "23:41 hours, 05/01/09", but triage sign-in notes are at timed at 10:52 p.m. Triage nursing notes documented her complaints of shoulder, knee, and back pain after a battery. However, Petitioner testified that the ER was crowded. The chart noted "no beds in the 119." Petitioner left without treatment (LWOT) at 00:30 hours May 2. She testified that staff at Jackson Park ER told her to go to Trinity Hospital. There was no documentation of that referral within PX 1.1.

Petitioner then went to Advocate Trinity Hospital ER (Trinity) where she complained of pain in her back, elbows, and knees (PX # 1.2). She testified that she was examined, and that X-rays were taken that night. Trinity records show that Petitioner registered at 15:19 hours May 2, 2009, but did not answer 3 calls from ER staff.

PX #1.2 contains ER notes from May 4, 2009. Petitioner then complained of 5/10 pain in both elbows, both knees, and the left shoulder. She gave a history of being attacked 4 days before and knocked down on a concrete sidewalk. No bleeding, bruising, or swelling was noted. There were no abnormalities noted on exam except for palpatory tenderness in the elbows and knees and the left shoulder. The back was not tender to palpation. X-rays of the left shoulder both elbows, and the left knee were normal. Petitioner was discharged in good condition with a diagnosis of contusions and to follow up with her primary physician, Dr. Richard Egwele.

Petitioner testified that she was advised to follow up with Dr. Wahi and that physical therapy was recommended. There was no documentation of these directions in the Trinity notes (PX #1.2)

Petitioner then went to the University of Chicago Medical Center ER [UofC] May 5, 2009 (PX #1.5). The records do not contain complete clinical notes regarding presenting complaints or history and physical examination. Thoracic spine and lumbar spine X-rays showed generalized degenerative changes throughout.

Petitioner was seen at UofC again November 12, 2010 with back pain and "red eye." She was diagnosed with lumbago and discharged with prescriptions for Flexeril, Norco, and Cipro (antibiotic). She was advised to follow up with orthopedics and dermatology. Petitioner testified that she was given aspirins and ibuprofen.

On cross-examination Petitioner testified that both of her knees were black and blue after the accident. Petitioner noted that her knees and elbows were OK after several weeks but that she continued to have back and shoulder pain.

Petitioner testified that someone referred her to Dr. Earl Thornton without naming the referring person. Petitioner's Exhibit #1. 7 is a copy of a check payable to Earl Thornton, MD for $40.00 dated May 21, 2009. Petitioner testified that Dr. Thornton did not treat her. No clinical records of this encounter were admitted in evidence.

Petitioner consulted Dr. Ranjit Wahi on May 20, 2009 (PX #1.8). Petitioner gave a history of being assaulted by her brother on May 1, 1009. She complained of severe left shoulder pain, left thoracic/lumbar spine pain, wrist pains, knee pains, and neck pain. Petitioner reported that she had been seen in the ER of Trinity Hospital and University of Chicago Hospitals.

On exam Petitioner complained of shoulder joint pain which radiated to the neck and the upper part of the upper arm. Shoulder extension, flexion, and abduction limited by pain. Dr. Wahi he noted mild to moderate swelling as well as tenderness in the suprascapular area with spasm trapezius muscle. Dr. Wahi noted mild moderate bilateral wrist pain with limited. There was mild muscle spasm for the lower back with radiation into the lower extremities. There was bilateral knee pain but no swelling. Various orthopedic maneuvers were negative, including Waddal's [sic] sign. Dr. Wahi diagnosed left shoulder pain, bilateral wrist pain, bilateral knee pain, and neck and low back pain. Dr. Wahi ordered Motrin and physical therapy 3-4 times a week. Dr. Wahi noted that if there was no relief in the week then an intra-articular shoulder injection be performed.

There is a consent for invasive/operative procedure dated May 29, 2009 for "L shoulder intra-articular injection." There is no procedure or operative report within PX 1.8 for that procedure. Petitioner testified that she received injections for her back and shoulder beginning May 20, 2009. She testified that the injections did not help relieve her symptoms.

Petitioner saw Dr. Wahi again June 1, 2009, noting that Petitioner had a shoulder injection May 29. Dr. Wahi noted that left shoulder abduction was improved but still restricted. Petitioner also complained of left ankle pain, but ankle movement was normal. There was bruising over that ankle "from the incident" which had not been documented before. Elbow movements were also normal although painful. Dr. Wahi referred Petitioner for a left ankle x-ray, which was done at Trinity Hospital June 4, 2009 (PX #1.2). The ankle was radiographically normal. On June 6, 2009 Dr. Wahi but that she still had the left shoulder and left leg pain. Dr. Wahi noted left leg pain was not present first week but was significant on June 2. Petitioner reported the pain was so bad that she could not walk and was using a cain [*sic*]. Dr. Wahi also noted that left shoulder abduction was still slightly limited.

Petitioner returned to Dr. Wahi June 27, 2009, much better. On examination Petitioner's severe pain in the shoulder, left ankle, and bilateral lower legs had subsided and were near normal. There was no neck pain. Dr. Wahi noted back pain had not been

treated earlier but have always been present. Muscle spasm in the lumbar spine was mild but flexion was limited, as was rotation. Extension was near normal. Dr. Wahi discontinued physical therapy for the lower extremities, neck and neck, and shoulder. Therapy for the low back was to continue 2–3 times per week for 2–3 weeks.

On July 10, 2009 Petitioner was complaining of bilateral low back pain. Dr. Wahi again noted minimal muscle spasm in the lumbar spine but that range of motion was within normal limits in all planes. Bilateral knee motion was within normal limits, although Petitioner complained of pain. Dr. Wahi noted the left shoulder pain was a lot better and that motion was within normal limits. Dr. Wahi ordered continued pain medication and physical therapy for the low back and knees.

On August 10, 2009 Dr. Wahi noted Petitioner's significant improvement. However, Petitioner continued to complain of low back pain, left knee pain, and shoulder "hump" pains. Dr. Wahi noted that Petitioner "must have had quite significant assault by her brother." Dr. Wahi further noted Petitioner had been advised to get interventional pain injections for the low back and left knee. The doctor noted there was no deficit in the shoulder and that motion was normal.

There is a consent for invasive/operative procedure dated August 17, 2009 for "caudal epidural." There is no procedure or operative report within PX 1.8 for that procedure.

On September 21, 2009 Dr. Wahi that her low back pain left shoulder pain and knee pains were not present every day but come and go. Dr. Wahi noted there were no neuro deficits in upper or lower extremities. Dr. Wahi ordered continued pain medication and physical therapy 2–3 times per week. The doctor noted that if low back pain "becomes worse then lumbar epidural injection." Therapy checklist notes in September and October 2009 documented therapy given to the left neck without clinical notes documenting a diagnosis or treatment plan for the neck.

There is a consent for invasive/operative procedure dated September 26, 2009 for "lumbar epid & bil L4-L5 (undecipherable)." There are no procedure or operative reports within PX 1.8 for those procedures. There is a handwritten note on September 26 which stated "lumbar epid today."

Petitioner continued with physical therapy at Dr. Wahi's facility through the end of 2009. There are physical therapy checklists covering several February 2010 dates but no clinical notes for that period. She wrote a letter to Dr. Wahi January 13, 2010 stating

that she hoped to resolve the outstanding billing balance once her Crime Victims claim was resolved and Blue Cross/Blue Shield coverage was clarified. Petitioner apparently hand wrote a note August 28, 2009 wherein she asked for an update on her treatment. She stated that she continued to suffer left shoulder, back, and left knees pain, with occasional pain in the lower legs. She stated that she could no longer do work requiring physical/domestic activities and had had chronic pain since May 1, 2009, despite physical therapy and cortisone injections.

Dr. Wahi's clinical notes in December 2009 indicate no significant change in Petitioner's condition since that start of therapy and care in May. The doctor's clinical and billing records last coincide December 30, 2009. The records suggest that Petitioner's condition had plateaued and stabilized by December even though Dr. Wahi did not note that Petitioner was at MMI.

Petitioner testified that she last saw Dr. Wahi in February 2010. She did not explain whether she was discharged or merely stopped care. However, notes indicate Petitioner resumed physical therapy on June 5, 2010 but which ended on June 25 (PX #1.8). There were no clinical notes relating to those sessions. There were no discharge notes by Dr. Wahi.

PX #1.8 contains clinical records and billing HICF statements. The physical therapy progress notes are entered on pre-printed checklist forms which, generally, do not provide any detailed information for the procedures billed for. There are no physical therapy progress notes for May 29, July 9, August 17, August 19, August 21, September 26, December 24, or December 30, 2009. There are no physical therapy progress notes for February 5, February 8, February 18, or February 24, 2010. There are HICF billing entries for all of the foregoing dates. Further, there are no HICF billing statements for December 14 and 18, 2009, and for June 5, June 19, and June 25, 2010.

Petitioner consulted chiropractor B. A. Sayre August 4, 2010 (PX #1.9). She testified that someone recommended Dr. Sayre. She wanted someone with a different approach to her problem because Dr. Wahi said maybe with time her condition would get better or that she may need surgery.

Petitioner complained of constant sharp low back pain and stiffness since being knocked to ground when attacked by a client. She also complained of nausea, blurred vision, and vertigo. On exam Dr. Sayre found palpatory tenderness from C4 to C7 and bilateral sacro-iliac, as well as the gluteal maximus and medius. Dr. Sayre found spasm in the right upper trapezius, left iliocostalis thoracis, iliocostalis lumborum, qaudratus

lumborum, left piriformis, and left hamstrings. Cervical range of motion was essentially normal. Thoracolumbar motion was limited in flexion and extension but otherwise was within normal limits. Petitioner marked the low back only on a pain diagram.

Dr. Sayre diagnosed lumbosacral sprain/strain, myalgia/myositis, muscle spasm, cervical spine subluxations, and DJD lumbar spine. The doctor's treatment plan included infra-red therapy, traction, mechanical massage, and manipulation therapy. Dr. Sayre added his opinion that Petitioner's injuries were a "direct result of the incident that occurred on 5-1-09."

An August 25, 2010 lumbar MRI ordered by Dr. Sayre demonstrated bulging discs without herniations at L3-4, L4-5, and L5-S1.

Petitioner received chiropractic care through October 27, 2010. Dr. Sayre billed $175.00 November 4, 2011 for a narrative report which was not included in PX #1.9.

Petitioner last received treatment for her shoulder approximately one year ago from internist Dr. Kumar Kaliana, who gave her an injection. No clinical records or bills of that encounter were offered in evidence.

Petitioner's Exhibit #1.11 included receipts and copies of checks for various pharmacies, including $39.87 Walgreens for a 4-prong cane, $47.09 Target for Soma Compound May 26, 2009, and unspecified checks totaling $120.27.

Due to her continuing complaints and current condition Petitioner has not be able to return to her employment as a Personal Assistant. She did return to consulting for CPS after a "few years" but was not specific as to when. The adjunct position with Chicago State was for one year only. She is able to do unpaid sedentary work for Wald Institute.

Petitioner still has problems with shoulder weakness and pain. She testified that she has problems with her shoulder now 3 or 4 times a year. Continuing problems with her back have limited her activities of daily living as well as housework. Petitioner has hired household help, Mr. Whitman, because of her continued problems.

On cross-examination Petitioner admitted that she received compensation from the Illinois Court of Claims for a Criminal Victims Compensation Act claim. She received $8,443.38 for her lost earnings and $72.70 for Preferred MRI. Respondent's Exhibit # 1,

Award from Illinois Court of Claims was offered in evidence but was rejected in response to Petitioner's objection.

Petitioner has not been paid for her lost wages. Her medical bills have not been paid.

CONCLUSION OF LAW

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

The Arbitrator finds that Petitioner proved that she sustained soft tissue injuries, including contusions, to both knees, both elbows, and left shoulder as a recall result of the work-related accident on May 1, 2009. The Arbitrator also finds Petitioner failed to prove that her claim to current condition of ill-being is causally related to the accident. The foregoing finding is based on the Arbitrator's determination that Petitioner was not incredible witness.

Petitioner testified that her traumatically brain injured brother attacked her during the process of his transfer from a seniors' living facility to a nursing home. Petitioner had described her brother's impaired capacity which included dementia. Petitioner had testified that her brother's transfer was not problematic. However, she also testified that the transfer him and attempted before the date of the accident and that her brother had "got away" from the nursing home and returned to the seniors' facility. This behavior of the brother's running away running away suggest the transfer was more problematic than what Petitioner alluded to.

Petitioner testified that she went directly from UFC Medical Center, where her brother was transported to, to Jackson Park Hospital. The Jackson Park ER records note that Petitioner registered after 11 PM May 1. Petitioner testified that Jackson Park staff had referred her to Trinity Hospital because the Jackson Park ER was full. As noted, no such referral is documented in the Jackson Park records.

Petitioner also testified that she went directly from Jackson Park Hospital to Advocate Trinity Hospital. The Trinity show Petitioner registered after 3 PM on May 2 but also that he failed to respond 3 calls from staff for triage. Petitioner did return to Trinity on May 4, 2009 but implied in her testimony that the care she received that day was actually provided on May 2. Petitioner further testified that to Dr. Wahi from Trinity Hospital where the records actually note a referral to Dr. Egwele.

Petitioner testified that she treated with Dr. Wahi through February 2010. Dr. Wahi's records contain notes of therapy provided in June 2010.

Petitioner subsequently came under the care of chiropractor B. A. Sayre. When she consulted Dr. Sayre August 4, 2010 Petitioner gave a history only of going to Jackson Park Hospital for emergency care. Petitioner did not disclose that in fact she had not received emergency care at Jackson Park. Petitioner did not disclose that she had received emergency care Trinity Hospital or the University of Chicago Medical Center. Petitioner did not disclose that she had received extensive care, including spinal and shoulder injections, as well as extensive physical therapy, from Dr. Wahi.

Petitioner testified that her knees were black and blue after her accidental injury. Petitioner was seen by a variety of healthcare professionals after her accident. There was documentation in any medical chart that Petitioner had bruising about her knees. The May 4, 2009 ER notes from Trinity Hospital specifically noted no bruising or swelling about the knees. On May 20 Dr. Wahi specifically noted no swelling about the knees, a sign which often accompanies bruising.

In summary, when the history of Petitioner's case is taken as a whole it is apparent that Petitioner is at least an unreliable reporter of her history, if not in fact untruthful. In light of the evidence as a whole, Petitioner failed to prove that her claimed current condition of ill-being is causally related to her work accident on May 1, 2009. The evidence only supports a finding of soft tissue contusions to the left shoulder, the knees, and the elbows. The evidence does not support a finding of long-term low back or left shoulder injury.

G: What were Petitioner's earnings?

The parties agreed that Petitioner's earnings from Respondent for the year preceding the injury was $10,216.96, for an average weekly wage of $196.48. Petitioner claims that her total earnings in the year preceding the injury included earnings from concurrent employment totaling $32,015.42, for an average weekly wage of $615.68.

The Arbitrator finds that Petitioner failed to prove that she had disclosed and informed Respondent of her claimed concurrent employment. The only evidence of Petitioner's claim of concurrent employment was her testimony that she "believed" she had informed one or more of her supervisors of whom she could not recall names. On its face Petitioner's evidence of concurrent employment is speculative. Of greater import is Petitioner's lack of credibility as described above.

While the burden of proof is based on the preponderance of evidence, here Petitioner has failed to meet that that required burden of proof. Accordingly, the Arbitrator finds that Petitioner's average weekly wage was $196. 48..

K: What temporary benefits are in dispute? TTD

The Arbitrator finds that Petitioner failed to prove that she is entitled to temporary total disability benefits. To prove entitlement to TTD benefits a claimant must prove that one or another of their healthcare providers determined that they were unable to form their normal and regular work duties.

The evidence clearly shows that at Petitioner's initial emergency room encounters at Jackson Park Hospital and at Advocate Trinity Hospital she left without receiving any medical care, much less discharge instructions to remain off work. When Petitioner returned to Trinity Hospital on May 4, 2009 she was discharged with instructions to follow up with her primary physician, Dr. Egwele. There were no discharge instructions that she remain off work. When Petitioner sought emergency care at the University of Chicago Medical Center May 5, 2009 she was not directed or recommended to remain off work. There are no notes with Dr. Wahi's records (PX #1.8) documenting or otherwise indicating that Petitioner was unable to continue working as a Personal Assistant as before. Dr. Sayre did not take Petitioner off work.

The only evidence at trial that Petitioner was unable to perform her normal work duties was Petitioner's testimony. The Arbitrator previously found that Petitioner was not a credible witness. Further, the Arbitrator notes that the work duties of a Personal Assistant, as described by Petitioner, were not strenuous. Petitioner did not provide the type of care which required bathing for the client or assistance in and out of bed or chairs. The Arbitrator finds that Petitioner's claim that she was unable to perform the light duties of her job was not credible.

Given all factors, the Arbitrator finds that Petitioner failed to prove that she is entitled to TTD benefits.

J: Were 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 a bill from Jackson Park Hospital for $249.00 for May 1, 2009 (PX #1.1). The clinical record indicates that Petitioner left the emergency

department without treatment (LWOT) after a nursing triage. The Arbitrator finds minimal justification for authorizing payment for registering at a hospital's emergency department but having only received nursing triage. The Arbitrator notes that Petitioner submitted records and bills from Advocate Trinity Hospital, which included notes from an emergency department encounter May 2, 2009 (PX #1.2). Petitioner was not billed for the May 2 emergency department encounter.

Petitioner testified that Dr. Wahi administered steroid injections to her left shoulder and to her back. Although there were billing records for an injection or aspiration of a joint (CPT 2610) on May 29, 2009, there was no clinical note or procedure report or operative report documenting that procedure, or documentation of the medical necessity for that claimed procedure, or even what joint was involved. Although there were billing records for lumbar injections August 17, 2009 and September 26, 2009 (CPT 26311 & CPT 64476), there were no clinical notes or procedure or operative reports documenting the injections or documentation of the medical necessity of the injections. Further, there is no evidence of what level or levels of Petitioner's lumbar spine were injected (PX #1.8). Due to lack of adequate clinical documentation regarding these injections and, particularly, the lack of documentation demonstrating medical necessity, all charges for procedures purportedly performed May 29, 2009, August 17, 2009, and September 26, 2009 are denied.

Dr. Wahi billed $500.00 for an initial, expanded new patient evaluation (CPT 99204). In addition, Dr. Wahi repeatedly billed $100.00 for expanded physical examinations (CPT 99213), which the doctor's clinical notes do not justify as "expanded": June 1, June 6, June 27, July 10, August 10, September 21, September 28, December 7, and December 30, 2009. Due to lack of adequate supporting documentation that petitioner failed to prove those charges were reasonable or necessary and therefore are denied. The Arbitrator approves the billing of $500.00 for the initial evaluation on May 20, 2009 only.

Further, Dr. Wahi, through Midwest Physician Pain Center, submitted extensive billing for claimed physical therapy. As noted above, the documentation for this therapy was woefully lacking. $120.00 was billed for electrical stimulation (CPT 97032) for which there is no clinical note. The Arbitrator particularly notes that there were no clinical notes relating to an initial physical therapy evaluation, or progress notes, or physical therapy discharge. Based on the failure to prove the reasonableness and necessity of physical therapy, all charges for physical therapy are denied.

Petitioner submitted a copy of the check dated May 21, 2009 payable to Earl B. Thornton, MD [*sic*] (PX #1.7). There are no clinical records from Dr. Thornton relating to any medical services provided on that date, or any other, causally related to Petitioner's claimed injuries. In addition, Petitioner testified that Dr. Thornton had referred her to Dr. Sayre for chiropractic care. There is no documentation or verification of such a referral by Dr. Thornton. It is noteworthy that the Dr. Sayre consultation was 15 months after the Dr. Thornton encounter. Due to lack of adequate supporting evidence the purported $40.00 Dr. Thornton charge is denied.

The Arbitrator further finds that Petitioner failed to prove that the care and billing by Dr. Sayre was reasonable or necessary. This finding is fundamentally based on Petitioner's questionable credibility.

Petitioner testified that she treated with Dr. Wahi through February 2010. Dr. Wahi's records, PX #1.8, contained clinical notes that ended December 30, 2009. In addition, there were physical therapy checklists covering several June dates which Petitioner did not testify to. As notes above, Petitioner testified that staff at Jackson Park Hospital ER had referred her to Advocate Trinity Hospital despite the absence of documentation in the Jackson park records. Petitioner also testified that staff at Trinity Hospital referred her to Dr. Wahi. The Trinity records show a referral to Dr. Egwele. Dr. Wahi's records do not any reference to a referral from another healthcare provider. Petitioner testified that she sought emergency care of the University of Chicago Medical Center ER November 12, 2010 for severe back pain. The clinical notes with PX #1.5 do document complaints of back pain but also include complains about "red eye", for which an antibiotic was prescribed but which Petitioner neglected to disclose at trial. Petitioner also testified that her knees were black and blue after being knocked down by her brother. There were numerous notes in various medical records noting no bruising.

Petitioner had a left ankle X-ray June 4, 2009 at Trinity Hospital which had been ordered by Dr. Wahi. Petitioner's first documented complaints of ankle pain were to Dr. Wahi June 1. The only objective finding on June 1 was bruising over the ankle which had not been noted earlier. (Petitioner did not testify to this bruising at trial.) The clinical exam of the ankle was otherwise normal. Absent swelling or weakness or diminished motion or altered gait, the Arbitrator finds no clinical reasoning or justification by Dr. Wahi to warrant an X-ray. The Arbitrator finds that Petitioner failed to prove the reasonableness or necessity of the June 4 ankle X-ray.

When Petitioner presented to Dr. Sayre August 4, 2010 she reported that she had been seen in the ER of Jackson Park Hospital but did not disclose her ER encounter at

Trinity Hospital or that X-rays had been taken at Trinity. Further, Petitioner did not report her treatment and physical therapy with Dr. Wahi, much less the claimed injections.

Dr. Sayre diagnosed, among other things, cervical subluxations and DJD (degenerative disc disease) of the lumbar spine. He further opined that petitioner's injuries were directly related to her work accident May 1, 2009. His diagnoses and causation opinions were necessarily based on the reliability and accuracy of Petitioner's history. The evidence is clear that Petitioner was an unreliable and inaccurate historian. A credible and persuasive opinion cannot stand if based on incomplete or inaccurate facts, as is here. Further, Dr. Sayre's diagnosis of cervical subluxations enters Petitioner's clinical record for the first time 15 months after the accident and without documented complaints of neck pain within that period. The Arbitrator notes that degenerative bony conditions may be aggravated by trauma but do not tend to be caused by trauma. Also,

Finally, the Arbitrator has previously found that Petitioner's condition of ill-being had stabilized before she consulted Dr. Sayre.

Correspondingly, the Arbitrator finds that Petitioner failed to prove that the care and treatment provided by Dr. B. A. Sayre was reasonable or necessary to cure or relieve the effects of her work-related accident on May 1, 2009.

The Arbitrator also finds the Petitioner failed to prove that the emergency department encounter at University of Chicago Medical Center on November 12, 2010 was reasonable or necessary to cure or relieve the injuries claimed from the May 1, 2009 accident. Petitioner testified that he sought this care because of continuing severe low back pain. While the U of C records document Petitioner's complaint of back pain they also document Petitioner's "red eye." The UofC records are incomplete. Petitioner was prescribed an antibiotic, a medication rarely administered for back pain. To ascribe what portion of the November 12, 2010 ER care between the complaints of back pain and red eye invites speculation and therefore fails to meet the burden of proving reasonableness and necessity.

Also, Petitioner submitted a copy of a June 1, 2009 Walgreens receipt for $39.87 for a med line quad cane (PX #1.11). Petitioner was under the care of Dr. Wahi on June 1, 2009. At a clinical visit June 1 there was no note by Dr. Wahi that Petitioner exhibited an altered or antalgic gait or that Dr. Wahi recommended use of a cane. There is no supporting documentation that this device was ordered by any treating physician or was

otherwise medically necessary. The Walgreens charge for $39.87 is denied. In addition, the Arbitrator finds that Petitioner failed to prove what was related to the $120.17 in copied checks to Rosenblum Drugs and University of Chicago in PX #1.11. The only reasonable expense within PX #1.11 is the $47.99 charge for Soma Compound from Target.

The Arbitrator finds that Petitioner proved the reasonableness and necessity of the following medical expenses, all to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act:

Jackson Park Hospital (PX #1.1)	$249.00
Advocate Trinity Hospital (PX 1.2)	$1,949.00
Chicago Imaging (PX #1.3)	$193.00 ($6.40 balance)
Windy City Emergency Physicians (PX #1.4)	$407.00 ($79.00 balance)
University of Chicago (PX 1.5)	$1,570.23 ($70.17 balance)
Dr. Gregory Stacy (PX 1.6)	$135.00 ($23.42 balance)
Dr. Ranjit Wahi (PX #1.8)	$500.00

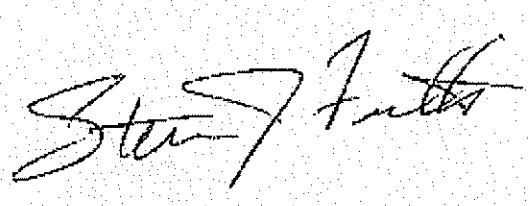
Therefore, Respondent shall pay the unpaid balances of the foregoing related medical expenses.

As an aside, the Arbitrator notes that Petitioner exceeded the two-healthcare provider limitation set forth in §8(a) of the Act. There was no competent evidence of a §8(a) chain of referrals. However, this issue was not disputed. Therefore, the Arbitrator makes no specific finding regarding exceeding the two-healthcare provider limitation.

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

Petitioner's medical records to show that Petitioner sustained minor soft tissue injuries as a result of her work accident on May 1, 2009. There is no objective evidence that Petitioner sustained an objective injury which would account for her ongoing subjective complaints. Radiological imaging demonstrated degenerative changes throughout Petitioner's thoracic and lumbar spine. However, there is no competent medical opinion that these pre-existing degenerative changes were in any way aggravated or exacerbated by the accident.

Therefore, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 3% loss of a person-as-a-whole, 15 weeks.



Steven J. Fruth, Arbitrator

January 21, 2019

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

Sheila Echols,
Petitioner,
vs.

NO: 17 WC 03202

Southern Illinois University,
Respondent.

19IWCC0468

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2015, is hereby affirmed and adopted.

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

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

DATED: AUG 28 2019
o081519
BNF/mw
045

Barbara N. Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ECHOLS, SHEILA Case# **17WC003202**

Employee/Petitioner

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE

Employer/Respondent

19IWCC0468

On 1/15/2018, 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 2.46% 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:

1187 WOMICK LAW FIRM CHTD
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HERRIN, IL 62948

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PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
SHANNON D RIECKENBERG
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

JAN 15 2019

Brendan O'Rourke, Assistant 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

Sheila Echols
Employee/Petitioner

v.

Southern Illinois University, Carbondale
Employer/Respondent

Case # **17** WC **003202**

Consolidated cases: _____

19IWCC0468

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 **Ed Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **11/15/2018**. By stipulation, the parties agree:

On the date of accident, **03/04/2014**, 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 $**67,452.00**, and the average weekly wage was $**1,297.15**.

At the time of injury, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $**721.66**/week for a further period of **25.625** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **loss of use of 12.5% of the right hand**.

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.

Edna Lee
Signature of Arbitrator

12/30/18
Date

JAN 15 2019

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SHEILA ECHOLS,
Employee/Petitioner,

v.

Case No. 17 WC 003202

SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE,
Employer/Respondent.

19IWCC0468

STATEMENT OF FACTS

On March 4, 2014, Petitioner was employed as an accountant at Southern Illinois University, Carbondale when she sustained a work-related injury to her right wrist when she slipped and fell on ice in a parking lot. This claim came before Arbitrator Lee for trial at the Herrin docket on November 15, 2018. The sole issue in dispute is the nature and extent of the injury.

On March 7, 2014, an Illinois Form 45: Employer's Frist Report of Injury was completed which indicated Petitioner fell to the ground, landing on her right wrist and causing it to fracture or break as she attempted to step over a clump of snow and ice in the parking lot. (RX1).

Also on March 7, 2014, Petitioner's supervisor, Tena Bennett, completed a Supervisor's Report of Injury or Illness form indicating Petitioner was walking over the snow and ice accumulation in the parking lot at the end of her workday when she slipped and fell, causing her to fracture/break her right wrist. (RX3).

On March 10, 2014, Petitioner completed a Workers' Compensation Employee's Notice of Injury form indicating she sustained a fractured/broken wrist when she slipped and fell in ice at the end of her vehicle in the parking lot behind the Neckers Building on the Southern Illinois University, Carbondale campus as she was leaving work for the day. (RX2).

MEDICAL HISTORY

On March 4, 2014, Petitioner presented to the emergency room at Carbondale Memorial Hospital after a fall which resulted in right wrist pain, bruising, and swelling. (PX1). Petitioner underwent an x-ray of the right wrist which showed an impacted traverse fracture of the distal radial metaphysis with mild dorsal angulation of the major distal fracture fragment with involvement of the articular surface. (PX1).

On March 6, 2014, Petitioner presented to Dr. John B. Wood at The Orthopaedic Institute for a right wrist fracture after being treated at the emergency room. Petitioner was placed in a cast in an attempt to avoid the need for surgery. (PX2). Dr. Wood reviewed Petitioner's radiographs and noted some abnormality involving the scapholunate joint which he believed could be chronic due to her congenital birth defect. (PX2). Dr. Wood suspected the entire portion of the wrist was affected by that defect. (PX2).

On March 17, 2014, Petitioner returned to Dr. Wood for follow up. (PX2). He noted her prior history of carpal tunnel syndrome and her use of braces at night. (PX2). Dr. Wood believed Petitioner's fall aggravated her condition as evidenced by an increase in symptoms of numbness and tingling. (PX2). Dr. Wood decided to allow Petitioner's fracture to continue to heal in the cast and then address the carpal tunnel syndrome. (PX2).

On April 23, 2014, Petitioner returned to Dr. Wood for follow up. (PX2). Radiographs showed Petitioner's fracture to have healed in an acceptable position. (PX2). Petitioner requested the right sided carpal tunnel release to be scheduled in May. (PX2).

On June 13, 2014, Petitioner returned to Dr. Wood for follow up. (PX2). Petitioner continued to feel numbness in her right long and index fingers. (PX2). Dr. Wood noted there were some early degenerative changes in the wrist along with a injury to the scapholunate ligament which he believed was an old injury. (PX2). An EMG was recommended. (PX2).

On July 8, 2014, an EMG was completed by Dr. Terrence P. Glennon which showed moderate right median neuropathy at the wrist. (PX2).

On July 16, 2014, Petitioner returned to Dr. Wood for follow up. (PX2). The results of the EMG showed moderate right carpal tunnel syndrome. (PX2). Dr. Wood opined this was directly related to Petitioner's work accident. (PX2). Petitioner wished to proceed with surgery. (PX2).

On October 10, 2014, Petitioner submitted to an Independent Medical Examination by Dr. Rayan P. Calfee at Washington University School of Medicine in St. Louis, Missouri. (RX4). Dr. Calfee diagnosed Petitioner with right sided carpal tunnel syndrome and complex regional pain syndrome (CRPS), type II, after a right wrist distal radius fracture. (RX4). The doctor believed this condition was brought about by the slip and fall incident and wrist fracture which resulted in compression of the median nerve. (RX4). Dr. Calfee recommended a right sided carpal tunnel release. (RX4).

On November 3, 2014, Petitioner returned to Dr. Wood for follow up. (PX2). Dr. Wood continued to recommend surgery for Petitioner. (PX2).

On November 11, 2014, Petitioner presented to Shawnee Healthcare Carbondale. (PX2). Petitioner requested and obtained pre-op clearance. (PX2).

On November 13, 2014, Petitioner underwent a right carpal tunnel release by Dr. Wood at the Southern Illinois Orthopedic Center without issue. (PX2).

On November 26, 2014, Petitioner returned to Dr. Wood for follow up after surgery. (PX2). Petitioner had yet to experience any benefit from surgery. (PX2). She was to begin occupational therapy. (PX2).

On January 9, 2015, Petitioner returned to Dr. Wood for follow up. (PX2). Petitioner continued to report pain and stiffness in her hand, but felt she was improving with therapy. (PX2). She was to continue with therapy. (PX2).

On February 25, 2015, Petitioner returned to Dr. Wood for follow up. (PX2). Dr. Wood noted Petitioner was currently unsatisfied with her situation. (PX2). He attributed this to her complex history of old and new injuries. (PX2). Petitioner requested referral to a hand surgeon. (PX2).

On March 19, 2015, Petitioner presented to Dr. Steven Young, also of The Orthopaedic Institute. (PX2). Petitioner completed an intake questionnaire in which she listed her hobbies as including gardening, sewing, reading, puzzles, drawing and art. (PX2). Petitioner reported a worsening in symptoms after her right sided carpal tunnel release by Dr. Wood. (PX2). Dr. Young noted Petitioner's x-rays showed diffuse arthritic changes in the wrist and a congenital deformity of the thumb of the right hand. (PX2). An MRI was ordered. (PX2).

On April 3, 2015, an MRI of Petitioner's right wrist was obtained which showed scapholunate advanced collapse in the right wrist. (PX2).

On April 28, 2015, Petitioner returned to Dr. Young for follow up and review of the MRI. (PX2). Dr. Young recommended a salvage procedure in the form of a proximal row carpectomy versus mid carpal arthrodesis. (PX2). Petitioner declined to proceed with such an aggressive procedure. (PX2).

On August 27, 2015, Petitioner presented to Dr. Goldfarb at Washington University School of Medicine in St. Louis, Missouri. (PX4). Dr. Goldfarb diagnosed a SLAC wrist with pain and recommended a scaphoid excision and 4 bone fusion. (PX4). Dr. Goldfarb noted that if Petitioner elects surgery, she may also want a non-workers' compensation procedure of an IP joint fusion of the thumb simultaneously. (PX4).

TESTIMONY

Sheila Echols, Petitioner

On direct examination, Petitioner testified that on March 4, 2014 she injured her right wrist and hand resulting in a distal radius fracture of the wrist. Petitioner confirmed that after visiting the emergency room, she was placed in a cast for four to six weeks. Petitioner explained that when the cast was removed her wrist felt stiff and numb, causing her difficultly with everyday tasks. Petitioner said she was referred to orthopedic surgery, Dr. John Wood. Right carpal tunnel surgery was recommended in May or June of 2014 and completed on November 13, 2014. Petitioner stated that following surgery, she continued to have issues despite the use of

occupational therapy and anti-inflammatories. Petitioner explained that her range of motion improved slightly with therapy, but she still experienced numbness in her fingers, along with pain and stiffness. Petitioner indicated she did not advance the way the occupational therapist had wanted her to. Petitioner also clarified that she has a congenital condition in her right hand and thumb as well that was not caused or effected by the accident. Due to Petitioner's continued complaints following surgery, Dr. Wood referred her to Dr. Young, a hand specialist at the same practice. Petitioner said she had only one visit with Dr. Young, at which time an MRI was ordered. Petitioner indicated she then sought treatment at Washington University with Dr. Goldfarb for a second opinion. In August of 2015, Dr. Godlfarb recommended a fusion procedure but Petitioner decided to forgo that surgery in light of the risk factors concerned. Petitioner stated that since that recommendation in August of 2015, she has been taking ibuprofen when her wrist is aggravated by activities like gardening, tending to her flower beds, and arts and crafts. Petitioner explained her wrist feels tender for a few says after she uses it a lot. Petitioner confirmed she is right hand dominant. Petitioner indicated she has trouble using doorknobs because of the gripping and twisting. Petitioner admitted she struggled with this type of activity a bit before her accident due to her congenital defect in the thumb. Petitioner added that she cannot lift heavy things and often must do things two handed. Petitioner testified she has not treated with any physicians for her injury since the last time she saw Dr. Goldfarb in August of 2015. Petitioner stated her condition has not improved since that time, but she could not say it has worsened.

On cross examination, Petitioner testified she was taken off of work for three days following her injury in March of 2014. Petitioner stated she subsequently retired on May 31, 2014 and has not sought additional employment. Petitioner confirmed surgery was not needed to correct the wrist fracture. Petitioner admitted she had a bit of numbness, tingling, and weakness in her hand prior to the work injury. She said she had started sleeping with her right wrist in a splint at night about a month prior to her slip and fall at work. Petitioner said she also had a history of hypertension and hyperthyroidism. Petitioner indicated she has not returned to Dr. Goldfarb or any other physician since August of 2015. Petitioner said that as of the date of trial, she did not wish to pursue the fusion surgery recommended by Dr. Goldfarb. Petitioner said she had not been told by any physicians that her symptoms may improve with time. Petitioner testified her congenital defect does not affect the strength in her hand but is now arthritic, causing joint issues. For example, it is difficult for Petitioner to thread a needle. Petitioner indicated she has noticed the arthritic changes over time and with age.

CONCLUSIONS OF LAW

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

At Arbitration, the parties stipulated that Petitioner sustained an accident arising out of and in the course of her employment with the State of Illinois and that Respondent has or will pay all reasonable and causally related medical bills. The parties agreed any temporary total disability benefits due Petitioner have been paid and there is no further dispute as to said benefits.

Section 8.1b of the Act is applicable to this claim as the accident occurred after September 1, 2011. The Arbitrator must rely on the following factors as contained in Subsection (b) to determine the level of permanent partial disability for Petitioner: (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. The analysis of the aforementioned factors is as follows:

(i) No weight is placed on this factor as neither party provided an AMA rating for consideration.

(ii) Petitioner was employed as an accountant at the time of her accident. She voluntarily chose to retire on May 31, 2014. Petitioner was never given work restrictions or placed on light duty and was only taken off work three days immediately following her accident. Petitioner has not sought other employment after her retirement. As such, Petitioner has voluntarily removed herself from the workforce.

(iii) Petitioner was 56 years old at the time of her injury.

(iv) There is no direct evidence of diminished future earning capacity in the record. Petitioner is working full duty without restrictions. The Commission recently addressed this issue in *McDonald v. Zurich North America*, 26 ILWCLB 107 (Ill. W.C. Comm. 2018). In *McDonald,* the arbitrator erroneously gave no weight to the factor of future earning capacity because no evidence of a negative impact on Petitioner's future earning capacity was submitted at trial. In reversing the arbitrator, the Commission reasoned that if an employee is able to return to his job and has no difficulty performing his job duties, such a situation would constitute competent evidence that the injury did not diminish his future earning capacity.

(v) Petitioner's readily admitted to having experienced symptoms of carpal tunnel syndrome prior to her work accident of March 4, 2014. This is supported by numerous medical records wherein the condition of her carpal tunnel syndrome was described as chronic and having predated her slip and fall. Petitioner disclosed that she had begun wearing night splints to address her symptoms prior to her work injury. Furthermore, Petitioner has a history of hypertension and hyperthyroidism which are risk factors for the development of carpal tunnel syndrome. Her hobbies also consist of hand intensive activities including gardening, sewing, reading, puzzles, drawing and art. The prolonged grasping and gripping present those hobbies serve as contributing risk factors to the development of carpal tunnel syndrome. Petitioner's congenital defect in her right hand and thumb also play a role her in overall condition. Petitioner was even considering surgical intervention for this defect in conjunction with the operation recommended by Dr. Goldfarb. Petitioner testified the arthritic changes brought about by the congenital defect have increased overtime. In her trial

testimony, Petitioner made minimal statements regarding the permanency of her conditions. Petitioner indicated she has some problems with turning doorknobs or lifting heavy objects and must use two hands with activities that previously required one. However, Petitioner has not returned for treatment with any physician since August 27, 2015. Petitioner failed to offer any evidence of her use of medications or other treatments to address her condition as well.

Ultimately, Petitioner's injuries which this Arbitrator considers to assess the permanency caused by her slip at fall while at work include the distal radial fracture of her right wrist, acute carpal tunnel syndrome and complex regional pain syndrome. These conditions were treated with a cast and right sided carpal tunnel release. The issue with the scapholunate joint was chronic in nature according to Petitioner's doctors. Dr. Wood believed this condition could be affecting the overall status of Petitioner's wrist. Dr. Young and Dr. Goldfarb each recommended a different surgical procedure for Petitioner. Yet, a causation opinion relating those procedures to the work injury was not provided. Permanency cannot be awarded on the basis of these recommendations for that reason and due to Petitioner's current intention to forgo those procedures.

After consideration of the foregoing factors, the Arbitrator concludes that Petitioner is now permanently partially disabled to the extent of 12.5% of the right hand as provided within the Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jordan Pinkham,
Petitioner,
vs.

NO: 16 WC 20849

Chenoa Locker Inc,
Respondent.

19IWCC0469

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses, 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 18, 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 28 2019
o08012019
BNF/mw
045

Barbara N. Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PINKHAM, JORDAN
Employee/Petitioner

Case# **16WC020849**

CHENOA LOCKER INC
Employer/Respondent

19IWCC0469

On 12/18/2018, 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 2.48% 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:

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STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jordan Pinkham
Employee/Petitioner

v.

Chenoa Locker, Inc.
Employer/Respondent

Case # 16 WC 20849

Consolidated cases: N/A

19IWCC0469

An *Application for Adjustment 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 **Bloomington**, on **October 29, 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 **July 3, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$11,760.00**; the average weekly wage was **$560.00**.

On the date of accident, Petitioner was **24** years of age, ***single*** with **0** dependent children.

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

Respondent is entitled to a credit for medical bills paid in the amount of **$0** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being is causally related to his accident of July 3, 2015. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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. Pike Gallivan

Signature of Arbitrator

12/14/18

Date

ICArbDec p. 2

DEC 18 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jordan Pinkham
Employee/Petitioner

Case # **16** WC **20849**

v.

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Chenoa Locker, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified he was injured while working for Respondent on July 3, 2015. Petitioner testified he was lifting a front right quarter of beef, which he estimated weighed 150-200 pounds, onto a saw table sometime between 7:00 and 8:00 a.m on that date when he felt a pulling sensation in his left shoulder. He testified he reported the injury to Respondent's owner, Terry Bittner, immediately after it occurred. He testified that after he reported the accident, he went to the emergency room at St. James Hospital.

When asked why he went to the emergency room, Petitioner responded that he was experiencing severe pain so he wanted to get somewhere immediately to where could either get help or get his pain taken care of. When asked what he told them at the emergency room, Petitioner responded that he did not tell them about work as his main concern was about getting back to work. He testified that he had had a bug sting while riding his motorcycle a few days before, and that he wanted to make sure he was not having an allergic reaction to that. He testified that leading up to the date of accident he had had inflammation and redness but no pain or pulling in his left shoulder, and that the pain on the date of accident was different in that it was a stabbing-type pain.

Petitioner testified that he first saw Dr. Li on April 1, 2016 and denied having received any treatment for his injuries to the left shoulder at any point between July 2015 and April 1, 2016. He testified that he could not afford to take time off work as he was supporting himself as well as his girlfriend and her child. He testified that the last thing that he was worried about was taking time off work as he could not afford it. He further testified that the pain began to affect his sleep and work, however, and that he could not allow himself to do that anymore. He testified that up until April 1, 2016, he had noticed progressive weakness, fatigue, soreness and swelling, and that his sleeping habits were uncomfortable.

After outlining the medical treatment that he received from Dr. Li, Petitioner testified that he was off work from July 19, 2016 through November 7, 2016. He testified that he worked for Respondent until he started working for Bridgestone as a machine operator, where he cuts steel rubber for tires. He testified that his earnings have increased from when he worked for Respondent and that he was now earning $19.50/hour while working for Bridgestone.

Petitioner testified that as to his left shoulder, the range of motion was great but that he has fatigue and/or soreness from working too much of if he stretched it too far. He also testified that he gets some soreness and tightness, and that he takes Ibuprofen or uses ice on his shoulder. When asked how often he took Ibuprofen, Petitioner responded a couple of times per week. He further testified that he iced his

shoulder at least twice per week. He testified that he uses stretch bands for his home exercise program. He testified that he does not feel restricted and that he continues to do things at his house and at work.

Petitioner testified that he worked full duty before the date of accident. Petitioner denied having received any medical treatment for the left shoulder before the date of accident.

On cross examination when asked how he ended up seeing Dr. Li. Petitioner testified that he was a previous patient of Dr. Li's and that he had performed a right shoulder surgery on him before. When asked how he had injured his right shoulder. Petitioner responded that he hurt himself while bench pressing. Petitioner denied having been bench pressing on the date of accident and further testified that he stopped regularly bench pressing after the surgery on his right shoulder.

Terry Bittner was called as a witness by Respondent at the time of arbitration. He testified that he was the owner of Respondent and that the date of accident was the Friday before the July 4th holiday in 2015. He testified that Respondent was open that date. When asked if he recalled a conversation with Petitioner that day, Mr. Bittner responded that he knew that Petitioner hurt his shoulder but could not remember what date it occurred. When asked if he recalled any conversations with Petitioner on the date of accident, Bittner responded affirmatively and testified that Petitioner indicated to him that he had injured his left shoulder while lifting a front quarter on the saw.

The transcript of the deposition of Dr. Lawrence Li dated May 8, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Li testified that his specialty is orthopedic surgery and that he is board-certified by the American Board of Orthopedic Surgery. (PX1).

Dr. Li testified that he saw Petitioner on April 1, 2016, at which time he gave a history of having increased left shoulder pain due to increased lifting, that it occurred when he was lifting a side out of an animal at work while butchering, that he went to the emergency room and followed-up with his primary care physician and that he still had significant discomfort with no improvement. He testified that Petitioner was not sure when it actually happened but that it was sometime within the last year and that when he went to the emergency room, his employer knew about it. He testified that Petitioner reported constant pain that he rated 7/10, that it had been getting progressively worse, that the pain was both sometimes sharp and sometimes dull, and that he had some tingling, popping, grinding, giving away and weakness. He testified that his diagnosis was that of left shoulder rotator cuff versus labral tear. He testified that he recommended getting an MRI and when asked why he recommended an MRI so soon, Dr. Li responded that Petitioner had been having pain for a while and that given his age, he would have expected that any sort of minor injury would have resolved by then. (PX1).

Dr. Li testified that he saw Petitioner again on April 7, 2016, which was after the MRI. He testified that the MRI showed that there was a blunting of the anterosuperior labrum without any well-defined tear but could be consistent with a tear, that otherwise the rotator cuff looked good and that Petitioner also had some spurring in the shoulder that was not the issue. He testified that he recommended physical therapy and anti-inflammatory medications, and that he recommended such treatment because Petitioner was having pain. He testified that he saw Petitioner on May 5, 2016, at which time his pain was worse. He testified that Petitioner was having trouble with the medications that he had given him, that he had issues with sleeping and that he was protecting the shoulder with the restrictions that were given, but still had pain. He testified that he was unable to locate Petitioner's work restriction note. He testified that he recommended a corticosteroid injection and that Petitioner continue therapy, and that if he was not better in four weeks he would consider surgery. (PX1).

Dr. Li testified that when he saw Petitioner on June 2, 2016, he reported that the injection helped him for 10 days but then the pain gradually returned, and that he felt that the medications he had been given had helped but not sufficiently. He testified that he felt at that point that Petitioner had failed non-operative

treatment and that he recommended arthroscopic surgery. He testified that when he saw him on June 7, 2016, Petitioner continued to have pain in his left shoulder and that he was really concerned about how much more time could pass without him getting permanent damage. He testified that when he saw Petitioner on June 23, 2016, he continued to have pain in the left shoulder that bothered him at work and that the therapy had helped, but the pain had not been relieved. He testified that Petitioner underwent surgery on July 19, 2016 and that he performed left shoulder arthroscopy with repair of the SLAP tear, repair of the biceps tendon attachment and debridement of the tenosynovitis and arthroscopic subacromial decompression. He testified that Petitioner would have been unable to work as of July 19, 2016. (PX1).

Dr. Li testified that when he saw him on July 26, 2016, Petitioner had typical post-op pain and that he was progressing as expected with therapy. He testified that he continued to prescribe physical therapy as well as Game Ready and the CPM machine, which were necessary to help improve Petitioner's range of motion, reduce his swelling and pain and improve his function. He testified that Petitioner would have been unable to work as of that date. He testified that when he saw Petitioner on August 26, 2016, his swelling was down to mild and his shoulder passive range of motion continued to be appropriate for that stage post-operatively. He testified that he continued to prescribe Petitioner medications and that he would have been able to work as of August 26, 2016. He testified that when he saw him on September 23, 2016, Petitioner was progressing well with the therapy and had decreased strength but full active range of motion. He testified that the ultrasound showed that the tendon repair was intact during dynamic testing and that he continued Petitioner in therapy. He testified that Petitioner would have been unable to work as of that date. (PX1).

Dr. Li testified that he saw Petitioner on October 24, 2016 at which time he noted that he had weakness but that his therapy overall was going well, that he had good range of motion, that he had decreased strength and that they were going to continue him on the medications and therapy for strengthening. He also testified that he was also going to let Petitioner return to work in two weeks with restrictions of no over-chest lifting and limited lifting with his left arm to 20 pounds. He testified that when he saw Petitioner on November 21, 2016, he still had pain with reaching and working overhead. He testified that the ultrasound showed that the biceps tendon repair was intact. He testified that Petitioner still had some residual weakness to 4/5 strength and that he continued his work restrictions. He testified that he also decided to end therapy and have Petitioner work with a home exercise program, but also have him work with restrictions. He testified that when he saw him on December 6, 2016 Petitioner had been doing fine until that morning at work, that he was using his left shoulder at work to throw away scraps and had some pain and that it got progressively worse so that was why he came back for a re-check. He testified that he recommended a corticosteroid injection in the shoulder and that Petitioner's work restrictions would have been the same. He testified that when he saw him on January 16, 2017, Petitioner was feeling great and that he thought that everything had resolved. He testified that he released Petitioner on that date to activities as tolerated. He testified that when he saw Petitioner on January 26, 2017 his inflammation was improved, that he had some discomfort with some of the heavier duties at work, that he generally did not have pain but a feeling of popping and grinding, and that he thought everything looked okay. He testified that he thought that it was just inflammation and recommended continued observation. (PX1).

Dr. Li testified that his diagnosis was that of a left shoulder SLAP tear, left shoulder biceps tendon attachment tear, impingement syndrome and tenosynovitis, glenohumeral joint. He testified that it was his opinion that lifting the side of an animal was what caused Petitioner's SLAP tear and biceps tendon tear, which led him to go to the emergency room for evaluation that day. He testified that his treatment was necessary. (PX1).

On cross examination, Dr. Li testified that Petitioner told him that he went to the emergency room and then months later saw him. He testified that he did not see any previous medical records. When asked whether the complaints that Petitioner gave at the emergency room on July 3, 2015 at OSF St. James were consistent with the findings that he diagnosed and operated on, Dr. Li responded that he was not provided

with the complaint of radiating pain from the medial clavicle out towards the shoulder, but that it was left shoulder pain. He testified that Petitioner never had medial clavicle pain when he first saw him or after surgery, so it was a different portion of the shoulder. He testified that none of the pathology that he operated on would cause medial clavicle pain. (PX1).

On cross examination, Dr. Li testified that the only reference that he saw in the emergency room records relative to work was that moving Petitioner's shoulder around during work aggravated the pain. He testified that he did not review the medical records of Dr. Mitchell. After having reviewed the medical records of Dr. Mitchell, Dr. Li testified that the complaints given to Dr. Mitchell were the same complaints given to the emergency room personnel. He testified that the complaints given to Dr. Mitchell were different than the complaints that were given to him when he saw Petitioner in April of 2016. He testified that the complaints that Petitioner gave to Dr. Mitchell were similar to the complaints that he gave to the emergency room and different than the complaints that he gave to him. He agreed that the history that Petitioner gave Dr. Mitchell was that he was stung by a bee while riding a motorcycle and had had pain in the left collarbone area since, that he went to the emergency room and that the pain was worse when he was working. He testified that the findings that he found in surgery could not possibly be caused by an insect hitting the medial aspect of the clavicle. (PX1).

On cross examination, Dr. Li testified that SLAP tears were distraction or traction injuries and that if jerked hard enough, it could be torn. He testified that the SLAP tear and the biceps tendon tear would have the same mechanisms of injury. He testified that Petitioner was not referred to him by his attorney's office and that he was a previous patient of his in 2012. He testified that the surgery in 2012 was performed on the right shoulder and that Petitioner was lifting weights at that time and ruptured his pec major tendon. When asked if there was any indication when he saw Petitioner in 2016 that he had continued to lift weights, Dr. Li responded that he did not know but that he was a fit, young man. He testified that he would not consider Petitioner to be muscular, but that skinny people lifted weights as well. (PX1).

The medical records of Dr. Lawrence Li (dated April 1, 2016 through January 26, 2017) were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on April 1, 2016, at which time it was noted that he was seen for left shoulder pain. It was noted that Petitioner stated that he had had increased left shoulder pain due to increased lifting and that it occurred when he was lifting the side of an animal at work while butchering. It was noted that Petitioner had gone to the emergency room and had x-rays and follow-up with his primary care physician, that he still had significant discomfort, that there had been no improvement, that he was not sure of the exact date but that it was sometime within the past year and that he did make his employer aware of the problem. The diagnosis was noted to be that of left shoulder rotator cuff versus labral tear. Petitioner was recommended to undergo an MRI arthrogram of the left shoulder. (PX2).

The records of Dr. Li reflect that Petitioner was seen on April 7, 2016, at which time it was noted that the MRI was interpreted as revealing questionable blunting anterosuperior labrum without a well-defined or discrete tear; intact rotator cuff tendons; acromioclavicular joint arthropathy with mild inferior spurring. The diagnosis was noted to be that of a left shoulder SLAP tear. Petitioner was prescribed medications and physical therapy. At the time of the May 5, 2016 visit, it was noted that Petitioner's pain was worse since the last visit, that he had had trouble with the Meloxicam and that was having trouble sleeping as a result of the pain. It was also noted that Petitioner's work restrictions were protecting his shoulder, but that he still had pain. It was also noted that therapy had helped Petitioner's function and allowed him to work but that it had not helped his pain, and that he reported 10/10 pain at night that woke him about three times. Petitioner was prescribed medications and was given a Kenalog injection. Petitioner was also recommended to continue physical therapy. (PX2).

The records of Dr. Li reflect that Petitioner was seen on June 2, 2016, at which time it was noted that he reported that the Kenalog injection helped for 10 days then his pain gradually returned, that therapy

had helped his function but that the pain had gotten worse and that he felt that the Celebrex, Norco and Ultram helped but not sufficiently. Petitioner was prescribed medications and was recommended to undergo arthroscopic surgery and repair of the SLAP tear. It was noted that Petitioner was currently scheduled for an IME. At the time of the June 7, 2016 visit, it was noted that Petitioner continued to have pain in the left shoulder and had questions about how much more time could pass without his having permanent damage that was irreversible. It was noted that Petitioner was to consider his options. At the time of the June 23, 2016 visit, it was noted that Petitioner continued to have pain in the left shoulder, that it bothered him at work and that therapy had helped his function but his pain was not relieved. It was noted that informed consent was obtained for surgery. The Operative Report dated July 19, 2016 noted that Petitioner underwent (1) left shoulder arthroscopy with repair of SLAP tear; (2) reattachment of the superior aspect of the biceps tendon attachment; (3) extensive debridement of tenosynovitis glenohumeral joint; (4) arthroscopic subacromial decompression for the diagnoses of (1) left shoulder SLAP tear with involvement of the superior aspect of the biceps tendon attachment; (2) extensive tenosynovitis, glenohumeral joint; (3) impingement syndrome. (PX2).

The records of Dr. Li reflect that Petitioner was seen on July 26, 2016, at which time it was noted that he had typical post-op pain and was progressing as expected with therapy. It was noted that vasopneumatic compression therapy was helping reduce swelling and pain, and that CPM was helping with improving range of motion and progressing in therapy. It was noted that Petitioner's shoulder passive range of motion was appropriate for this stage post-op. Petitioner was recommended to continue physical therapy, vasopneumatic compression therapy and the CPM machine. At the time of the August 26, 2016 visit, it was noted that Petitioner was progressing as expected with therapy. It was noted that vasopneumatic compression therapy was helping reduce swelling and pain, and that CPM was helping with improving range of motion and progressing in therapy. Petitioner was prescribed medications and was recommended to continue therapy. At the time of the September 23, 2016 visit, it was noted that Petitioner was progressing well with therapy and that Lunesta, Mobic and Terocin were helping significantly. Petitioner underwent ultrasound on the left shoulder, which was interpreted as revealing that all tendons and ligaments appeared intact during static and dynamic testing. Petitioner was recommended to continue therapy. (PX2).

The records of Dr. Li reflect that Petitioner was seen on October 24, 2016, at which time it was noted that his therapy was going well and that he was overall much improved, but that there was still some weakness. Petitioner underwent ultrasound on the left shoulder, which was interpreted as revealing a normal examination and that all ligaments and tendons appeared intact. Petitioner was recommended to continue therapy and return to work with restrictions in two weeks. At the time of the November 21, 2016 visit, it was noted that Petitioner still had pain with reaching and working overhead, but otherwise was doing well. Petitioner underwent ultrasound on the left shoulder, which was interpreted as revealing that all ligaments and tendons appeared intact during static and dynamic testing. Petitioner was prescribed medications and recommended to continue his home exercise program. At the time of the December 6, 2016 visit, it was noted that Petitioner had been doing fine until that morning at work, that he was using his left shoulder at work throwing away scraps and had pain, and that it had gotten progressively worse which was why he was there on that date. A Kenalog injection was performed and Petitioner was instructed to follow-up as scheduled. (PX2).

The records of Dr. Li reflect that Petitioner was seen on January 16, 2017, at which time it was noted that he had been feeling great the last two weeks and that all the pain he was feeling before had been resolved. Petitioner underwent ultrasound on the left shoulder, which was interpreted as revealing a normal examination of the left shoulder. Petitioner was recommended to continue his home exercise program and advance activities as tolerated. At the time of the January 26, 2017 visit, it was noted that Petitioner had been working and noticed popping in the left shoulder and that there was no pain, but that the popping had gotten worse so he was concerned. Petitioner underwent ultrasound on the left shoulder, which was interpreted as revealing that the biceps tendon appeared intact with evidence of mild thickening without

subluxation. Petitioner was recommended to continue Meloxicam and his home exercise program. Petitioner was recommended to follow-up in four weeks. (PX2).

The medical records of St. James – John Albrecht Medical Center dated July 3, 2015 were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that he presented with left shoulder pain, that the incident occurred more than one week ago, that Petitioner was riding a motorcycle and was struck by a large bug on the left clavicle area and that the left shoulder was affected. It was noted that there was no history of shoulder injury. It was also noted that Petitioner stated that moving it around during work aggravated the pain. Petitioner was recommended to take NSAIDs/Tramadol and to rest/ice the area on that date, and to follow-up with his primary care physician if not improved by the following Monday. (PX3).

The medical records of Advocate Medical Group dated July 6, 2015 were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on that date, at which time it was noted that he had collar bone pain, that it was 8/10 at rest and 10/10 on circumduction and extension, that he had been stung by a yellow jacket while riding his bike and that he had had pain ever since. It was noted that Petitioner's pain was a little worse while working, that he was a butcher at Chenoa Meats and that he had been seen at OSF and was told that he might need an MRI. The assessment was noted to be that of pain of the left clavicle and pain of the sternum. Petitioner was prescribed medications and was ordered to undergo blood work and x-rays of the left clavicle. It was noted that Petitioner had a very unusual presentation and that there were no signs of infection or trauma. (PX4).

The Interpretive Report for the MRI Arthrogram of the Left Shoulder Dated April 5, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. It was noted that the films were interpreted as revealing questionable blunting anterosuperior labrum without a well-defined or discrete tear; intact rotator cuff tendons; acromioclavicular joint arthropathy with mild inferior spurring. (PX5).

The medical records of Dr. Lawrence Li (dated April 1, 2016 through June 7, 2016) were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner completed a Patient Information questionnaire on April 1, 2016, at which time it was noted that his left shoulder popped in and out of the socket and that he had constant pain with work; when asked to describe how the injury occurred, Petitioner indicated that he believed it was "overlifting" and stress with his work. It was noted that his job title was that of a butcher, that his main job duties involved cutting meat and that the injury occurred within the last year. The Initial Evaluation (physical therapy) dated April 14, 2016 noted that Petitioner reported injuring himself at work the prior summer when he was lifting a piece of cow and felt a sharp pain in his shoulder. It was noted that Petitioner went to the emergency room that day and had x-rays taken which yielded no significant results, that his shoulder had been painful ever since and that he had continued to work at full capacity and just dealt with his pain. It was noted that Petitioner had been prescribed pain medication for his pain, and that he was fed up with dealing with his pain and just wanted to get it taken care of. (PX6).

Physical Therapy records were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. At the time of the Initial Evaluation on July 21, 2016, it was noted that Petitioner reported that he was at work lifting part of a cow with his left arm outstretched all the way and that he felt a pop/stretch/pull when he did it and that it hurt. It was noted that Petitioner reported that he did write an incident report right away, but that he did not turn in the report until he came to see Dr. Li about the shoulder. At the time of the October 24, 2016 visit, it was noted that Petitioner stated that his shoulder was doing very well, that he was not really having any difficulty around the house, that he did not have any pain but would get sore if he did too much and that he was "really happy" with how things were going. (PX7).

Additional Physical Therapy records were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. At the time of the November 4, 2016 visit, it was noted that Petitioner's pain was 0/10 and that he was going back to work on Monday. It was noted that Petitioner was to be discharged to a home exercise program at that time. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The transcript of the deposition of Dr. Edward Kolb was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Kolb testified that he is a board-certified orthopedic surgeon. He testified that in addition to performing medical-legal work he also treats patients, and that 95% of his practice is devoted to treating patients. (RX1).

Dr. Kolb testified that he performed an examination of Petitioner on June 23, 2016. He testified that based on the history that he obtained from Petitioner, the medical records that he reviewed, the physical examination performed and the diagnostic testing results, his diagnosis for Petitioner was that of a possible labral versus a SLAP tear and left shoulder pain of unclear etiology. He testified that he was unable to relate Petitioner's left shoulder condition to his employment as a butcher given the discrepancies noted in his history from those in the medical records. He testified that Petitioner claimed to have had a work-related injury on July 3, 2015, but that he did not appreciate any documentation suggesting that the injury actually occurred at that time. (RX1).

When asked if there was documentation in the medical records of another mechanism of injury besides something that occurred as his employment as a butcher, Dr. Kolb responded that Petitioner was apparently involved in an incident while riding his motorcycle where a bug struck his shoulder at which time he was seen for medical care pertaining to the left shoulder. He testified that he indicated in his report that it was certainly possible that Petitioner's current symptoms were related to the motorcycle accident and that his interpretation was that there did not appear to be a work-related incident at least documented until April 1, 2016. (RX1).

On cross examination, Dr. Kolb agreed that when he saw Petitioner he gave a history of a work-related injury, that he indicated to him that he recalled picking up the front half of a cow at which time he felt a pulling sensation in his left shoulder and that he agreed that it was the type of event that could cause a SLAP tear. He testified that he believed that he supposed that it was the type of event that could potentially lead to an impingement syndrome. (RX1).

On cross examination, Dr. Kolb agreed that Dr. Li took a history from Petitioner as well and that he noted that Petitioner stated that he had had increased left shoulder pain due to increased lifting and that it occurred when he was lifting the side of an animal at work while butchering. He agreed that if this was the history it was the type of event that could cause a SLAP tear, and testified that he felt that it was possible to lead to an impingement syndrome. (RX1).

On cross examination, Dr. Kolb agreed that typically one would not expect to see a bee sting or a bug bite cause a SLAP tear. He testified that there would have to be some unusual motions of the shoulder during a motorcycle ride to cause a SLAP tear from a bee sting. He testified that typically SLAP tears were caused by some type of traction or stretching out-type motion. (RX1).

On cross examination, Dr. Kolb agreed that pain with increased lifting was consistent with an injury and that dull, sharp, aching pain that was constant and severe could be consistent with a lifting injury. He agreed that decreased strength could be consistent with a lifting injury. When asked whether the pathology seen on the MRI could be consistent with lifting a cow, Dr. Kolb responded that the MRI showed some

blunting of the labrum and no evidence of rotator cuff tendon pathology, so he was unable to say with any degree of medical certainty that there was specific pathology present on the MRI. (RX1).

On cross examination, Dr. Kolb agreed that when he saw Petitioner he had 6-10/10 pain levels and that he mentioned that he had changed his job duties. He agreed that he found slightly decreased strength. He agreed that the Yergason test appeared to be positive and that it was a test used to test for possible biceps tendon pathology. He agreed that there was no symptom magnification. He agreed that he thought it was possible that Petitioner had a SLAP tear. He further agreed that at the time that he saw Petitioner, he felt that he needed some type of restrictions. (RX1).

On redirect when shown the operative report of Dr. Li, Dr. Kolb testified that there was no information in the operative report which prompted him to change any of the opinions that he testified to. Dr. Kolb testified that it was possible that when a patient had an injury in the shoulder that they could potentially start getting some impingement-type symptoms where the rotator cuff could rub up against the front part of the acromion and cause pain or become irritated, but that in this case he could not say with any degree of medical certainty whether or not the impingement symptoms would have been related. (RX1).

On further cross examination, Dr. Kolb testified that it was possible that the diagnosis of left shoulder SLAP tear with involvement of the superior aspect of the biceps tendon attachment was the type of diagnosis that one could receive from the lifting of a cow as described to him by Petitioner. He testified that it was possible that the shoulder could become inflamed after an injury and that he could not say one way or another whether the impingement syndrome would have been related to the specific injury. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on July 3, 2015.

Petitioner testified at the time of arbitration that on the date of accident, he was lifting the front right quarter of a side of beef that he estimated weighed between 150-200 pounds when he felt pulling in his left shoulder. Terry Bittner, the owner of Respondent Chenoa Locker, Inc., testified at the time of arbitration that he knew that Petitioner hurt his left shoulder but was unable to recall the specific date. Mr. Bittner further testified that he recalled having a conversation with Petitioner on the date of accident and that Petitioner stated that he injured his left shoulder while lifting a front quarter on the saw. Based upon the witness testimony proffered at the time of arbitration, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on July 3, 2015.

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the left shoulder is causally related to the accident of July 3, 2015.

The Arbitrator notes that the medical records of St. James – John Albrecht Medical Center dated July 3, 2015 reflect that Petitioner was seen in the emergency room on that date, at which time it was noted that he presented with left shoulder pain, that the incident occurred more than one week ago, that Petitioner was riding a motorcycle and was struck by a large bug on the left clavicle area and that the left shoulder was affected. It was noted that there was no history of shoulder injury. It was also noted that Petitioner stated that moving it around during work aggravated the pain. No mention of the lifting of an animal was mentioned in this note. (PX3). The Arbitrator also notes that on July 6, 2015 - which was three days after

the accident at issue - Petitioner saw his primary care physician at Advocate Medical Group, at which time it was noted that he had collar bone pain, that it was 8/10 at rest and 10/10 on circumduction and extension, that he had been stung by a yellow jacket while riding his bike and that he had had pain ever since. It was noted that Petitioner's pain was a little worse while working, that he was a butcher at Chenoa Meats and that he had been seen at OSF and was told that he might need an MRI. The assessment was noted to be that of pain of the left clavicle and pain of the sternum. No mention of the lifting of an animal was mentioned in this note. (PX4).

The Arbitrator further notes that even at the time of his first visit with Dr. Li on April 1, 2016 – which was nearly 39 weeks post-accident -- Petitioner completed a Patient Information questionnaire in which he noted that his left shoulder popped in and out of the socket and that he had constant pain with work; when asked to describe how the injury occurred, Petitioner indicated that he believed it was "overlifting" and stress with his work. It was noted that his job title was that of a butcher, that his main job duties involved cutting meat and that the injury occurred within the last year. (PX6).

As to the medical testimony offered by the parties, the Arbitrator notes that Respondent's Section 12 physician, Dr. Kolb, testified that he was unable to relate Petitioner's left shoulder condition to his employment as a butcher given the discrepancies noted in his history from those in the medical records. (RX1). Dr. Kolb testified that Petitioner claimed to have had a work-related injury on July 3, 2015, but that he did not appreciate any documentation suggesting that the injury actually occurred at that time. (*Id.*). When asked if there was documentation in the medical records of another mechanism of injury besides something that occurred as his employment as a butcher, Dr. Kolb responded that Petitioner was apparently involved in an incident while riding his motorcycle where a bug struck his shoulder at which time he was seen for medical care pertaining to the left shoulder, and he further testified that he indicated in his report that it was certainly possible that Petitioner's current symptoms were related to the motorcycle accident. (*Id.*). Furthermore, while the Arbitrator acknowledges that Dr. Li testified that testified that the findings that he found in surgery could not possibly be caused by an insect hitting the medial aspect of the clavicle, Dr. Li also testified on cross examination that SLAP tears were distraction or traction injuries and that if jerked hard enough, it could be torn. (PX1). Dr. Li further testified on cross examination that the SLAP tear and the biceps tendon tear would have the same mechanisms of injury. (*Id.*). Additionally, the Arbitrator finds to be significant in this case that Dr. Li admitted on cross examination that the complaints that Petitioner gave to Dr. Mitchell were similar to the complaints that he gave to the emergency room and different than the complaints that Petitioner gave to him. (*Id.*). In light of foregoing, the Arbitrator places greater weight upon the opinions proffered by Dr. Kolb than those proffered by Dr. Li in this matter.

Having considered and reviewed the entirety of the medical records and testimony in the matter, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being in the left shoulder is causally related to the accident of July 3, 2015. 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)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GREGORY CADY,

Petitioner,

19IWCC0470

vs.

NO: 17 WC 8414

STATE OF ILLINOIS – CHESTER MENTAL HEALTH CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner suffered a stipulated compensable accident on January 2, 2017. He was trying to subdue an unruly patient and he pushed Petitioner over a bed. Petitioner injured his lower back, left shoulder, and right elbow. He had an injection in his shoulder and it resolved that problem. He was not claiming permanent partial disability benefits for the shoulder. However, he was seeking permanent partial disability benefits for his elbow because his right elbow hurts when placed on hard surfaces and Dr. Mall told him there was nothing could be done for it. Regarding his lumbar spine, conservative treatment failed and on October 4, 2017 Dr. Gornet performed disc replacement surgery at L4-5 and L5-S1. On November 16, 2017, Dr. Gornet noted that Petitioner continued "to do wonderfully well" six weeks post surgery, Petitioner was "exceedingly pleased with his progress," and had 5/5 strength in all groups. Petitioner was declared at maximum medical improvement on June 24, 2018 and went back to work at full duty. Petitioner testified that his post-return evaluation was satisfactory.

19IWCC0470

After his lumbar surgery, Petitioner developed a hernia/hematoma-like condition, that Dr. Gornet noted was clearly secondary to his lumbar disc replacement surgery. On May 23, 2018, Dr. Charles performed ventral hernia repair. Petitioner continued to treat with Dr. Charles after that surgery. On June 18, 2018, Dr. Charles noted that the drainage had almost resolved and released Petitioner from treatment prn.

Petitioner testified that despite his improvement and weaning off narcotic pain medication, he still has low back pain when lifting heavy things, running for periods of time, sitting in bleacher seats, and riding in cars for long periods. The pain is related to his level of activity. All he takes is Ibuprofen "every other day or several times a week." He has not returned to scuba diving because the tanks are heavy and it hurts his back to lift them. Since being released by Dr. Gornet, he has only ridden his motorcycle very short distances. If his back is hurting he "kind of will stay back" in emergencies at work, but he will try to run if his back was OK. He cannot perform his job 100% like he did before the accident.

Petitioner treated with Dr. Mall for his elbow as well as his shoulder. Petitioner last saw Dr. Mall on March 28, 2017. Petitioner reported he no longer had any symptoms in the left shoulder. He still had pain in the right elbow when putting it on something or flexing it up. Otherwise, it was not really bothering him. Dr. Mall recommended Petitioner avoid placing his elbow on hard surfaces. He believed his problems resulted from a soft-tissue injury and surgery was not indicated. He also thought it would improve with time, but it might take up to a year. However, Dr. Mall also noted "he may always have some difficulty resting his elbow on hard surfaces." He released Petitioner to full-duty work for those conditions.

The Arbitrator awarded Petitioner 75 weeks of permanent partial disability benefits representing loss of the use of 15% of the person-as-a-whole. The Arbitrator did not award permanency benefits for Petitioner's injury to his elbow and did not specifically note Petitioner's post-surgical hernia/hematoma condition, which required an additional surgical procedure and additional treatment.

The Commission concludes that Petitioner is entitled to some permanency award for his elbow injury. In addition, the Commission concludes that Petitioner is entitled to a somewhat higher permanency award for his lumbar condition due to the post-surgical complication of the hernia/hematoma which required additional treatment including additional surgery.

Permanent Partial Disability

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b. Specifically, Section 8.1b provides:

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

With regard to subsection (i), the record contains no impairment rating. Thus, the Commission assigned no weight to this factor.

With regard to subsection (ii), the record reflects that Petitioner was employed as a security therapy aide II, but has ongoing complaints related to the performance of his duties despite a release to work without restrictions. Petitioner's testimony is unrebutted. Thus, the Commission gives greater weight to this factor.

With regard to subsection (iii), the parties stipulated that Petitioner was 54 years old at the time of the accident with years of anticipated work remaining. Thus, the Commission gives greater weight to this factor.

With regard to subsection (iv), the record reflects no evidence of diminution in earnings. Thus, the Commission gives greater weight to this factor.

With regard to subsection (v), the record reflects that Petitioner sustained a traumatically induced injury to the low back as a result of an undisputed accident while attempting to subdue a

19IWCC0470

patient involving his right elbow and lumbar spine. Petitioner underwent conservative treatment for the right elbow condition. He also underwent conservative treatment to the lumbar spine, which failed. Then Petitioner underwent a two-level disk replacement surgery at L4-5 and L5-S1. Petitioner developed a small mass at the incision post-operatively that required a ventral hernia repair. Petitioner testified regarding his ongoing subjective complaints in the right elbow and low back, which are supported by the medical records and findings of Petitioner's treating physicians. No Section 12 examination report was submitted to the contrary. Thus, the Commission gives greater weight to this factor.

In consideration of all of the enumerated factors, the Commission finds that Petitioner has sustained a loss of 100 weeks representing 20% loss of use of the person-as-a-whole pursuant to Section 8(d)2 of the Act and 6.325 weeks representing 2.5% loss of use of the right arm pursuant to Section 8(e) of the Act, and modifies the decision of the Arbitrator accordingly.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $651.10 per week for a period of 106.325 weeks, pursuant to §8(d)2 of the Act because the injuries Petitioner sustained resulted in the loss of the use of 2.5% of the right arm and loss of the use of 20% 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.

DATED: AUG 29 2019

Barbara N. Flores

Marc Parker

BNF-MP/dw
O-8/15/19
46

19IWCC0470

Concurrence in Part and Dissent in Part

I respectfully concur in part and dissent in part with the decision of the majority. I concur with majority in awarding Petitioner 3.326 weeks for loss of the use of 2.5% of his right arm for the elbow injury. Petitioner testified to some ongoing symptoms with the elbow and his treating doctor, Dr. Mall, indicated that he might continue to have some problems with the elbow in the future. However, I dissent with the decision of the majority increasing the permanency award for Petitioner's lumbar condition.

The medical records show that Petitioner had an excellent recovery after his lumbar disc replacements and was able to return to his physically demanding job. Petitioner's spine surgeon and treating doctor, Dr. Gornet, indicated that Petitioner had progressed "wonderfully well," and that Petitioner was "exceedingly pleased" with his condition after surgery. The Arbitrator's award of loss of the use of 15% of the person-as-a-whole seems appropriate for the two-level disc replacement surgery. There was no proof that he suffered any permanent impairment or disability from the hernia/hematoma and that if there is any extremely minor permanency that could be attributed to the hernia/hematoma, that is effectively offset by his excellent overall recovery and regaining of functionality after his lumbar surgery.

For the reasons stated above, I concur with majority in awarding Petitioner 3.326 weeks for loss of the use of 2.5% of his right arm for the elbow injury and I respectfully dissent from the decision of the majority increasing the permanency award for Petitioner's lumbar condition.

Deborah L. Simpson

DLS/dw

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0470

CADY, GREGORY
Employee/Petitioner

Case# **17WC008414**

SOI/CHESTER MENTAL HEALTH
Employer/Respondent

On 1/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% 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:

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
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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 15 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

19IWCC0470

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
NATURE AND EXTENT ONLY

Gregory Cady
Employee/Petitioner

v.

SOI/ Chester Mental Health.
Employer/Respondent

Case # **17** WC **08414**

Consolidated cases: **NA**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 15th, 2018.** By stipulation, the parties agree:

On the date of accident,1/2/17, 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 **$56,428.73**, and the average weekly wage was **$1085.16.**

At the time of injury, Petitioner was **54** years of age, **Married,** with **0** dependent children.

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

Respondent shall be given a credit for All TTD Paid, **$0** for TPD, **$0** for maintenance, and, for a total credit of **ANY 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 permanent partial disability benefits of $651.10 for 75 weeks for 15 % of a Person as a whole, for injuries to the lower back, as provided in Sections 8(d)2 of the Act.

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

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

Edward Lee
Signature of Arbitrator

12/30/18
Date

JAN 15 2019

FINDINGS OF FACT

A full hearing was held in this matter. The sole issue was nature and extent of the injuries to the Petitioner.

Mr. Cady works as a Security Therapist Aide II at the Chester Mental Health Center, having been employed there for 7 ½ years at the time of trial. The Parties stipulated Petitioner suffered an accidental injury in the course of his employment. The Petitioner testified he injured while trying to subdue an unruly patient. He was pushed, falling over a bed, landing on his buttocks after crashing into a wall hitting his left shoulder, and injuring his lower back and right elbow. He noted for the record he was not claiming permanent injury to his left shoulder. He noted he is claiming injury to his right elbow but is not taking any medication for it.

Petitioner initially presented to Chester Memorial Hospital in Chester Illinois with complaints of left shoulder, right elbow and low back/tail bone pain. It was noted his right elbow had full range of motion with no numbness or tingling in his fingers or at the site of injury. He was tender without bruising at that location. His lumbosacral spine had tenderness to palpation, not pain midline or bruising. The assessment was lumbar strain, right shoulder strain, and contusion of the right elbow. Mr. Cady followed up on 1/10/17 with continued complaints of pain in the elbow and tailbone. X-rays were performed of the right elbow with no evidence of acute fracture, dislocation of appreciable joint effusion, there was spurring noted along the olecranon process. X-rays of the lumbar spine found no evidence of acute fracture, subluxation or frank bony destruction. There was mild disc space narrowing again [this was a comparison with 10/16/13] seen at L3-4 with marginal spurs, consistent with degenerative disc disease.

Mr. Cady was seen by Dr. Nathan Mall of the Orthopedic Center of St. Louis on 1/19/17 presenting with two complaints; left shoulder pain and right elbow pain. Petitioner described a dull ache in his shoulder with shooting pains when moved into a downward position. Dr. Mall noted palpable triceps and biceps tendons with no significant pain over the medial or lateral epicondyles of the elbow. There was mild sensitivity over the ulnar nerve with palpation of the cubital tunnel. But he noted equivocal flexion compression test with some mild symptoms into the fore but no numbess or tingling down into the digits. The Tinel's test was also equivocal. He had right shoulder pain over the AC joint and pain with cross-body abduction but no pain to palpation over the biceps tendon. He had 5/5 strength in the supraspinatus, infraspinatus, and subscapularis distributions bilaterally. There was no pain over the right AC joint. Dr. Mall's initial assessment was right elbow contusion with left shoulder AC joint sprain and inflammation in the setting of some mild arthritis. His recommendation was an MRI and he performed a cortisone injection into the left AC joint. He also recommended physical therapy for the elbow and opined the elbow would improve over time given he didn't see any major structural damage to the elbow on the MRI. There was no acute ligament or tendon injury found on the elbow MRI. There was a 7 X 5 MM of gr. IV chondrosis involving the capitellum and focal subcutaneous edema involving the posterior aspect with the report indicating olecranon bursitis could not be excluded. The MRI of the shoulder was found to be normal. An MRI of the lumbar spine was conducted with central protrusions at L3-4, L4-5 and L5-S1 resulting in dural displacement, but no definite central canal stenosis, with mild foraminal stenosis found at all three levels.

Petitioner returned on 2/15/17 stating his left shoulder was better with minimal to no symptoms at that time. But he continued to complain of significant pain with resting the right elbow, even with light touch to the area. On 3/28/17 he reported no longer having left shoulder symptoms. Also he reported his right elbow having pain when he put it directly onto a structure and flexed his elbow up, otherwise his elbow was not really bothering him. Dr. Mall recommended against surgery believing the elbow would probably improve over time but that it would take several months if not a year for this to improve fully.

Petitioner presented for Physical therapy on 1/20/17 at Perry County therapy services. On 2/9/07 he presented with a new authorization for his right elbow but reported his right elbow didn't bother him too much. He

reported he had good motion and strength but it was tender to the touch.

Mr. Cady was referred by Dr. Mall to Dr. Gornet. He was seen on 2/10/17 presenting with complaints of low back pain central to both sides, but denying radicular leg pan. Dr. Gornet recorded Mr. Cady had treated with him previously for neck pain back in June of 2012. Dr. Gornet had an MRI conducted on the same day and his interpretation was of a central disc protrusion at L3-4 and possibly a subtle change at L4-5 with a fairly large central annual tear at L5-S1 which he noted correlated best with his symptoms. Dr. Gornet placed Petitioner on light duty. Petitioner returned on 4/17/17 with little to no changes in the notes. Dr. Gornet's plan at that time was to continue to manage him conservatively. Injections were performed on 4/25 and 5/9 at L5-S1 and L3-4. Dr. Gornet performed a discogram on 8/1/17. The summary of findings was non-provocative disc at L4-5 and a provocative disc with concordant pain at L3-4 and L5-S1 with annular tears. Two days later on 8/3 Dr. Gornet recommended surgery in the form of a disc replacement at L5-S1 and L3-4.

Surgery was performed on 10/4/17 consisting of an anterior decompression at L3-4 and L5-S1 and a disc replacement at the same levels. Mr. Cady returned on 11/16/17 continuing to do "wonderfully well" and was exceedingly pleased with his progress. He had minimal pain and symptoms and his exam showed 5/5 strength in all groups. On 1/20/18 films revealed excellent position of his devices, Mr. Cady continued to do well. On 6/18/18 Petitioner reported the surgery had helped him dramatically. He was returned to work full duty with no restrictions on 6/24/18. Dr. Gornet recorded that clinically he was doing well.

At trial Petitioner testified the physical therapy and surgery helped his condition. He testified he currently suffers low back pain with related to his activity level. The medical records demonstrate Mr. Cady had an excellent result from his surgery and is back to work full duty with no restrictions. There was essentially nothing found wrong with his right elbow objectively. There is certainly nothing demonstrating permanent injury to his right elbow and thus this portion of his claim is denied.

CONCLUSIONS OF LAW

Respondent shall pay Petitioner permanent partial disability benefits of $651.10 for 75 weeks for 15 % of a Person as a whole, for injuries to the lower back, as provided in Sections 8(d)2 of the Act.

In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured

employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability; corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." 820 ILCS 305/8.1b(b).

(i) Impairment Rating: The Arbitrator notes that no AMA rating has been offered in this case. Therefore, the Arbitrator gives no weight to this factor.

(ii) Occupation: Petitioner continues to be employed for the State Of Illinois but for a different entity and position. The Arbitrator gives less weight to this factor.

(iii) Age: At the time of accident Petitioner was 54 years old. There was no evidence offered demonstrating his age is a factor in his healing or future.

(iv) Earning Capacity: There is no evidence that Petitioner's future earning's capacity has been affected. The Petitioner is able to work full duty.

(v) Disability: As a result of his accidental injury, Petitioner sustained injury to his lumbar spine and underwent surgery. He was able to return to work full duty.

Based on the five factors enumerated above, the Arbitrator finds that Petitioner suffered an injury resulting in the 15 % loss Person as whole for injury to the lumbar spine.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Bayard,

Petitioner,

19IWCC0471

vs.

NO: 17 WC 15369

Hayes Mechanical,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 18, 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.

19IWCC0471

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 29 2019
o7/11/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

19IWCC0471

BAYARD, ROBERT
Employee/Petitioner

Case# **17WC015369**

HAYES MECHANICAL
Employer/Respondent

On 10/18/2018, 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 2.41% 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:

5328 LAW OFFICE OF DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

1109 GARAFALO SCHREIBER & STORM
JAMES CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ROBERT BAYARD
Employee/Petitioner

v.

HAYES MECHANICAL
Employer/Respondent

Case # **17** WC **15369**

Consolidated cases: ___

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Gerald Granada, Arbitrator of the Commission, in the city of Bloomington, on 8/28/2018. 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. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS

On the date of accident, 4/12/2016, 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 $143,457.60; the average weekly wage was $2,758.80.

On the date of accident, Petitioner was 39 years of age, ***single*** with 2 dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $8,387.15, as provided in Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule.

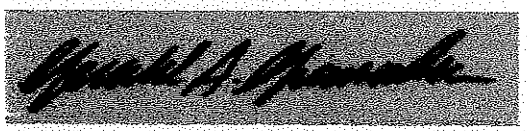
Respondent shall approve prospective medical as recommended by Dr. Li.

Respondent shall pay temporary partial disability by benefits of $1172.53/week for 65 weeks, commencing 5/30/2017 to 8/28/2018 as provided in Section 8(a) of the Act.

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

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

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



Signature of Arbitrator

10/17/18
Date

OCT 18 2018

19IWCC0471

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on April 12, 2016. Respondent disputes Petitioner's claim and the issues in dispute are: 1) causation, 2) medical expenses, 3) TTD/TPD, and 4) prospective medical care.

Petitioner testified he worked for the Respondent as a boilermaker. He performed work activities, which included welding, grinding, using sledge hammers, pry bars and lifting heavy objects. Petitioner worked 50-60 hours per week. (PX6). Petitioner stated at the beginning of April, 2014 he was moved from a regular boilermaker to supervisor.

On April 12, 2016 Petitioner was inspecting work. This required him to climb scaffolding, and on his way down he hit his left elbow on a bolt. (PX 9a) Petitioner stated he felt immediate pain and swelling in his left arm and his hand. (PX9 b,c) Petitioner hoped the swelling and pain would go away and continued to work.

On May 20, 2016, Petitioner went to OSF Occupational Medicine and was treated by Dr. Braun. Petitioner gave a history of striking his left elbow on an exposed bolt while climbing on scaffolding. (PX2). Petitioner next followed up with Dr. Braun on May 24, 2016 complaining of ongoing left elbow pain. Dr. Braun diagnosed Petitioner with left elbow bursitis and informed Petitioner the symptoms would settle down. Dr. Braun recommended an elbow pad. Dr. Braun informed Petitioner if his elbow pain and swelling did not subside, to follow up with an orthopedic surgeon. (PX2).

Petitioner continued to work as a boilermaker supervisor for Respondent. In the summer of 2016 he was laid off and then rehired in the fall. Petitioner stated in the fall of 2016 he worked for several months as a regular boilermaker and experienced pain and swelling in his left arm and hand.

Due to continued swelling in his left arm, Petitioner followed up with Dr. Li on May 8, 2017. (PX2). Petitioner gave a history of hitting his left elbow while on scaffolding. Dr. Li noted continued swelling in the left elbow and hand. (PX2). Dr. Li diagnosed the Petitioner with contusion and cubital tunnel. An MRI was completed on May 9, 2017 that demonstrated a small focal low-grade partial thickness tear of the common extensor tendon at the lateral epicondyle. (PX2).

On May 23, 2017, Petitioner underwent an EMG with Dr. Trudeau. (PX3). After the EMG was performed, Dr. Trudeau diagnosed Petitioner with neuropathy of the left elbow and the left wrist.

On May 30, 2017, Petitioner followed up with Dr. Li after the MRI and EMG. (PX2). After reviewing the EMG and MRI, Dr. Li diagnosed Petitioner with left cubital tunnel, left ulnar tunnel syndrome and left tricep tendinitis. Based on this diagnosis, Dr. Li recommended left cubital and ulnar release. (PX2). Dr. Li gave Petitioner restrictions of limited lifting, pushing and pulling 20 pounds with the left arm. (PX7).

Dr. Li testified via evidence deposition on March 19, 2018. (PX5). Dr. Li is a board certified orthopedic surgeon that focuses on shoulders, arms, hands and knees. (PX5 pg4). Dr. Li testified he first saw

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Petitioner in May of 2017. Petitioner gave a history of hitting his elbow against a piece of metal a year prior. (PX5 pg 4-5). As part of the deposition, Dr. Li reviewed photos of the scaffolding and bolt Petitioner hit his elbow on, and the swelling in his hand and elbow right after the accident. (PX5 pg 5-6). Dr. Li stated his initial physical exam demonstrated continued swelling in his left arm. Petitioner gave Dr. Li a history of symptoms in his left arm and hand. Also, Petitioner informed Dr. Li he continued to have pain over the back of his elbow and tingling in his elbow, forearm and fingers when doing strenuous work. (PX5 pg 5-8). Dr. Li diagnosed Petitioner with left elbow contusion and cubital syndrome. Dr. Li opined that Petitioner's left elbow contusion and cubital tunnel syndrome were related to his April 12, 2016 accident. (PX 5 pg 9).

Dr. Li further testified that after reviewing the MRI and EMG he felt Petitioner suffered from double-crush syndrome. Dr. Li stated the compression of the nerve in the elbow caused problems in his wrist. Also, Dr. Li felt Petitioner was more susceptible to his injuries due to his arm and hand intensive work. Dr. Li explained the continued swelling in Petitioner's left arm and hand accelerated his issues. (PX5 pg13). Dr. Li recommended a left cubital and left ulnar tunnel release – which he believed would be related to the April 12, 2016 accident. (PX5 pg 14-15). Dr. Li also testified Petitioner has ongoing restrictions until surgeries are performed. The restrictions are limited lifting, pushing, pulling 20 pounds with the left arm. (PX5 pg 15). On cross examination, Dr. Li stated he felt the pooling of the blood and problems in his elbow and his hand caused compression on the nerves and is a reason why he developed cubital and ulnar nerve issues. (PX5 pg16-18).

On October 12, 2017 Petitioner saw Dr. Stiehl for an independent medical examination. (RX 1). Dr. Stiehl was given a history of immediate pain and swelling over the flexor volar forearm from a contusion caused by hitting his elbow on a bolt on April 12, 2016. Dr. Stiehl reviewed the MRI and he felt it was basically normal. Dr. Stiehl reviewed the EMG and summarized Dr. Trudeau's findings as left elbow cubital tunnel syndrome and a Guyon's canal involvement in the wrist, which caused a double, crush injury. There is no evidence of cervical radiculopathy or brachial plexopathy. Dr. Stiehl disputes Dr. Trudeau's interpretation of the EMG. Dr. Stiehl noted Petitioner had mild to moderate cubital tunnel and Guyon's canal involvement of the left wrist. Dr. Stiehl opined he found no significant evidence of an injury that would have caused cubital tunnel syndrome. Dr. Stiehl stated he did not see significant treatment initially nor any evidence of a contusion of the cubital tunnel. Thus, from his review of the records there was no evidence of a neurological impairment caused by the claimed injury of April 12, 2016. Dr. Stiehl did opine Petitioner should be able to cure his neuropathies if surgical intervention was entertained. As it related to the accident, Dr. Stiehl opined Petitioner had reached maximum medical improvement at the last visit with Dr. Braun on May 26, 2016 and that he would not need any restrictions. (RX1).

Petitioner testified Respondent laid him off and he couldn't find work as a boilermaker with his restrictions. Petitioner was able to find work with his restrictions as a salesman for $1,000.00 per week. Petitioner also testified that he would like to proceed with the surgery recommended by Dr. Li.

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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 the Petitioner's unrebutted testimony and the medical evidence. The Arbitrator finds persuasive the testimony of Dr. Li on this matter. Petitioner credibly testified that following his April 12, 2016 accident, he continued to have left arm and hand swelling and pain but did not seek immediate medical treatment because he thought his pain would go away. He saw Dr. Braun of OSF Peoria approximately 1 month later, and ultimately followed up with Dr. Li on May 8, 2017. Consistent with Petitioner's ongoing complaints, Dr. Li noted continued swelling on his physical exam. Dr. Li opined Petitioner's left arm and wrist injury were causally related to his April 12, 2016 accident after having reviewed the following: Petitioner's EMG showing neuropathy at the left elbow and left wrist; photographs of the bolt on which Petitioner struck his left arm; photographs of his left arm and hand at time of accident; and a detailed history of Petitioner's work duties, which included intensive hand work. The Arbitrator notes that Respondent disputes this issue based on the Dr. Stiehl IME – who opined that he did not believe Petitioner's arm/hand conditions were causally related despite not being able to identify any pre-existing condition or any other explanation for Petitioner's maladies. The preponderance of the evidence supports the conclusions of Dr. Li in this matter. Therefore, the Arbitrator concludes that the Petitioner's current condition of ill-being is causally related to his April 12, 2016 work accident.

2. Consistent with the Arbitrator's conclusions on the issue of causation, the Arbitrator finds that the Petitioner's medical treatment thus far has been reasonable and necessary in addressing his work-related condition in his left arm and hand. As such, the Arbitrator awards the Petitioner all reasonable and necessary medical expenses, subject to the fee schedule, related to the treatment of Petitioner's left arm and wrist condition including the following: $3,898.00 for Dr. Trudeau (EMG 5/23/17); $2,017.40 for Prescription Partners (5/8/17 – 5/30/17); and $2,471.75 for Dr. Li (5/8/17 – 5/30/17).

3. With regard to the issue of TTD/TPD, the Arbitrator finds that Petitioner was temporary and partially disabled from May 30, 2017 to August 28, 2018, representing 65 weeks. The Petitioner was able to obtain employment within his restrictions at $1,000.00 per week and his Average Weekly Wage with Respondent was $2,758.80. This equates to a weekly temporary partial disability benefit of $1,172.53, which calculates to an award for TPD in the amount of $76,214.45. Respondent shall receive a credit for any disability benefits it has paid for the time period in question.

4. Also consistent with the Arbitrator's conclusions above, the Arbitrator further finds that the medical care recommended by Dr. Li is reasonable and necessary in addressing Petitioner's work-related conditions in his left arm and hand. Accordingly, the Arbitrator awards the Petitioner the prospective medical care he is seeking per the recommendation of Dr. Li, including the proposed surgical procedure involving a left cubital and ulnar release. Respondent shall authorize and pay for said prospective medical care.

STATE OF ILLINOIS)	☒ Affirm and adopt (with explanation)	☐ 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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KURT KORTE,

Petitioner,

19IWCC0472

vs. NO: 16 WC 17671

U.S. STEEL CORPORATION,

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 all issues, 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.

I. *Findings of Fact*

Petitioner began working for Respondent in 1996 and was subsequently laid off on January 29, 2016 in a general plant shutdown. He was also previously laid off for a six-month period in 2008. When Petitioner first started working for Respondent, he was a "kerfer" for six to eight months. This position, which Petitioner described as hand-intensive, required him to remove pieces of kerf from steel slabs using a chisel attached to a long bar. Petitioner thereafter went to work on "the hot strip" in 1997 as a laborer under Joe Spanberger's supervision. While on the hot strip, Petitioner held laborer, banding, and utility man positions before becoming a gauger for ten years. Petitioner worked as a gauger for Respondent from 2006 or 2007 until January 29, 2016.

Petitioner alleges that he developed bilateral carpal tunnel syndrome manifesting on January 29, 2016 due to the repetitive trauma of his work activities in the gauger position. These repetitive work activities included using a hand chisel to remove slag from the steel, pushing a bright boy stone against steel strips, rolling steel throughout the mill, dragging pieces of steel by a hook, and using a hand-held grease gun. Petitioner's testimony regarding his work activities conflicted with the testimony provided by his supervisor, Mr. Spanberger, especially as related to the amount of time per day Petitioner was required to use the bright boy stone and chisel.

Mr. Spanberger further testified that although injuries in his department were required to

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be reported to him, he never received any report that Petitioner had suffered hand injuries while at work. Petitioner conceded that he was familiar with Respondent's injury protocol, but he nevertheless had not reported his symptoms to anyone at Respondent's plant.

After the January 29, 2016 layoff, Respondent called all its gaugers, including Petitioner, back to work around January 2017. Petitioner testified that he had felt numbness and tingling in his hands for a couple months before the January 2016 layoff, but he did not seek treatment at that time. Petitioner also testified that the week following his layoff, he went on vacation and felt numbness and tingling in his hands that came on suddenly as he was driving the eight hours to Wisconsin.

Approximately three months after the layoff, Petitioner presented for treatment with Dr. John Dawdy on May 4, 2016. Petitioner reported having bilateral hand numbness since February and denied any trauma or injury. He told Dr. Dawdy that he had been laid off from Respondent and working on a diary farm when he first noticed the numbness. Dr. Dawdy diagnosed Petitioner with neuropathy of the bilateral arms and hands and referred him to Dr. Michael Beatty. A subsequent May 25, 2016 nerve conduction study showed findings consistent with severe bilateral carpal tunnel syndrome. On June 20, 2016, Dr. Beatty recommended bilateral carpal tunnel releases and listed January 2016 as the onset date of Petitioner's symptoms. Petitioner underwent the right carpal tunnel release on June 24, 2016 and the left carpal tunnel release on July 12, 2016. During the recovery time that followed, Petitioner remained laid off and never called Respondent to provide notice. Petitioner put his surgeries through his own healthcare at that time.

On August 16, 2016, Dr. Beatty's certified medical assistant ("CMA"), Bev Brown, noted that Petitioner was using his hands without any problems and released him to return to work. Petitioner next spoke to CMA Brown over the phone on September 13, 2016, at which time Petitioner reported he was working out of town and still using his hands without any problems. CMA Brown indicated that she would relay Petitioner's message to Dr. Beatty and released him from their care.

The parties deposed Dr. Beatty on August 23, 2017. Dr. Beatty testified that he was not provided with a formal job description to review from Respondent; however, he had asked Petitioner to complete his own job description form that described his job duties in detail. Dr. Beatty opined that Petitioner's bilateral carpal tunnel syndrome was caused by his work duties as listed in the form that Petitioner filled out on June 21, 2016. On the form, Petitioner indicated that he had to manually grind steel using his hands and arms for two and a half hours each day. Dr. Beatty did not know when Petitioner had been laid off or whether Petitioner had been working in any capacity when he first sought treatment for his upper extremity complaints. He testified that Petitioner had never mentioned working on a dairy farm to him. Dr. Beatty further opined that Petitioner's surgeries had been successful in relieving his pain and symptoms.

At the arbitration hearing, Petitioner clarified that he had worked for four months at Vonbokel Dairy Farm after he was laid off. On the dairy farm, Petitioner operated tractors, hauled manure, and conducted herd checks. None of these duties were hand-intensive. After his surgeries, Petitioner thereafter worked for four months clearing brush with a Barko machine in Alabama. He was then called back to work by Respondent around January 2017 and initially given

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the position of DMI inspector. However, Petitioner had enough seniority to move to a checker position, which is the position he still maintained at the time of arbitration.

At Respondent's request, Dr. Mitchell B. Rotman performed a Section 12 examination of Petitioner on October 31, 2016. Petitioner was laid off from Respondent at that time and had been working for two months at his job in Alabama clearing brush. Dr. Rotman initially opined that Petitioner's work could be an aggravating factor for his carpal tunnel syndrome if Petitioner had used both hands heavily or operated the grinding stone for two hours daily as described. Nevertheless, Dr. Rotman opined that Petitioner had achieved maximum medical improvement with no further treatment necessary.

Dr. Rotman subsequently authored an addendum on January 12, 2017 after receiving additional information on Petitioner's work activities from Respondent's strip mill operations coordinator. The coordinator advised Dr. Rotman that Petitioner's alleged two hours of grinding steel was an exaggeration and indicated that he would instead only be grinding for 30 minutes to an hour during an eight-hour shift. Based on this new information, Dr. Rotman concluded that Petitioner's carpal tunnel syndrome was not work-related, because his grinding time was minimal compared to all the other activities he completed throughout the day. Dr. Rotman further opined that Petitioner's other work activities, as summarized in his October 31, 2016 report, were also not aggravating factors in Petitioner's development of carpal tunnel syndrome or need for treatment.

Dr. Rotman was thereafter deposed on September 21, 2017 and testified consistent with his reports. Dr. Rotman further testified that Petitioner's symptoms had begun after he had worked on the dairy farm and not while working for Respondent. He believed that Petitioner's conditions were not work-related because his symptoms were not generated while at work for Respondent. Instead, Dr. Rotman opined that Petitioner's symptoms were aggravated by his work on the dairy farm. He further explained that Petitioner's job duties were not the type of activities that could be an aggravating factor for idiopathic carpal tunnel syndrome, because they were not repetitive.

The matter proceeded to hearing on June 21, 2018. In the Decision issued on August 14, 2018, the Arbitrator found that Petitioner had not sustained an accident that arose out of and in the course of his employment and that the current condition of his bilateral hands was not causally related to his repetitive work activities. The Arbitrator further found that Petitioner had failed to provide timely notice of his injuries and Respondent was prejudiced as a result. All benefits under the Illinois Workers' Compensation Act were denied accordingly.

II. *Conclusions of Law*

The Commission agrees with the Arbitrator's finding that Petitioner failed to prove the current condition of his bilateral hands was causally related to the repetitive trauma of his work activities manifesting on January 29, 2016.

The date of an accidental injury in a repetitive trauma case is the date on which the injury manifests itself. *Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 531 (Ill. 1987). The manifestation date is the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent

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to a reasonable person. *Id.*; *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 65 (Ill. 2006).

The Commission finds Petitioner failed to establish January 29, 2016 as the manifestation date of his alleged repetitive trauma injuries. Petitioner testified that he experienced numbness and tingling in his hands for several months prior to his January 2016 layoff. However, he did not seek any treatment until May 4, 2016, and at that time, Petitioner told Dr. Dawdy that he was working on a diary farm when he first noticed the numbness. In addition to Petitioner's work on the dairy farm, he held another job in Alabama for four months. Although neither of these post-accident positions were described as hand-intensive, Petitioner's treatment records clearly show that he had already moved on from working with Respondent at the time that he first treated for and reported noticing his symptoms. Moreover, Petitioner did not stop working on January 29, 2016 for reasons related to his symptoms. Instead, he only ceased working at that time because he was affected by Respondent's general plant layoff of all gaugers. In consideration of these facts, the record fails to establish that Petitioner's bilateral carpal tunnel injuries had in fact manifested on January 29, 2016.

The Commission further finds that Petitioner failed to provide proper notice of his injuries to Respondent as required by the Illinois Workers' Compensation Act. Pursuant to Section 6(c), notice of an accident must be given to the employer no later than 45 days after the accident. 820 ILCS 305/6(c). During the entire year Petitioner was laid off, he never called Respondent to provide notice of any injuries. Mr. Spanberger further testified that he had never received a report that Petitioner had suffered any hand injury while at work. Even as Petitioner was recovering from his two surgeries on June 24, 2016 and July 12, 2016, Respondent still had no notice of his alleged work-related injuries. The Commission finds that Petitioner's failure to provide adequate notice deprives it of jurisdiction.

Therefore, the Commission finds that all workers' compensation benefits under the Act were properly denied. However, the Commission acknowledges that Respondent cannot receive a Section 8(j) credit, as there is no award to apply the credit against. The Commission affirms and adopts the Decision of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2018 is hereby affirmed and adopted.

IT IS FURTHER ORDERED that all workers' compensation benefits pursuant to the Illinois Workers' Compensation Act are hereby denied.

IT IS FURTHER ORDERED that Respondent's Section 8(j) credit is not applicable, as there is no award in which to apply a Section 8(j) credit against.

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The 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 30 2019

Deborah L. Simpson

Barbara N. Flores

D. Douglas McCarthy

DLS/met
O- 7/11/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0472

KORTE, KURT
Employee/Petitioner

Case# **16WC017671**

U.S. STEEL CORPORATION
Employer/Respondent

On 8/14/2018, 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 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2412 BEATTY & MOTIL
RONALD S MOTIL
78 S MAIN ST
GLEN CARBON, IL 62034

0000 KEEFE & DEPAULI PC
ANDREW J KEEFE
2 EXECUTIVE DR
FAIRVIEW HEIGHTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kurt Korte
Employee/Petitioner

v.

U.S. Steel Corporation
Employer/Respondent

Case # 16 WC 17671

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **06/21/18**. 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. ☒ 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?
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **01/29/16**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$60,516.80**; the average weekly wage was **$1,210.34**.

On the date of accident, Petitioner was **46** 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 **$0** for other benefits, for a total credit of **$0**.

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

ORDER

For reasons outlined below, Petitioner failed to establish that he sustained an accident arising out of and in the course of his employment allegedly manifesting on January 29, 2016 or that his condition of ill-being is causally related to his work activities for Respondent. Petitioner also failed to provide timely notice of the alleged injury and Respondent was prejudiced. For these reasons, Petitioner's claim for benefits is hereby denied as explained in the Arbitrator's Findings of Fact and Conclusions of Law.

Respondent is entitled to a credit under Section 8(j) of the Act for all bills submitted and paid under the group insurance policy.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

8/12/18
Date

STATEMENT OF FACTS

Petitioner filed an Application for Adjustment of Claim alleging injuries to his bilateral hands, wrists and arms as a result of repetitive motions with his hands, wrists and arms while manually grinding steel strips off of coils by hand using a bright boy stone. The Application alleges a January 29, 2016 manifestation date. The case was filed with the Commission on June 7, 2016. Respondent received notice of the allegation on June 24, 2016. Respondent disputed the claim based on accident, notice, and causation. Respondent also disputed liability for outstanding medical bills listed in Petitioner's Exhibits 4 & 5. The parties stipulated Respondent is entitled to an 8(j) credit for amounts paid under Petitioner's group insurance policy. Petitioner did not claim entitlement to temporary partial or temporary total disability benefits. Nature and extent was in dispute.

Petitioner presented to his primary care physician Dr. John Dawdy on May 4, 2016 reporting complaints of bilateral hands and arms going numb since February. Dr. Dawdy documented Petitioner noticed the symptoms suddenly. Petitioner stated he was laid off at U.S. Steel and had been working on a dairy farm. Dr. Dawdy documented Petitioner was working on the farm when he noticed the numbness. Petitioner denied trauma or injury. Petitioner stated he would have symptoms when sitting and lying in bed. Petitioner reported that when he is active, all the numbness and tingling symptoms go away. Dr. Dawdy noted Petitioner had been in a motor vehicle accident last year and sustained a whiplash neck injury. He received chiropractic care for the injury. Dr. Dawdy diagnosed bilateral arm and hand neuropathy. An EMG/NCS study was ordered. (PX 2, RX 2).

Petitioner underwent an EMG/NCS study at Anderson Hospital on May 25, 2016. Dr. Syed Ali interpreted the study to reveal findings consistent with severe bilateral carpal tunnel syndrome. (PX 3). Dr. Dawdy subsequently referred Petitioner to Dr. Michael Beatty for a surgical consultation. (PX 2).

Petitioner completed a patient history form in advance of Dr. Beatty's evaluation, documenting having heart problems and pericardia. Dr. Beatty evaluated Petitioner June 20, 2016. Dr. Beatty documented Petitioner had an onset of symptoms in January 2016 and noted Petitioner was a steel worker. Dr. Beatty noted Attorney Ron Motil had filed a workers compensation claim on behalf of Petitioner. He noted a job description was pending. Following examination, Dr. Beatty recommended staged bilateral carpal tunnel releases. (PX 6).

Petitioner completed a job description for Dr. Beatty's office on June 21, 2016. He documented being employed at U.S. Steel for 20 years and working as a gauger for the past 10 years. He documented his symptoms manifested on January 29, 2016 and that he had filed a claim. When asked to describe his job duties in as much detail as possible, including physical movements required to perform the job and approximate number of times during the day, Petitioner documented "I manually grind steel with my hands and arms approximately 2-1/2 hours of each

day and everyday + overtime. I grind the steel by using a bright box stone with my hands when not grinding I drag or carry strip of steel to acid tank, it weighs up to 50 pounds I use my hands continually on the job." He documented working "8+ hours" in a normal work day and would use hand tools. He did not identify the amount of time he used hand tools. (PX 6).

Petitioner underwent a right hand carpal tunnel release on June 24, 2016 and a left hand carpal tunnel release on July 12, 2016. The operative report documents nearly identical findings. (PX 6).

Petitioner was released to resume a regular workload effective August 16, 2016. Dr. Beatty's assistant documented in a September 13, 2016 note that Petitioner was out of town working and using his hands without any problems. Petitioner was released from care and instructed to call with any problems or concerns. (PX 6).

Petitioner's Exhibit 4 reflects a balance of $3,056.10 owed to Dr. Beatty. Petitioner's Exhibit 5 reflects a balance of $1,174.20 owed to Anderson Hospital.

Pursuant to Section 12 of the Act, Petitioner underwent an examination with Dr. Mitchell Rotman on October 31, 2016. Dr. Rotman noted Petitioner had undergone bilateral carpal tunnel releases and presently had no complaints. He documented Petitioner was doing well and sleeping all night now. Dr. Rotman documented Petitioner had no complaints of numbness or tingling. Dr. Rotman documented Petitioner was a steel worker and had been laid off since January 29, 2016. Petitioner was currently clearing brush in Arkansas, working 40 hours per week.

Dr. Rotman documented Petitioner's work history, noting he had been employed at U.S. Steel since 1996 and worked 8-16 hours shifts, 40+ hours per week. Petitioner reported his job was testing coil strips. Dr. Rotman understood Petitioner handled eight strips per day. The strips were cut off, transferred on a hook and placed in an acid tank, then removed. Petitioner reported he would then be required to use an 8-10 inch bright boy, similar to a grinding stone, and rub over the surface of the coil strip. He understood the bright boy would get smaller with use. Petitioner reported the amount of use depended on the number of pieces being tested. Petitioner stated it generally took 15 minutes per piece. Petitioner also reported he would also have to use a chipper type chisel to get slag off. This would take 2-5 minutes. Petitioner reported having to measure with a measuring tape. He would use a micrometer. Petitioner reported the most hand-intensive part of the job was use of the bright boy and chisel. Petitioner reported using both hands for those activities. He would wear gloves.

Dr. Rotman reviewed records dating back to 2007, noting Petitioner had wrist injuries in 1996 and 2007. He reviewed records concerning Petitioner's motor vehicle accident. He reviewed Dr. Dawdy's records, the EMG/NCS study and Dr. Beatty's records – including the job description provided to Dr. Beatty.

Following examination, Dr. Rotman opined Petitioner had done very well from bilateral carpal tunnel release. He did not believe additional treatment was required. He believed treatment to date was reasonable and necessary. Regarding causation, Dr. Rotman stated that if Petitioner used his hands heavily at work, then his work could possibly have been an aggravating factor. If Petitioner used the grinding stone two hours a day and shared between both of his hands, then it could be an aggravating factor. Dr. Rotman noted that Petitioner did not volunteer any information about his work on the dairy farm. Based on record review, Dr. Rotman believed Petitioner's carpal tunnel condition was aggravated by his work on the dairy farm and the true aggravating factor may be his work at the dairy farm.

Dr. Rotman stated he would be happy to review a videotape of Petitioner's work at U.S. Steel if he went back to his job as gauger to get a better idea of the true hand usage at work and to determine whether or not it truly would be an aggravating factor with regard to use of the grinding stone. He noted that Petitioner described no other work activity that could be considered a risk factor. Dr. Rotman offered a permanent partial impairment rating of 2% at the level of each upper extremity in accordance with the AMA guidelines. (RX 1 depo exhibit).

Dr. Rotman generated an addendum report dated January 12, 2017 following review of additional information provided by the Strip Mill Operations Coordinator. Based on the Coordinator's comments, he understood Petitioner's reported two hours of grinding was an exaggeration. Based on new information, he understood a gauger would use the grinding stone between 30 minutes and an hour per eight hour shift. The time stone grinding would be from five to 10 minute intervals, for up to six times per shift, given the gauger would relieve the speed operator and coiler operator position. Additionally, the lunch break had not been taken into consideration. Dr. Rotman calculated that grinding did not account for more than 1/16th of the shift and at most 1/8th of a shift with several breaks in between. He concluded grinding was not at all frequent or continuous. Therefore, Dr. Rotman opined Petitioner's work activities were not even an aggravating factor in the development of carpal tunnel syndrome and the need for subsequent treatment. (RX 1 depo exhibit).

Dr. Beatty's deposition was taken August 23, 2017. On direct examination, Dr. Beatty recited the job description Petitioner completed. Dr. Beatty confirmed that he had never seen a bright box stone. Dr. Beatty stated Petitioner "would use power tools, but when asked, he would go back to using the hands, grinding using his hands, and again refer to that stone that he would use." He elaborated that Petitioner "did not list any kind of standard tools, and there was no job description, formal job description, provided through him from U.S. Steel." (PX 1 at 6-7). Dr. Beatty testified consistently with the diagnosis and treatment contained in his notes. Regarding causation, he stated "my opinion would be that his bilateral carpal tunnel syndrome is as a direct cause of his work as best explained to me in his job description of June the 21st, 2016." (PX 1 at 9). He stated Petitioner's prognosis following surgery and release from care was "quite satisfactory for him, and I think it's proven because of the time interval." (PX 1 at 14). Dr. Beatty explained his billing practices and believed his bills were submitted through Petitioner's private insurance company. (PX 1 at 15).

Petitioner's attorney posed a hypothetical to Dr. Beatty based on Dr. Rotman's October 31, 2016 report over an objection. (PX 1 at 16-18). Dr. Beatty responded, "I doubt that that information was provided by Mr. Korte per se. They may have given him paper to give to Dr. Rotman, but I would have to kind of look a little bit there. But based upon what Dr. Rotman has submitted in the form of a report or record, I would agree with him without question, and it certainly supports what I have talked about previously." (PX 1 at 18).

On cross-examination, Dr. Beatty agreed he had received payment from Blue Cross/Blue Shield for his services in the amount of $1,576.76. He stated the money would be returned if the workers compensation case is found meritorious. (PX 1 at 20). Dr. Beatty acknowledged there is literature concerning idiopathic carpal tunnel syndrome but he did not subscribe to the theory. (PX 1 at 20-21). Dr. Beatty confirmed that as of his initial evaluation, the only information he had concerning Petitioner's job was that he was a steel worker. He testified that he received a job description from Petitioner the following day and that was the only description relied on when initially formulating his causation opinion. (PX 1 at 22- 25). When asked his understanding of a gauger, he stated "we can refer to Dr. Rotman's report" (PX 1 at 25) and his "Dictionary of Occupational Titles." (PX 1 at 27). When asked whether his opinion that Petitioner's used power tools was supported by the job description, Dr. Beatty conceded "no," but suggested "you may find it in Dr. Rotman's description. And obviously, Dr. Rotman was provided with information that I wasn't provided with." (PX 1 at 28). Dr. Beatty confirmed he was not aware of Petitioner using any other type of hand tools other than the bright box stone and he did not know how much force was required to use the bright box stone. (PX 1 at 28-29). Dr. Beatty was asked if the information provided to him on the job description dated June 21, 2016, particularly Petitioner reporting he was required to do two and a half hours of grinding, was inaccurate, would his opinion regarding medical causation change. He stated, "yeah, it's possible." (PX 1 at 30-31). He elaborated that "if we had a major difference, then I would take a look at that, of course, again, and, of course, consider your question. I think it's valid." (PX 1 at 32). Dr. Beatty acknowledged that he takes into account breaks individuals have throughout a shift and there were no breaks documented in the job description he reviewed. (PX 1 at 33). Dr. Beatty did not know the motions required to carry the sample steel strips, but believed he carried them after grinding. (PX 1 at 34). Dr. Beatty confirmed that he did not know Petitioner was working on a dairy farm when he first reported symptoms. (PX 1 at 37-38). He testified that he has never treated a dairy farmer for carpal tunnel syndrome, but he has seen farmhands with carpal tunnel syndrome. (PX 1 at 39). Dr. Beatty was asked if his causation opinion would change if Petitioner's reported complaints did not coincide with his employment at U.S. Steel but were first reported after working on the dairy farm. Petitioner's attorney objected. Dr. Beatty stated, "Well, you know, records are records. He has every right to obtain the records – Attorney Motil, of course, has every right to obtain the records from U.S. Steel, and if he sees fit for me to look at those records or they might be helpful or so on and so forth, I'm sure I'll get those. So other than that, I can't answer your questions." (PX 1 at 46-47).

Dr. Rotman's deposition was taken September 21, 2017. On direct examination, Dr. Rotman confirmed the history contained in his initial report and his review of previous medical records. (RX 1 at 5-9). Dr. Rotman testified that at no point did Petitioner report to him developing bilateral upper extremity symptoms while working at U.S. Steel. He also testified there were no medical records indicating Petitioner reported numbness and tingling complaints while working at U.S. Steel. (RX 1 at 9-10). Dr. Rotman was asked whether he believed Petitioner's condition and need for treatment was work related. He testified, "it wasn't. His symptoms were aggravated, as suggested in the records, from his work on a dairy farm. He was already laid off from U.S. Steel, so when he presented with symptoms and suggested that had come on since February 2016 that would suggest that whatever he was doing at the time had brought out his symptoms of carpal tunnel, and that was his work on the dairy farm." (RX 1 at 12). Dr. Rotman testified that based on Petitioner's description that he would be required to use a grinding stone for two hours, then it could be an aggravating factor. (RX 1 at 13). However, review of information provided by the mills Operation Coordinator, assuming it be correct, then his did not believe Petitioner job at U.S. Steel was a contributing factor. (RX 1 at 14-18).

On cross-examination, Dr. Rotman testified he received approximately $3,850.00 to perform an independent medical examination, generate an addendum report and testify in this case. (RX 1 at 24-25). Dr. Rotman testified that he did not know how much a bright boy weighed or it's width but it would go from one size to another after rubbing and grinding use. He assumed force would be required to grip the bright boy. He further assumed that if Petitioner used the bright boy for a prolonged period of time, it could be an aggravating factor, "but if you're telling me it really wasn't that big, and it really wasn't that heavy, and it was pretty light" then his opinion could change. (RX 1 at 27-28). Dr. Rotman testified that his "opinions from the dairy farm were generated from the records that his symptoms began after working on the dairy farm, and that's all" he could say based on the records. He said it was not important to know what Petitioner actually did on the farm because the issue was whether or not work at U.S. Steel was an aggravating factor. (RX 1 at 31-32). Dr. Rotman testified that carpal tunnel syndrome is idiopathic and the cause is unknown. He stated he sees more and more people that get carpal tunnel for no reason whatsoever. He stated the issue is whether carpal tunnel is aggravated by work. If it is, "symptoms are generally documented while working" and if the symptoms are generated while not at work, then they are not related to work. (RX 1 at 32-33).

At trial, on direct examination, Petitioner testified that he has been employed for Respondent since 1996 and worked continuously until a January 29, 2016 layoff. He initially worked as a kerfer for approximately 6-8 months in 1996. He then transferred to the hot strip and worked as a laborer. He worked in that position until approximately 2008 and then became a gauger. He worked as a gauger up until the layoff. When asked to describe the gauger position, Petitioner stated "when they roll the steel through the mill they roll it to the thickness and the width of the customer, what they want, and then we take the third one of every cycle so the crane man will put it on a bed, open it up and we will burn a six-inch piece off it." He stated "every cycle has – it's either like a cold rolled cycle or a hot rolled cycle." He stated, "so at the start of the cycle you take the third one so then after the third one you do every 30 after that, or if you have a

defect or you change seven or if you've been down a while or whatever. There's a lot of factors why you have to take another one." Petitioner testified that after the piece of steel is brunt off he writes a number on the coil. He then catches the piece with a hook and drives it down to the acid tank and then hoists it up in the acid tank. When asked to give a weight range for a piece of steel, he stated "it can get up to 50 pounds." He testified the acid tank takes the impurities out of the steel. He stated there are still pieces of slag stuck to the piece after the acid tank. After the piece comes out of the tank, he rinses it off with water and then drags it back to the gauger check. He testified he then uses a hand chisel to chisel all the slag off. Petitioner stated that the chisel is "8-10 inched long, just a regular flat chisel and it has a sharp edge on it where you go along and knock the kerf." He demonstrated a backhand motion when using the chisel. He stated he would use both hands depending on which way he was going. He stated you "got to use some force on it to get some of it off there, some of it is on there pretty good." Petitioner stated that after chiseling he would use a bright boy. He stated he pushes the bright boy with pressure "all the way down the strip and that cleans the steel up where you can see salt and pepper, you can see pitting, you can see all the defects in the steel. You go really hard."

The bright boy is made out of some type of carbide and is softer than a sharpening stone. It was described as approximately eight inches long, one inch wide, and weighing less than a pound. Petitioner testified the stone "doesn't smooth the steel surface, it shines it up." The bright boy takes the oxide off the top of the steel. Petitioner testified they go through about four bright boys a week as they wear down. Petitioner testified the amount of force used "makes whiteness in your knuckles" in order to clean the steel up nice. Petitioner's attorney stated "I think it removes – instead of cleaning like a polish it removes part of the slag as well," but Petitioner intervened stating the slag is already off from the chisel, and the bright boy brightens it up. Petitioner testified he used both hands with the bright boy.

Regarding chipper and the bright boy use on the samples, Petitioner stated, "usually we're doing one every hour if not every 45. Depends on how fast we are running." He also testified that use of the tools would take five to 15 minutes per sample and he believed he would use the tools two to 2-1/2 hours per shift.

Regarding any other hand tools used while on the job site, he stated, "on the job, no." Petitioner's attorney then stated, "I thought you – do you ever use a grease gun?" Petitioner responded, "Well, whenever that mill is down, yes." He described the grease gun similar to a handgun that you squeeze to get the grease to come out. He testified that on down days he volunteers to do that. He testified the mill is down "usually every Monday and Sunday." Petitioner testified he greases for 16 hours on Mondays.

Petitioner testified he began noticing symptoms before the January 29, 2016 layoff. He stated he would wake up in the middle of the night with his hands numb and tingling. He did not seek out treatment. He stated he went on vacation to Wisconsin the week after the layoff and "as I was driving my hands were going numb as I was driving and then after that is when I called my doctor to get an appointment."

Petitioner testified he worked at his cousin's dairy farm after getting laid off. He stated he did "a little bit of everything" on the farm but denied it being hand intensive. He stated "it was mostly operating tractors and scraping shit, hauling it." He stated there were 800 cows and "800 cows is a lot of shit." When asked if he milked the cows, he stated "no, Mexicans did that." Petitioner stated every Monday "we had to do herd checks so we had to separate and move the cows around." This entailed opening the gate and walking with the cows.

Petitioner underwent carpal tunnel surgery on June 24, 2016 and July 12, 2016. He testified having a good result and no longer has numbness or tingling. He resumed working at U.S. Steel in either December 2016 or January 2017. He now works as a checker. His job entails writing number on coils with chalk and a long stick. He occasionally helps out with the gauger or inspector jobs.

The Arbitrator inquired into the alleged manifestation date. Petitioner testified he had numbness and tingling in his hands and fingers a couple of months before being laid off. Petitioner's attorney stated "Okay, that would have been generally January or the end – January 2016 and December of 2015." Respondent's attorney pointed out the calculation was not accurate and Petitioner stated "it was before that, '15."

On cross-examination, Petitioner acknowledged he did not work continuously from 1996 to January 2016 because there was a six month layoff in 2008. He acknowledged he did not go through four bright boys personally, noting the bright boys were shared among other crews. Petitioner testified the only tool he uses, other than a chisel and bright boy, is a grease gun on down days. When asked how many days a week working up until 2016 would he use the grease gun, he stated "if we had an outage then I would do it every day." He stated there were "maybe two" outages a year "would be safe." He stated he also uses the grease gun on down days, testifying "every week I volunteer for overtime. I work 16 hours a day on my day off greasing and oiling." He stated, "The mill doesn't run straight through, we have down days, so on the down days I come in and grease and oil. Every Monday. Like last Monday was a down day. I greased 16 hours."

Respondent's attorney inquired when Petitioner would grease from 2012 to 2016 and Petitioner responded "every down day, every time the mill's down I'm greasing and oiling. Even before 2012." He stated "52 weeks in a year, two days I'm oiling and greasing, sometimes one. Right now it's one." Petitioner's attorney then inquired "per year" and Petitioner responded "per week." Petitioner testified that from 2012 to 2016 that he would use the grease gun at least once a week for 16 hours.

Petitioner confirmed he is aware of the injury protocol at U.S. Steel and the importance of reporting any sort of injury, no matter how minor. He was asked whether he reported his upper extremity symptoms to his supervisor or the Veeder Clinic, he responded, "I didn't know what it was. I didn't know if I was sleeping on it. I didn't know why." Asked again, he stated "I really didn't have – you know, it was falling asleep, my arms were falling asleep. I didn't know – I'm

not a doctor, I didn't know what the cause was and I didn't know what the problem was, maybe I was sleeping on it wrong, maybe I'm getting old." He finally confirmed that he didn't report his symptoms to anyone at the plant.

Petitioner was asked for additional details about his work on the dairy farm. He stated he drove "big tractors." He stated the tractors "ain't bumpy rides, they got flow with them, the seat flows." He stated he cleans up manure "with skid-steer the alleys. The alleys is where the cows shit and piss." He testified a skid steer "is a Bobcat." He stated "you don't go fast with this, you're scraping shit." The Arbitrator inquired whether a skid-steer was a tractor and not a Bobcat. Petitioner stated "right," "that's hauling shit out too." Petitioner denied doing any farm work prior to his layoff at U.S. Steel. He admitted working on the farm "four months" helping his cousin out. Petitioner denied his motor vehicle accident in the spring of 2015 caused arm, elbow or hand symptoms. He admitted sustaining a wrist fracture in 2007 or 2008.

Petitioner addressed Dr. Dawdy's May 4, 2016 office note. He agreed reporting noticing his symptoms happened suddenly "over time" and that he was working on the farm when he first started noticing symptoms. He acknowledged reporting having symptoms when sitting or lying in bed. He acknowledged reporting his symptoms would go away when active. Petitioner's attorney also stated during an objection that Petitioner had symptoms while driving on vacation.

When asked whether he used the bright boy or chisel ten hours a week, he responded "If I'm hung over, yes. Is that per 12 hours you're saying?" He then stated, "two hours per eight hours, yes." He agreed that he does not have to drag lighter coil samples. He testified the weight range of the samples varied from five pounds up to 50 pounds, all depending on the gauge. He stated if the plant was running hot roll, heavier gauge was used and lighter gauge with cold roll. He estimated having to transfer the samples eight times per day or one every hour. He stated it would take 5-7 minutes to transfer the sample to the acid tank. He stated it was a 50 yard transfer. He then stated "whenever that's in the acid tank we walk the line to look for damage for the coils or if we have to go to the bathroom, the bathroom is on the way while that test is in the acid soaking to take the impurities out. We already went through this." He testified that he visually inspects lines once every hour. He did not identify how many minutes per hour he inspects, but it would depend how long it takes to get from the acid tank all the way down to OS 2 where the coils are on the conveyor.

Petitioner acknowledged he gets two breaks per shift in addition to a lunch break.

On re-direct, Petitioner stated he developed numbness and tingling in his hands suddenly while driving to Wisconsin, which was an eight hour drive. Petitioner's attorney stated two medical bills remained unpaid and Petitioner stated yes. On re-cross, Petitioner agreed the bills were submitted through Blue Cross/Blue Shield group insurance, and he has not ever seen the bills his attorney referred to.

Joe Spanberger testified on behalf of Respondent. He has worked at the mill for 22-1/2 years. He is currently a process coordinator. He testified that he is familiar with Petitioner and that Petitioner works in the hot strip department. He testified he was Petitioner's direct supervisor for 12 years. Mr. Spanberger is now in charge of Petitioner's shift managers. He stated there is branch between him and Petitioner but he still spends a lot of time on the floor with Petitioner. As a process coordinator, Mr. Spanberger coordinates operations of the hot mill. He does scheduling for the employees, the steel, how material is run, how much material is run, trains supervisors, and trains employees. He testified he trains employees how the operations work. He testified that he is familiar with Petitioner's job as gauger. He was familiar with Petitioner's job requirements before the January 29, 2016 layoff.

Mr. Spanberger explained the hot mill operation. He stated they take slabs, reheat them, and reduce them down to different size widths. He stated a gauger is part of the operation. Mr. Spanberger stated a gauger does relief jobs for coiler operators and finish mill operators, assists with the DMI (inspectors), inspects coils on the conveyors, and help out in any type of upset conditions by directing work force in cleaning up steel scatters after a wreck.

Mr. Spanberger testified that on an average shift or good turn, between 150 -200 coils are run in eight hours. He stated the coils are made of different size gauges. He stated the heavier gauge coils were run about two days per week and the lighter gauge would be run three days per week in 2016. He stated the testing samples weighed between four pounds and the heaviest being 30 pounds. He did not think any samples got up to 50 pounds.

Mr. Spanberger explained when a sample is taken, a hole is burned in the top of it and it is then hooked by either a gauger or burner (depending on whether the gauger is relieving a different position) and the sample is then taken to the acid station. He stated the station is 30 yards away and it would take 20 - 30 seconds to move the sample to the tank. He testified the employee will then lift the sample about waist high into the acid bath and there is a lever that drops the sample into the bath. He estimated the sample sits in the bath five to seven minutes. He stated the employee just waits while the sample is in the bath. He estimated a gauger would handle six samples per shift, noting they are only doing the gauger job five and half hours in light of a lunch break and relieving other operators.

He stated the acid tank cleans the impurities off the steel and it is then removed and dragged back to the gauger shack for inspection. The sample is placed on a table. If it is a light gauged material, the gauger would use the bright boy to grind and shine it off. He stated it removes the oxide that is created after it comes out of the tank. He testified the gauger shines up both sides. With heavier gauge, the gauger will use the chisel to knock off or push off any of the slivers and then use the bright boy after that. The bright boy weighs less than a pound.

The Arbitrator inquired whether the bright boy was industry standard, Mr. Spanberger stated he has never see anything else used. He stated you don't want to reduce the thickness of the steel because they're actually gauging this area. He stated you would have no control over how much a power tool would reduce the surface. Mr. Spanberger stated that after using the bright boy, measurements are taken down to the thousandths.

Mr. Spanberger testified chisels are not used on lighter gauges. He stated that in the last two weeks he has gone down and watched a gauger perform this activity and he estimated it would take 45 seconds to a minute to do both sides of a sample.

He estimated that on a good shift, a gauger would have to use the bright boy about six times. He stated that having reviewed paperwork over the last two weeks, on 12 hour shifts, the most a gauger would do was eight samples using a bright boy.

On an eight hour shift, he estimated bright boy use would be 10 minutes or less for the lighter gauges. He stated with heavier gauge when the chisel was required, each sample might take seven to 10 minutes. He estimated six or less samples were taken a shift when using heavier gauge and therefore chiseling/bright boy use would take between 30 minutes and an hour per shift in total. Mr. Spanberger testified Mr. Korte's two hour estimation in terms of bright boy/chiseling use per shift was extremely excessive.

Mr. Spanberger testified he reviewed the job description Petitioner provided to Dr. Beatty, confirming it only contained two activities required of the gauger position.

Mr. Spanberger testified a gauger performs two types of inspections during a shift. One inspection is "walking the line," in which the gauger walks along the conveyor inspecting the coil package. This is an observation process with no hands-on activity. The other inspection is a "pickle-test." He stated that is when gaugers use the bright boy and all that. They cut the outside wrap, then use a spotlight along with the DMI and inspect the surface for any imperfections. He stated once the coil is cut, the gauger will use the bright boy/chisel and then a micrometer to measure the sample. If there is an issue during the inspections, the gauger reports the issue and other workers will eliminate the problem.

Mr. Spanberger testified gauger's relieve the coiler operator and speed operator during the course of the shift. Gauger's relieve each position an hour per shift. Additionally, they relieve the coiler operator a couple more times for restroom breaks or whatever. They shorter reliefs are between five to 10 minutes. He stated gaugers also get 30 minute lunch breaks and two other short breaks during a shift.

Mr. Spanberger explained that a coiler operator controls three panels. In relief, the gauger would have to push some buttons, use a touch screen, and move a three-point toggle switch (similar to a light switch) while they are observing the operations on the floor. He stated there was little pressure required to push the buttons or touch screen. He stated duties required when relieving the speed operator were similar to the coiler operator position. Mr. Spanberger testified that during the relief period, gauger's do not use the bright boy, chisel, or drag samples.

In light of the gauger providing relief, Mr. Spanberger did not believe Petitioner's testimony that he would be required to use the bright boy or chisel eight times per shift.

Mr. Spanberger testified that a gauger was never required to use a grease gun. In other words, Petitioner would not have been required to use the grease gun from 2006 to 2016. Mr. Spanberger agreed Petitioner has volunteered to grease after he returned from the lay-off in 2017 and it could take up to 16 hours.

Mr. Spanberger testified all injuries in the hot mill operations are reported to him as required. Mr. Spanberger testified that he never received a report Petitioner was having hand issues while working. Mr. Spanberger confirmed all gaugers were laid off on January 29, 2016 and no one returned to the position until either December 2016 or January 2017. In light of the layoff, it was not possible to shoot any sort of video or perform a demands analysis of the gauger position during that time period.

On cross-examination, Mr. Spanberger agreed it was possible to video the gauger position or perform a job analysis prior to the trial date. He confirmed that he reviewed production records in the last two weeks to be certain his testimony would be accurate. Mr. Spanberger confirmed that he provided the information Dr. Rotman reviewed and addressed in his addendum report.

Per Petitioner's attorney's request, Mr. Spanberger broke the bright boy in half. When asked if it was a pretty tough piece of material, Mr. Spanberger stated it's not nearly as tough as he thought it would be to break, and believed it to be flexible. Mr. Spanberger confirmed the bright boy was used to scrub oxide and the chisel was used to take molten metal off. He stated the activity requires some force.

Mr. Spanberger addressed standard operating procedures, noting that while a gauger is supposed to scrape the entire sample, that's not the way it happens. Mr. Spanberger confirmed overall production at the plant is down since returning from the layoff; however, that was not true of the hot strip operations.

CONCLUSIONS OF LAW

In regard to disputed issues (C), (D) and (F), the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner failed to establish he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent allegedly manifesting on January 29, 2016, or that Petitioner's current condition of ill-being is causally related to his work activities. Therefore, Petitioner's claim for entitlement to outstanding medical bills and permanent partial disability is denied.

In support of this conclusion the Arbitrator notes the following:

Petitioner worked as a gauger for 10 years leading up to the January 29, 2016 layoff and his alleged injury date. Mr. Spanberger provided a credible and comprehensive recitation of Petitioner's job requirements in the gauger position. Based on Mr. Spanberger's description, the Arbitrator does not believe Petitioner's job duties can be considered highly repetitive or require repetitive heavy hand use. Petitioner's job consisted primarily of visual inspection. He would relieve coiler and speed operators a minimum of two hours each shift. While relieving the operators, he would observe the hot mill operations and push buttons and levers occasionally. No significant forces were required for these activities. Petitioner received a 30 minute lunch break and two other breaks during a shift. A gauger would have a fair amount of downtime and breaks in between activities. The only hand tools Petitioner used as a gauger were a chisel, bright boy, and micrometer. Use of these tools could be considered limited at best. Petitioner was required to drag steel samples weighing between five and 30 pounds between 6-8 times per shift. Petitioner was not required to use power tools. He was not exposed to vibration. No credible evidence was presented that Petitioner would be required to use a grease gun while in the gauger position.

Petitioner alleged injuries to his bilateral hands and wrists as a result of repetitive motions with his hands, wrists and arms while manually grinding steel strips off of coils by hand using a bright boy stone. Chisel use was not alleged in the Application but addressed at trial. The issue is whether these activities caused or contributed to Petitioner's development of carpal tunnel syndrome. The Arbitrator does not believe Petitioner satisfied his burden of establishing a causal relationship.

As a preliminary matter, the Arbitrator notes the bright boy was used to rub oxidation off steel samples and not "grinding steel strips off of coils." A chisel would be used to remove molten metal on the samples. Petitioner would only use the chisel when the mill was running higher gauge coils, which was no more than two times a week. Petitioner would use the bright boy on the lighter and heavier gauges to rub oxidation off.

Credible evidence presented suggests a gauger would be required to use the bright boy and/or chisel anywhere between six and eight times per shift, depending on the length of the shift.

Petitioner estimated he would be required to use the tools a minimum of two hours and perhaps two and a half hours per shift. Based on Mr. Spanberger's testimony, the Arbitrator does not find Petitioner's estimation to be credible. Mr. Spanberger estimated that with lighter gauge, it would take 45 seconds to a minute of bright boy use to remove oxidation on both sides of a sample. In other words, the total time a gauger would use the bright boy in a shift might reach 10 minutes. He stated when the chisel was required for heavier gauge, each sample might take seven to 10 minutes. In other words, the total time a gauger would use the chisel and/or bright boy during a shift in these instances would be between 30 minutes and an hour on the outside. The Arbitrator further notes Petitioner would not perform these activities at all when relieving the speed operator, coiler operator, or when he was on other breaks. In sum, the evidence demonstrates Petitioner exposure to these activities were minimal.

The Arbitrator also finds significant that Petitioner did not report upper extremity complaints while working in the gauger position. The first documentation of Petitioner reporting symptoms is in Dr. Dawdy's May 4, 2016 office note. Petitioner reported complaints of bilateral hands and arms going numb since February. Petitioner was not working at U.S. Steel at the time. Dr. Dawdy documented Petitioner noticed the symptoms suddenly. Petitioner stated he had been working on a dairy farm when he noticed the numbness. Petitioner denied trauma or injury. Petitioner stated he would have symptoms when sitting and lying in bed. Petitioner reported that when he is active, all the numbness and tingling symptoms go away.

At trial, he confirmed the accuracy of the office note. He also testified that the "sudden symptoms" occurred when he was driving eight hours to Wisconsin for vacation.

The Arbitrator also finds the opinions of Dr. Rotman to be more persuasive than Dr. Beatty's regarding medical causation. It is clear from the record that Dr. Beatty had a very limited understanding of Petitioner's job requirements as a gauger. Dr. Beatty's testimony was not convincing. Conversely, the evidence at trial confirms Dr. Rotman had an accurate understanding of Petitioner's job requirements. Dr. Rotman's testimony reasonably took into account Petitioner's actual job requirements and his opinion is therefore more credible than Dr. Beatty's.

Finally, the Arbitrator was not convinced as to the veracity of Petitioner's testimony and notes Petitioner was often evasive when answering questions on both direct and cross-examination.

For these reasons, the claim for benefits is denied.

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

The Arbitrator concludes Petitioner failed to provide Respondent with timely notice and prejudiced Respondent's ability to investigate and defend against the claim.

In the event of an alleged accident, an employee must provide notice either orally or in writing to the employer. The notice should provide the approximate date and place of the accident. Notice must be given as a soon as practicable, but no later than 45 days after the alleged accident. The *Peoria County Belwood* Court held that the date of the injury for repetitive trauma claims is the date on which the injury manifests itself. The manifestation date occurs when the fact of the injury and the causal relationship to the employment become plainly apparent to a reasonable person. *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

Petitioner alleges a repetitive trauma injury occurring on January 29, 2016 – his last day working for Respondent. There is no dispute Petitioner did not notify Respondent of the alleged injury on January 29, 2016 and that Respondent did not learn of the claim until June 24, 2016 when Respondent received a copy of the Application for Adjustment of Claim filed with the Commission.

Petitioner has alleged a January 29, 2016 manifestation date. By law, Petitioner had 45 days from the manifestation to notify his employer of her injury. He did not timely do so. As such, the inquiry becomes whether Respondent was prejudiced by the late report.

The Arbitrator finds Respondent was prejudiced by the late report – particularly its' investigation of the claim. Respondent did not become aware of the claim until 147 days after the alleged manifestation date. Petitioner had been laid off. There were no gaugers working at the plant during the time. Even when Petitioner returned from the layoff, he did not return to the gauger position. Petitioner underwent surgery before Respondent could even secure a Section 12 examination. Even though afforded a Section 12 examination, Respondent were not able provide Dr. Rotman a demands analysis or a job video of Petitioner for consideration. Due to the late reporting, Respondent could not timely identify possible witnesses or interview supervisors to determine precisely what Petitioner's job requirements were at the time of the alleged injury. Without being afforded these investigative opportunities in a timely, Respondent's defense is prejudiced.

In sum, notice was not timely and Respondent was prejudiced. Therefore, Petitioner's claim for expenses and other benefits is denied.

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

For the reasons outlined above, Respondent is not liable for payment of medical bills set forth in Petitioner's Exhibit 2.

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

For the reasons outlined above, Petitioner is not entitled to permanent partial disability benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis Fisher,

Petitioner,

19IWCC0473

vs.

No. 15 WC 5672

State of Illinois/Department of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Respondent and Petitioner, and notice given to all parties, the Commission, after considering the issue of permanent 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. The Arbitrator awarded Petitioner 7½% person-as-a-whole pursuant to §8(d)2.

In determining Petitioner's permanent partial disability to be 7½% person-as-a-whole under §8(d)2, the Arbitrator considered the five factors enumerated in §8.1b(b). The Commission affirms and adopts the Arbitrator's assigned weights for the first four §8.1b(b) factors, for the reasons stated by the Arbitrator.

With regard to the fifth factor of §8.1b(b), "*(v)* evidence of disability corroborated by the treating records," the Arbitrator omitted assigning any particular weight to that factor. However, it is apparent from reviewing the Arbitrator's detailed analysis of this factor that he gave it significant weight. The Commission finds the Arbitrator's reasoning in his discussion of factor *(v)* of §8.1b(b) to be detailed and sound. The Commission accordingly finds that factor (v) is due *significant weight*.

19IWCC0473

The Commission has considered the entire record and finds the Arbitrator's award of 7½% person-as-a-whole award under §8(d)2 is appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator awarding Petitioner 7½% person-as-a-whole under §8(d)2, filed February 4, 2019, 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.

AUG 30 2019

DATED:
o-08/15/2019
MP/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0473

FISHER, DENNIS Case# **15WC005672**

Employee/Petitioner

ILLINOIS DEPT OF TRANSPORTATION

Employer/Respondent

On 2/6/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.44% shall accrue from the date listed above to the day before the 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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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 - 6 2019

Brandon O'Rourke, Assistant 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

DENNIS FISHER
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # **15** WC **05672**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **December 7, 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 **March 3, 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 **$58,980.00**; the average weekly wage was **$1,134.23**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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 all related medical expenses paid by Respondent prior to hearing 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 with Respondent on March 3, 2014.

The Arbitrator finds that the Petitioner's low back condition is causally related to the March 3, 2014 accident.

Respondent shall pay reasonable and necessary medical expenses contained in Petitioner's group exhibit, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any awarded medical expenses that have been paid prior to the hearing pursuant to 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).

Respondent shall pay Petitioner permanent partial disability benefits of **$680.54 per week** for **37.5 weeks**, because the injuries sustained caused the **7.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **March 3, 2014** through **December 7, 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.

Signature of Arbitrator

February 4, 2019
Date

FEB 6 - 2019

STATEMENT OF FACTS

A five-year employee, the Petitioner testified he was working for Respondent IDOT on 3/3/14 as a community liaison, involving desk work as well as driving to meet with and reach out to various mayors and county boards and then conveying information back to the IDOT Secretary. He also would attend public events which involved both sitting and standing. Petitioner testified it was wet outside due to snow on the morning of 3/3/14 when he arrived at work sometime between 7:30 and 7:45 a.m. He testified that when he went up the stairs he slipped on an approximate 2" x 3" puddle of water on the second step that looked like it had been tracked in: "my leg slid out from underneath me to the left, and my upper body went to the right, and the railing kept me from falling over." He testified he injured his low back. He went upstairs and got paper towels and used them and a tissue in his pocket to wipe up the wet spot.

Petitioner had previously undergone an L4/5 discectomy but testified he did not have any work restrictions as a result. He would see his neurosurgeon Dr. Kraus on a routine yearly basis "to stay in his system." He was not taking any medications for his back at the time of the accident. Petitioner could not recall the last time he saw Dr. Kraus prior to the accident.

Petitioner initially sought treatment on 3/5/14 at Corporate Health at Decatur Memorial Hospital (DMH). He was diagnosed with a lumbosacral sprain and placed on work restrictions of no heavy lifting. He was to begin medication and advised to use heat and ice to the low back as needed along with gentle stretching. Petitioner continued to follow up at DMH Corporate Health, though the records from this facility do not contain information regarding the Petitioner's specific complaints or any exam findings. On 3/10/14, Petitioner's work restrictions were increased, and a myelogram was prescribed to rule out a herniated disc. (Px3). A note from Dr. Kraus' office indicates his 4/1/14 visit was postponed until the CT/myelogram was completed.

The lumbar CT/myelogram was performed on 4/21/14. The lumbar CT findings included disc degeneration with posterolateral disc bulges, endplate spurring and facet arthropathy at multiple lumbar levels. At L1/2, there was a 9 mm left paramedian peripherally calcified disc herniation causing mild canal stenosis, while endplate spurring and facet arthropathy at that level caused severe bilateral foraminal stenosis. At L2/3 there was a posterolateral disc bulge and right lateral diffuse disc bulge with peripheral calcification and endplate screening, more significant on the right and associated with facet arthropathy with mild canal, severe right foraminal and mild to moderate left foraminal stenosis. A diffuse bulge at L3/4 with facet arthropathy involved no canal

stenosis and moderately severe bilateral foraminal stenosis. A mild L4/5 bulge with moderate facet arthropathy caused moderate to severe bilateral foraminal stenosis (left greater than right). No herniation was noted at L5/S1, but left facet arthropathy caused severe left foraminal stenosis. The myelogram identified degenerative disc disease at all lumbar levels with mild central canal stenosis at L1 to L4. (Px7). On 4/25/14, DMH continued the Petitioner under the same restrictions, prescribed further therapy and referred him to Dr. Kraus for specialist evaluation. (Px3).

Petitioner saw Dr. Kraus on 5/30/14, and the doctor noted he had previously performed a revision lumbar discectomy on Petitioner in 2004. Petitioner related his current back pain to torqueing his lower back in March when he slipped going up the stairs at work. He noted hip discomfort but no leg pain. Petitioner reported he was doing well with physical therapy and had pain at 2/10, which was close to his baseline pain level. Dr. Kraus reviewed the lumbar CT/myelogram and noted post-operative changes on the left at L4/5 level and spurring or a calcified disc herniation at the L1/2 disc space. Dr. Kraus believed Petitioner had most likely suffered a muscular sprain/strain injury to his back and he found nothing worrisome on exam. Additional diagnoses were chronic low back pain and morbid obesity. He continued Petitioner on Naproxen for his pain, recommended a continuation of physical therapy and released him to return to work. He noted Petitioner's job did not involve manual labor and advised Petitioner to lose weight and avoid prolonged sitting. (Px5).

Petitioner continued to treat with DMH Corporate Health through 11/18/14. On 6/9 and 7/9/14 he was kept under restrictions of no heavy lifting, no frequent up and down movements, stairs only twice a day, and limited bending at the waist. Physical therapy, a home exercise program and Naproxen as needed for pain were continued. On 8/20/14, PA Sheers noted Petitioner appeared to be improving, had completed his therapy program and had discontinued oral medications. Petitioner was advised to continue his home exercise program and the plan was to release him on 10/1/14. At his 10/2/14 visit, Petitioner reported developing some tightness in his back. The report is confusing in that it recommends both that Petitioner continued regular duty while also specifying work restrictions of no heavy lifting, no frequent up and down movements and limited bending. He was to begin Flexeril and to continue Naproxen and home exercise. On 11/18/14, Petitioner was noted to have regressed over the past few months. He was to continue regular duty and he was released from care and advised to follow up with Dr. Kraus. (Px3).

Petitioner was hospitalized at Decatur Memorial Hospital following a 12/15/14 visit to the ER with complaints of intractable back pain which he related to the work accident. He reported his pain had gradually increased over the past several days, and a triage note stated he reported an increase in pain two days ago and developed new symptoms of left foot drop since Saturday and an inability to walk. Petitioner also reported his pain had been progressing daily since completing physical therapy. He reported burning pain to the posterolateral left thigh, and that his medications were not managing his pain. He was admitted for pain control. X-rays showed marked left foraminal encroachment at L5/S1, posterior spondylosis, disc bulging, degenerative changes and a small protruded L1/2 herniation were "again seen." A 12/16/14 CT scan showed marked foraminal encroachment laterally on the left at L5/S1, posterior spondylosis and disc bulging, and small protruded herniation was again seen at L1/2, along with multilevel degenerative changes. A 12/17/14 lumbar MRI showed multilevel disc herniations with significant neuroforaminal encroachment and lateral recess stenosis on the right from L1 to L4 and at L5/S1. There was also significant left neuroforaminal encroachment and lateral recess stenosis at L4/5. Dr. Kraus was consulted, but he indicated there was no current recommendation for surgical intervention. Petitioner was strongly advised to lose weight as "obesity is a large contributing factor to his chronic pain." Petitioner was also noted to have diabetes and diabetic neuropathy. Dr. Rehman from pain management was also consulted, and he recommended medication management as well as possible physical therapy, but noted: "Obviously a big part of the symptoms is the weight which is exacerbating an already degenerated back." Petitioner was discharged on 12/20/14 and advised to follow up the DMH Wellness center for diet and exercise

management. He was prescribed Tramadol for breakthrough pain and to follow up with Dr. Rehman for pain management at Millennium Pain Center. (Px4).

On 12/29/14, Petitioner saw Dr. Rehman, reporting constant low back pain radiating into the bilateral buttocks and left hip and leg to the knee, and that he awoke that morning with tension and spasm. He reported having a similar episode two years prior that required muscle relaxers and high dose anti-inflammatories. Petitioner wanted a second opinion besides Dr. Kraus regarding whether he was a surgical candidate. The report notes both that medications were and were not helping his pain. Petitioner was kept overnight and advised to follow up in a month. When he returned on 1/30/15, Petitioner reported similar symptoms and that medications were keeping the pain tolerable. (Px3).

Petitioner returned to treat at the DMH pain center from 2/27/14 and 5/27/14, and Petitioner continued to take narcotic medication throughout this time to manage his lower back pain. (Px6).

On 7/20/15, Petitioner was seen by orthopedic surgeon Dr. Williams. An intake form and the report noted a work accident involving slipping on stairs with his lower body going left and his upper body going right, catching himself on the handrail, resulting in a torqueing motion to the back. Petitioner reported 5 out of 10 pain in his low back that was constant and radiated into the bilateral buttocks, left thigh and left calf, as well as numbness and tingling in the left leg from the knee to the foot. He indicated that his pain was alleviated by NSAIDs and narcotics. Petitioner told Williams that when Dr. Kraus saw him at the hospital in December 2014, he said the symptoms were too far gone and Petitioner should go to "Mayo Clinic or someplace in Texas" for surgery. On examination, Dr. Williams noted tenderness to low back palpation and tenderness over the left greater trochanteric region. Dr. Williams reviewed the 12/17/14 lumbar MRI. Petitioner told Dr. Williams he did not want to stay on narcotics but wanted to be able to function, noting he had a new job in the Secretary of State's office. It is unclear if Dr. Williams performed an epidural injection at left S1, but it was recommended. He noted Petitioner could require surgery in the future, specifically an L1/2 posterolateral lumbar decompression and possibly decompression of additional levels. (Px8).

On 9/2/15, Petitioner followed up at the DMH pain center, reporting his pain was "creeping up", which he attributed to returning to work in July. Petitioner was advised to continue his medications (Fentanyl, Norco, Tramadol, and Lyrica) which he reported help with the pain. (Px6).

Petitioner followed up with Dr. Williams on 11/3/15 and reported the epidural did not provide much relief and his pain remained severe. This appears to indicate an epidural was performed on 7/20/15. Reiterating Petitioner's 3/3/14 accident history, Dr. Williams stated: "We can't rule out the fact of it being work related." Petitioner reported being terminated by Respondent in January and that he was continuing to work for the Secretary of State. Petitioner reported that Dr. Rehman did not want to perform an epidural because of Petitioner's obesity. Dr. Williams again recommended a left S1 epidural, but Petitioner wanted to hold off until after 1/16/16 "due to time of reasons." (Px8).

Petitioner returned to DMH on 9/16/15. He stated his pain remained the same, but he was having increasing difficulty sleeping due to the pain. The pain typically radiated from his low back to his bilateral posterior and lateral hips and to his buttocks and posterior left thigh, radiating to the calf when severe. He also reported increased left leg numbness. Petitioner continued to take Fentanyl, Norco, Tramadol and Lyrica, which he reported did help to keep his pain in check. He was to continue the medications and follow up in three months. (Px6).

Dr. Williams testified via deposition on 1/26/16, noting he believed Petitioner had been referred by his primary care physician for complaints of low back pain radiating down the left leg. The films he reviewed indicated a lot of multilevel degenerative changes with disc protrusions at multiple levels. Petitioner reported a 3/26/14 injury where he fell at work while walking up some stairs. Dr. Williams testified Petitioner's overall exam was negative, though he was morbidly obese, and he had moderate tenderness to lumbar palpation. Dr. Williams testified that the degenerative condition is something that occurs over a significant period of time, though films disclosed some herniations that could have been "acute, subacute." He agreed it was possible the work injury would have aggravated the degenerative conditions, noting its common to get a flare or exacerbation of symptoms or worsening of the degenerative process after an injury. There also can be acute changes in the context of longstanding chronic degenerative changes. Without having a pre-accident MRI to compare it to, he noted the L1/2 herniation seen on 12/17/14 could be a new finding. He discussed a possible L1/2 surgery with Petitioner but given his obesity he would be at a higher risk of complications, so his recommendation was epidural injection to try to improve the leg pain and possibly some back pain. Despite his 11/3/15 report indicating Petitioner had undergone the injection, Dr. Williams indicated Petitioner had not undergone the injection and hadn't been able to schedule it. Petitioner was taking a long list of medications, and Williams didn't prescribe any other medications, and Petitioner was planning to decrease them. He again recommended an epidural at left S1 on 11/3/15 and opined that Petitioner had not yet reached maximum medical improvement (MMI) at that point, noting surgery was still a possibility in his future and that weight reduction would be a significant benefit for him. He also recommended minimizing his narcotic use, advised him to perform a home exercise program and use NSAIDs and injection if possible. He opined Petitioner was able to work "to some degree." (Px10).

On cross-examination, Dr. Williams acknowledged he didn't know if Petitioner had lumbar symptoms prior to the accident date, and thus he had no way of knowing what Petitioner's pre-accident baseline was other than Petitioner's stated history. He agreed Petitioner had prior surgery that likely was performed due to symptoms similar to what he was currently complaining of given the surgical location. Dr. Williams agreed that the Petitioner's degenerative conditions were longstanding and could cause nerve impingement and lead to radicular symptoms. He testified that a calcified disc is not an acute finding and would have existed for some time. Dr. Williams agreed that the Petitioner's films did not show any identifiable lumbar pathology that would necessarily require a traumatic cause. He opined it was unlikely that the herniations (L1/2 and L3/4) see in April 2014 imaging had progressed by the time of December 2014 imaging and that the discs could be chronic but added that he never reviewed the April CT scan. He agreed the epidural he was recommending was at S1, not one of the herniation levels: "His symptoms are more of an S1, and so that's what the reasoning is behind using the S1 distribution." As to Dr. Kraus' 5/30/14 indication that Petitioner's injury could have been muscular, Dr. Williams testified: "That's possible. The only reason I would disagree is because of the pain down the lower extremity, the left lower extremity. That's definitely not muscular. It's subjective. It's not – it can't be explained by a muscle, necessarily." He did agree with Dr. Kraus that the Petitioner's injury didn't result in changes that were visible in the CT scan. Dr. Williams testified that he had no concern about the possibility of secondary gain with Petitioner at this time. He agreed that Petitioner's weight put him at increased risk of developing degeneration and would put him at an increased risk with a surgery. Dr. Williams reiterated that all he could do was rely on the Petitioner's reporting that his pain was worse after the noted work accident, but again agreed that he didn't see any significant acute findings in his review of Petitioner's films. (Px10).

Petitioner followed up with at the pain center every three months from 12/16/15 to 10/11/17, generally receiving refills of his pain medications. He continued to complain of low back pain traveling into his buttocks and down the left leg. He indicated his pain remained at a 5 to 6/10 with his use of medications and that without the medication he would not be able to get out of bed. (Px6).

On 12/29/17, Petitioner presented to DMH with extreme back pain. He reported waking up with tension and spasms in his lower back that worsened throughout the day. He was given an IV with narcotic pain medications for pain and was released the following morning. (Px4).

Petitioner then treated at DMH pain center again from 1/10/18 through 6/22/18. Petitioner continued to report constant low back pain that radiated from his back down through his bilateral buttocks down to his mid leg. He continued to take Norco, Fentanyl and Lyrica daily, which kept his pain at a 5/10 to 6/10 level. (Px6).

On 6/14/18, Petitioner presented to Dr. Gornet with complaints of bilateral low back pain radiating bilaterally, but mainly to the left buttock and leg to the ankle. Petitioner reported that his symptoms hadn't resolved since his work accident in March 2014 and that the medications he was taking continued to affect him and his quality of life. His main problem was the left leg pain. Upon physical examination and review of 2014 and 3/13/18 lumbar MRIs and a CT scan, Dr. Gornet concluded Petitioner suffered a disc injury at L5/S1 involving an annular tear as well as an aggravation of his preexisting disc pathology at L4/5. Dr. Gornet further opined that Petitioner had severe foraminal stenosis that was probably aggravated as well. Dr. Gornet noted Petitioner had been placed on high dose narcotics "which obviously does not fix or help anything and at this point, I agree with the other providers that I do believe that his current symptoms are causally connected to his injury as described." Dr. Gornet recommended that Petitioner wean off Fentanyl and lose weight. He also recommended an updated MRI of higher quality and that Petitioner could continue to work his regular job, which was sedentary. He was advised to follow up in six weeks. (Px9).

At the last visit to DMH prior to hearing, dated 6/22/18, Petitioner noted he had seen Dr. Gornet and was being weaned off Fentanyl but advised to continue with Norco and Lyrica for the time being. He was to be off the medication by August as he was planning to have back surgery. Petitioner otherwise had the same ongoing symptoms. He did report having undergone an injection on 4/11/18 at OCI in Springfield and a June 2018 sacral injection there with good relief, but "per pt, no records." The report further notes Petitioner had been too large to have injections but was down to 328 pounds and "may be eligible for injections now." (Px6).

At Petitioner's follow-up with Dr. Gornet on 8/9/18, he was noted to have discontinued Fentanyl, which left him "in a bad place right now as far as feeling the need for further medications." He was taking what Dr. Gornet believed was an acceptable dose of two to three hydrocodone per day. Petitioner was at 344 pounds and Gornet wanted him to get down to the 270 to 280 pound range before considering further testing. Petitioner was advised that he should put all of his energy into weaning. At his last visit with Dr. Gornet prior to the hearing, 11/12/18, Petitioner reported that he remained off Fentanyl but continued to take hydrocodone, noting pain management advised him to increase his hydrocodone intake to 4 pills a day. Dr. Gornet noted Petitioner was up to 371 pounds, which Petitioner attributed to getting his gallbladder removed in August and gaining 30 pounds of fluid since that time. Dr. Gornet reiterated that Petitioner needed to decrease hydrocodone use to no more than two per day before he would be able to perform a work-up of his back, and to lose weight before an updated MRI could be completed. Full duty in his sedentary job was continued. (Px9).

Petitioner reviewed his medical records and testified that they accurately described what he reported to his providers. He said he provided them with consistent histories, including his prior history of low back problems. Petitioner testified he developed stiffness and significant left low back pain into the left leg after the work injury that he did not have prior to the incident.

Petitioner testified that his prior attorney referred him to a physician who continued him on pain medications. He testified that prior to seeing Dr. Gornet he was taking 4 to 5 hydrocodone pills daily as well as taking Flexeril, Tramadol and Naproxen and using a Fentanyl patch.

Petitioner testified it was his understanding that he had reached maximum medical improvement: "they don't think they can do anything for me." Petitioner testified he takes his medication and lives a mostly sedentary life. At the time of hearing he was taking two hydrocodone per day and was off the rest of his medications. He testified he had lost about 125 pounds to get down to 335 but noted the fluid weight gain following a recent gallbladder surgery.

Petitioner testified that as a result of the 3/3/14 incident he has an ongoing pain increase as well as a reduction in his range of motion. The pain is between a 6/10 and 8/10 level and goes into both buttocks and down the left leg to the foot and the right leg to about mid-thigh. Prolonged sitting increases his pain. Petitioner testified that he is currently employed by the Illinois Treasurer's Office, Unclaimed Property division, in Springfield, Illinois, where he basically handles claims on the computer and on the phone with claimants. He testified that he has a doctor's note allowing him to get up and walk around hourly as needed but it ultimately doesn't help much. Petitioner testified that he can no longer really traverse uneven ground or do yard work. He has difficulty going down stairs to his basement.

On cross-examination, Petitioner acknowledged that he completed an accident report for Respondent (Rx1). In this document, Petitioner indicated he was coming to work and going upstairs on 3/3/14 around 8 a.m. He indicated he was "going upstairs & on bottom step my left foot slid on ice/water & my body went opposite way. My hand was on the handrail which kept me from falling. I cleaned up water on the step wit a tissue I had in my pocket." The report is dated 3/7/14, and in a section which asks why the accident wasn't reported on the accident date, Petitioner wrote: "I felt a little tight but was not that bad when it happened." As to the document's accuracy, Petitioner testified he slipped on the second step, not the bottom one, and he did have a tissue in his pocket, but he also went and got paper towels. He agreed the document does not detail this. He did not fall down when he slipped, his left leg slipped out to the left, followed by the right leg, his body went to the right and he caught himself on the handrail with his body and hands. He could not recall if he struck his knees, noting it was "just kind of a torque accident."

Petitioner couldn't recall if he reported any radicular symptoms at his initial visit to DMH, noting it was five years before the hearing, His recollection was that after he slipped on 3/3/14, he went upstairs and did desk work for a while followed by driving in his car and moving around. Later that day is when he got really stiff with pain in the buttock and down the left leg, and he reported the injury to his supervisor the next morning.

With regard to the 12/2/14 report of PA Sheers at DMH indicating concern about "secondary gain", Petitioner testified he provided DMH an accurate history of his post-injury symptoms. He denied having any contentiousness with her and indicated the only "treatment" she provided was medication (Naproxen, Flexeril). Petitioner denied any discussion with Sheers about secondary gain and said he didn't even know what this term meant. Petitioner testified that after the 3/3/14 incident, he moved slower at work and couldn't sit for as long as he could before at the office or home, but he just did the best he could. He agreed that no one had to cover his duties and that he had consistently worked from 2014 through the date of hearing. He testified he was "purged" from his job at IDOT in January 2016 when a new governor came in, and that he sought a more sedentary job. He noted he worked for the Secretary of State briefly before starting with the Treasurer's Office.

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 finds that the Petitioner sustained accidental injury arising out of and in the course of his employment on 3/3/14. Our courts have held that accidental injuries sustained on property that is either owned or controlled by an employer within a reasonable time before or after work are deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the hazardous condition of the employer's premises. *Archer Daniels Midland Co. v. Industrial Comm'n*, 91 Ill. 2d 210, 216, 62 Ill. Dec. 921, 437 N.E.2d 609 (1982). Petitioner credibly testified that he slipped and fell on a wet spot on stairs he was going up to go to his desk when he arrived at work. This constituted a hazardous condition located on the staircase provided by and under the control of the Respondent. This appears to have been due to snow dragged in from the outdoors, located on the indoor staircase where Petitioner fell. This is consistent with the Petitioner's accident report (Rx1). Any discrepancies noted between the testimony and this document were minor and not significantly relevant. The staircase was a part of the employer's premises and Petitioner's path to access his work space. As cited in the above case law, injuries arise out of the employment if they are caused by defects or slippery indoor surfaces at the worksite. Here, Petitioner was inside his work place walking to his office when he slipped on a puddle accumulated by snow tracked in from outside. The Petitioner has sustained his burden of proof that he sustained a compensable 3/3/14 accident.

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

The Petitioner in this case clearly had a significantly degenerated back prior to the work accident and had undergone prior L4/5 discectomy and revision surgeries. He also was and remains morbidly obese.

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the condition such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Compensation Comm'n*, 864 N.E.2d 266 (2007). The accidental injury also need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665 (2003). Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (2000). Employers take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1999). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665 (2003).

Although Petitioner had the noted preexisting problems, no medical evidence was presented which indicated exactly what the Petitioner's baseline condition was. There is one note from Dr. Kraus on 5/30/14 where Petitioner noted his pain was at a 2 out of 10 level and reported that this was close to the baseline pain level he had from his prior back issues. He testified to a significant increase in his low back pain which involved radiating pain into his buttocks and into his left leg, somewhat into the right leg. The Arbitrator notes that there is evidence that Petitioner did not have leg pain and that his back pain was at 2/10 at the time he saw Dr. Kraus on 5/30/14. However, there was no evidence of ongoing treatment prior to the accident and the Petitioner had consistent and ongoing treatment after the accident. The Petitioner also reported, and the timeline appears to support, that he did have reduced symptoms when he saw Dr. Kraus on 5/30/14 but that his symptoms increased again when formal physical therapy ended and he returned to work. Again, it is important to note that the work

accident only need be a causative factor in the current condition, not necessarily the sole or primary cause, pursuant to *Sisbro*.

The Arbitrator finds that the treating physicians in this case generally support a causal connection in this case based on a chain of events analysis. The Arbitrator therefore finds that Petitioner credibly established that his current condition of ill-being is causally related to his work accident. The Arbitrator does note, however, that the Petitioner's preexisting condition in the lumbar spine appears to have involved some significant degenerative conditions, including nerve compression at at least one level that was due solely to bone hypertrophy. The Respondent must take the Petitioner as he is found by the Respondent, which includes the Petitioner's morbid obesity, but it is also a fact based on the evidence that the Petitioner's symptoms are significantly related to his weight.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the treatment received by the Petitioner to date has been reasonable pursuant to Section 8(a) of the Act. No evidence has been presented which would tend to show the treatment was not reasonable, and the main thrust of the Respondent's defense on this issue related to liability. Respondent is therefore ordered to pay the expenses for the reasonable and necessary medical care contained in Petitioner's group exhibit. Respondent shall have credit for all of the awarded expenses paid by Respondent through its group carrier pursuant to Section 8(j) of the Ac, and Respondent shall hold Petitioner harmless from any claims made by any providers arising from the expenses for which it claims credit.

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 an AMA permanent partial impairment report or rating was not submitted into evidence by either party. This factor therefore carries no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, and with regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner was employed by Respondent as a community liaison at the time of the accident. He was able to continue to perform that job until his employment there ended, but he has continued to work in state employment for both the Secretary of State and Treasurer's Office, most recently with the latter in what is essentially a desk job in the Unclaimed Property department. There is no evidence that specifically indicates the Petitioner would not have been able to continue working for Respondent as a result of the accident. There was no evidence presented that indicates the Petitioner's current income or whether any permanent disability resulting from the accident resulted in a loss of earning capacity. However, the Petitioner does appear to be limited to sedentary work. These factors do carry reasonable weight in the permanency determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Neither party has presented evidence which would tend to show how the Petitioner's age impacts any permanent disability resulting from the work accident. This factor therefore carries no significant weight in the permanency determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the evidence supports that the Petitioner sustained an injury to his low back on 3/3/14 which increased any baseline back symptoms he had prior to that date. It is unclear exactly what this injury was. Dr. Kraus, Petitioner's prior back surgeon, about three months post-accident noted Petitioner had essentially returned to his baseline condition and had no leg pain, and a muscular strain was diagnosed. Dr. Williams indicated that a disc at L1/2 causing spinal canal stenosis could have been due to the accident, but that Petitioner mainly had a degenerative condition and opined that the condition could have been aggravated by the accident based on the Petitioner's stated history of the accident causing an increase in any preexisting low back pain. Dr. Gornet also opined that there was an aggravation of a preexisting lumbar degenerative condition. Petitioner underwent some fairly extensive conservative care initially, mainly involving initially therapy and throughout involving significant medication use. Petitioner testified that he was not taking medication for his back prior to the accident and no evidence was presented to rebut this. Petitioner testified he has continued to have daily pain traveling from his lower back into the bilateral buttocks and left leg and to a lesser degree into the right leg. He noted increased difficulty with some basic daily activities. He has significantly reduced his medication. There have been referenced to possible surgery for Petitioner, but nothing has been specifically prescribed. The Petitioner testified that as of the time of trial he had reached MMI and that his physicians had essentially indicated there was not much more that could be done for him. Petitioner's complaints are generally corroborated by the medical evidence in the record.

The Arbitrator notes that the evidence indicates some significant degenerative problems throughout Petitioner's lumbar spine. The evidence also strongly supports that one of the Petitioner's main ongoing triggers for his ongoing pain is his weight. The objective diagnostic findings show longstanding conditions such as calcified disc herniations. At the same time, the preponderance of the evidence shows that the work incident resulted in an increase in back pain, in particular left-sided radiculopathy, that remains ongoing and has increased the Petitioner's level of disability. Fortunately, he has been able to continue working in a sedentary capacity, which is essentially what his job was with Respondent. It is abundantly clear from all of the expert opinions in this case that Petitioner's future symptoms will be significantly dictated by his ability to lose weight. Weight loss

and home exercise are within the Petitioner's voluntary control to a large degree, and therefore the ongoing nature of his symptoms will necessarily be impacted by his own actions moving forward.

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 the loss of use of 7.5% of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Gleason,

Petitioner,

vs. No. 04 WC 60096

Spartan Light Metal Products, Inc.,

19IWCC0474

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of maintenance, permanent disability and mileage reimbursement, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that Petitioner is not entitled to maintenance benefits after July 16, 2015, for failure to perform a good-faith job search. Having carefully reviewed all evidence, the Commission finds that Petitioner is an employable individual who failed to perform a self-directed job search diligently, completely and appropriately, and failed to properly follow up with prospective employers.

All else is affirmed and adopted. In affirming and adopting the Arbitrator's finding of permanent partial disability to the extent of 65 percent of the person as a whole, the Commission highlights the surveillance videos, which show Petitioner to have significantly greater physical ability than he reported to Dr. Kennedy and Dr. Feinberg. The Commission finds the restrictions from Dr. Kennedy and Dr. Feinberg, which are based on Petitioner's subjective complaints of pain, to be unreliable.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 7, 2018 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $336.80 per week for a period of 362 5/7 weeks, from December 4, 2004 through November 16, 2011, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner maintenance benefits of $336.80 per week for a further period of 191 1/7 weeks, from November 17, 2011 through July 16, 2015 only.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses of $12,124.22, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary mileage expenses in the sum of $865.47, pursuant to §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $303.12 per week for a period of 325 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 65 percent of the person as a whole.

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

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

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

DATED: AUG 30 2019
o-07/03/2019
SM/sk
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GLEASON, RICHARD
Employee/Petitioner

Case# **04WC060096**

SPARTAN LIGHT METAL PRODUCTS
Employer/Respondent

19IWCC0474

On 8/7/2018, 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 2.18% shall accrue from the date listed above to the day before the 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:

4599 SCHUCHAT COOK & WERNER
CLARE R BEHRLE
1221 LOCUST ST STE 250
ST LOUIS, MO 63103

2795 HENNESSY & ROACH, PC
RICK DAY
415 N 10TH ST
ST LOUIS, MO 63101

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

RICHARD GLEASON
Employee/Petitioner

v.

SPARTAN LIGHT METAL PRODUCTS
Employer/Respondent

Case # **04** WC **60096**

Consolidated cases: _____

19IWCC0474

An *Application for Adjustment 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 **June 15, 2017** and in **Mt. Vernon** on **August 8, 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 **Mileage Expenses**

FINDINGS

On **September 30, 2004**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,270.40**; the average weekly wage was **$505.20**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$182,449.36** for TTD and maintenance, and **$N/A** for other benefits, for a total credit of **$182,449.36**.

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 **$336.80 per week** for **362-5/7 weeks**, commencing **December 4, 2004 through November 16, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of **$336.80 per week** for **298-6/7 weeks**, commencing **November 17, 2011 through August 8, 2017**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$182,449.36** for TTD and maintenance benefits.

Respondent shall pay reasonable and necessary mileage expenses totaling **$865.47**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of **$12,124.22**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any awarded medical expenses and/or mileage that was previously paid prior to hearing, 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 **$303.12 per week** for **325 weeks**, because the injuries sustained caused the **65% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **September 30, 2004** through **August 8, 2017**, 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

July 31, 2018
Date

AUG 7 - 2018

STATEMENT OF FACTS

On 9/30/04, Petitioner was working for Respondent as a die cast operator. While shoveling aluminum scrap, he felt a pop and pain in his low back on the right with the pain traveling down his right leg. He initially sought medical treatment at Sparta Community Hospital. The hospital gave him a pain shot and he followed up with his family physician, Dr. Beckemeyer, who ordered diagnostic tests and physical therapy. (Px1). He was placed on light duty but his complaints continued and he was referred to Dr. Kennedy by the Respondent.

Petitioner first saw Dr. Kennedy on 10/20/04. Dr. Kennedy kept the Petitioner on restrictions, prescribed medications and referred him to Dr. Graham, where he received a series of trigger point injections on 10/29/04, 11/12/04 and 9/19/04. (Px3). The injections helped temporarily, but Petitioner's symptoms continued and Dr. Kennedy ordered a lumbar myelogram and follow-up CT, after which he recommended surgery. An L5/S1 fusion surgery was performed by Dr. Kennedy and Dr. Robson on 4/15/05. (Px2; Px7; Px8).

Following his injury, the Petitioner continued to work for Respondent within his restrictions until he testified he was fired by Respondent on 12/3/04. Dr. Kennedy took him completely off work as of the 4/15/05 surgery. Following surgery, Petitioner testified he was progressing well in physical therapy until the therapist increased the weights he had to lift, resulting in an increase in his back and leg pain. Petitioner returned to Dr. Kennedy, who in September of 2005 ordered an updated lumbar myelogram and post CT scan. He was continued off work and was ultimately referred to pain physician Dr. Feinberg. Following further testing, Dr. Kennedy recommended a revision surgery based on a lack of solid fusion.

Petitioner was sent to Dr. Bernardi by Respondent pursuant to Section 12 of the Act. Dr. Bernardi agreed with the recommended procedure and agreed it was reasonable and related to the work injury. (Rx1). The revision surgery was scheduled to take place in June of 2006, but Petitioner testified that, after speaking with Dr. Kennedy, he declined the surgery, as he was told there was only a 50/50 chance of his back fusing, and Petitioner decided it was not worth going through the pain again for something that wasn't going to benefit him.

Dr. Kennedy referred Petitioner back to Dr. Feinberg for pain management, and Petitioner testified he has been treating with both Dr. (Barry) Feinberg and his wife, Dr. Rachel Feinberg, since that time. From late December 2006 and early 2007, Petitioner's care consisted of medication given for pain, sleep, and muscle relaxers. He had additional diagnostic testing late 2006 and early 2007, after which Dr. Feinberg recommended a dorsal column stimulator. Dr. Kennedy agreed with this recommendation.

The Respondent obtained a psychological evaluation of the Petitioner with Dr. Stillings on 5/30/07. Dr. Stillings opined that Petitioner was a reasonably good candidate for the spinal cord stimulator from a psychiatric standpoint. He also recommended that contemporaneous treatment with an antidepressant medication would be appropriate and beneficial. Dr. Stillings did not find any signs that Petitioner had exaggerated pain behaviors or symptom magnification. (Px6).

Following a 4/11/11 trial placement of the stimulator, Dr. Kennedy implanted the stimulator on 6/7/11. (Px4). Petitioner continues to use the stimulator and controls it via a remote-control device. He testified it lessens the pain in his legs and his low back.

Petitioner continues to treat with Dr. Feinberg, testifying that because he takes a narcotic medication, he drives to St. Louis to see him monthly for a medication check and to pick up his prescriptions. At the time of trial, he was being prescribed Oxycodone, Wellbutrin, Gabapentin and Ambien. His medications have changed from time to time as they become less effective, but he has treated with Dr. Feinberg for pain, spasms and sleep. Petitioner testified he has fallen at times due to a lack of feeling or heaviness in his legs, some of which have resulted in visits to the emergency room. On two occasions, he testified he had to go to the emergency room when his medications were not authorized by Respondent, causing withdrawal symptoms. Following those occasions Petitioner began having his medication filled through Injured Workers Pharmacy (IWP), testifying this was at Dr. Feinberg's recommendation.

Petitioner testified he continues to have constant pain in his low back and legs, right greater than left, noting the pain can fluctuate with some days being better or worse than others. Prolonged sitting, standing and walking all increase his symptoms. He testified he can stand for approximately 45 minutes before his pain increases and his legs start feeling heavy, after which he has to either sit or lie down. A typical day has pain levels between a 4 and 7 on a 10 point scale (4/10 to 7/10). He has difficulty lifting heavier weight without an increase in pain. He testified he can lift 15 pounds regularly, but it increases his pain. Again, some days he can lift more than others. He has difficulty with stairs and there are days when his legs feel heavy and he feels like he can't lift his feet high enough. He experiences numbness and tingling in his legs. He cannot run. He has trouble driving - if he has to go a prolonged distance, from 45 minutes to an hour, he will have to stop and take a break. He testified that because his spinal stimulator can create an overstimulation, he was advised to turn it off when driving. Petitioner testified to difficulty with twisting, bending and stooping, and that if he bends too far his pain increases and the wires for the stimulator will catch and pull. Petitioner testified he performs household activities like sweeping, laundry, cooking and washing dishes, but those activities increase his pain levels and numbness and tingling in the legs. He mows the lawn, but he cuts it in sections because it increases his pain. He testified he is more active on some days, but notices more difficulty the next day when he is. He will have greater pain in his low back and spasms in his legs and low back, and he gets relief by taking his pain medication and laying down. Petitioner experiences nightly muscle spasms which disrupt his sleep, indicating he only gets a full night's sleep every couple of weeks. He has increased complaints with cold or stormy weather.

Petitioner testified he was not able to return to work with the Respondent, has not worked anywhere else since his accident, and has not been offered any other jobs. Dr. Kennedy found him to be at maximum medical

improvement (MMI) on or about 11/16/11. Petitioner testified he received vocational assistance via the Respondent from approximately 9/11 through 8/13 via counselor Patricia Cope. He testified she helped him with his resume and counseled him in applying for jobs. For the most part, she provided job leads to him, and she also signed him up for online computer courses. Ms. Cope asked that he also provide his own job leads and wanted him to apply in person to jobs he found or she provided. She also asked him to apply to jobs online, which he did via Indeed, Career Builder and Monster. He would attend job fairs and apply through staffing companies such as Extra Help and Priority Staffing. His job search also consisted of making phone calls and cold calls.

Petitioner testified he applied for clerical, retail and food service jobs, including office assistance, bank teller, data entry, store manager and assistant manager jobs. While he did obtain interviews, none of them resulted in a job offer. He testified that there were times the job leads he received were inappropriate for him because they were outside of his restrictions, such as a job with Perry County Counseling. He had an interview with DaVita, a dialysis care facility, Extra Help as a warehouse clerk, Holiday Inn as a guest representative and Pepsi Mid America for a receptionist/clerical job. Petitioner testified that when formal assistance ended in August of 2013, he continued to search for jobs on his own.

There were times during his job search that Petitioner was criticized by Ms. Cope for not following up with in-person calls in a timely manner. He testified that he had financial problems causing him not to follow up as quickly as she wanted him to. He indicated he was receiving $336.80 a week in maintenance benefits, and had to pay $160.00 a week out of that for child support. He testified he also had to economize on his travel because he would have to travel to St. Louis monthly to see Dr. Feinberg.

Petitioner was also criticized by Ms. Cope for providing his work restrictions to potential employers, and he admitted there were times he did so, including for the Perry County Counseling lead. He testified he did so with Perry County because he had already been interviewed by them once before, had been asked if he were able to do the job and was rejected due to the restrictions. Ms. Cope asked him to apply again for the same position and he showed his restrictions to the company. Petitioner testified he may have shown his restrictions to other employers, but stated that he could probably count on one hand how many times he did so. A meeting was held with Ms. Cope so he knew how to handle things in the future. He testified that from time to time there were other issues in the vocational process that had to be discussed with his counselor, and he would then try to work within her expectations. Ms. Cope advised him to use Dr. Cantrell's restrictions as opposed to Dr. Kennedy's, which were more restrictive, including a 10 pound weight limit, no bending, twisting, stooping and lifting and no sit/ stand longer than ten minutes. Dr. Kennedy also noted that Petitioner might need to lay down throughout the day.

Petitioner lives in a rural town, and testified it was difficult for him to find enough jobs to apply to within his job search area, so he found himself applying to the same places over and over. Petitioner testified that he applied for thousands of jobs, noting he often didn't initially know what many of the jobs entail because the places didn't give a detailed description.

Respondent called Terry Freeman to testify at the hearing. A Sparta, Illinois resident, Mr. Freeman testified he is a former employee of Respondent, but is currently disabled due to bilateral leg amputations. He knew the Petitioner through work. Mr. Freeman testified he spoke to Petitioner in late June or early July of 2014 regarding Tupperware. Mr. Freeman told Petitioner he was trying to obtain disability benefits, and testified that Petitioner suggested he sell Tupperware for him and use someone else's social security number so it wouldn't show up under his own name. Mr. Freeman testified Petitioner told him he was using Greg Holt's (Petitioner's

spouse's) name and social security number for business purposes. Petitioner asked if he would host a Tupperware party.

Mr. Freeman also testified he saw Petitioner at a craft fair selling Tupperware at Pistol City Restaurant in Coulterville, Illinois. Mr. Freeman testified he was at the party an hour and saw Petitioner demonstrating some of the products they had there on display. Mr. Holt was present but was not demonstrating the product. Mr. Freeman testified he and Petitioner had a couple of conversations about Tupperware, and that Petitioner offended him by suggesting he was a "sissy" about being caught. He went to the Respondent and told Bill Reed, the plant safety supervisor, about this conversation, as it upset him that he was called a sissy and that Petitioner was trying to hide money. Petitioner testified he recalled talking to Mr. Freeman about Tupperware, and told him he would get a discount if he signed up to sell the product, but denied telling Mr. Freeman that he should sign up to sell Tupperware using someone else's name and social security number and denied doing so himself, as this would be illegal.

Bill Reed also testified on behalf of Respondent. A 40 year employee, he testified he has worked as the safety manager since 2008. Mr. Reed testified that presently the top pay for a die cast operator would be about $15.20 an hour, and time and a half for overtime hours. In addition, employees receive benefits of health, vision and dental insurance, and a 401(k) and profit sharing based upon the hours worked. Profit sharing is paid four times a year and has been paid regularly except for a time in 1990 when it wasn't paid because the company didn't do well that year.

Mr. Reed testified he saw Petitioner mowing grass once when he lived in Sparta. He also saw him at a Mardi Gras party in Pinckneyville in 2015, where he and another gentleman were behind the counter of a Tupperware stand. He watched Petitioner for five or ten minutes, saw him pick up a bowl from under the table and demonstrate the product. He did not see Petitioner alternate between sitting and standing, and did not observe him using a brace or cane. He saw Petitioner again at a Mardi Gras party in October 2016 for roughly five minutes, once again behind a Tupperware counter. He testified Petitioner walked from behind the counter and stood on the other side of the table. Mr. Reed didn't observe Petitioner limping or using a cane.

Greg Holt-Gleason testified on Petitioner's behalf. He is the Petitioner's spouse, and testified they have been legally married four years. Mr. Holt-Gleason has been working as an assistant manager for Dollar Tree since 2014. He is considered full time and his schedule changes on a weekly basis. Prior to that, he worked at Walmart until sometime in 2013. Mr. Holt-Gleason testified he has been a Tupperware consultant since late 2013, hoping it might provide a viable income stream. In order to sell Tupperware, he testified that a consultant holds parties, attends vendor and charity events and tries to get a name out there and network with people. He incurs expenses as a consultant, such as vendor fees, website maintenance, mailing expenses, travel expenses and the purchasing of samples, brochures and catalogs. He also has to pay to rent space at vendor events. Mr. Holt-Gleason testified that Petitioner helps him with the Tupperware business because there are times he is unable to attend scheduled events due to changes in his work schedule at Dollar Tree, and he doesn't want to lose the vendor fee. When this occurs, the Petitioner will attend the event to help with customers and orders. Mr. Holt-Gleason also attends these events and shows and sells products.

Mr. Holt-Gleason testified he's had a website advertising Tupperware since 2013 (Px21), in which he is identified as the consultant. He also has had a Facebook page since at least mid-2013, but does not actively post. (See Px22). The last post he made on his page was in September of 2015 looking for people to help fill date books by having Tupperware parties and inviting their friends. There are two or three earlier posts regarding Tupperware. There is also a 4/27/12 entry indicating the Petitioner had mowed the lawn. Mr. Holt-Gleason testified that he is not social media savvy and has difficulty posting things, while the Petitioner activity posts on

his Facebook account. He is aware that Petitioner posts on his Facebook page regarding Tupperware and has no problem with him doing so as it is a form of advertising.

Petitioner acknowledged that he posted on his own Facebook page that he has been a Tupperware consultant since November 2013, and posts regarding different Tupperware products and the hosting of parties, indicating he does this because Mr. Holt-Gleason does not. His posts refer people to Greg's website. He has identified himself on cards as a consultant because he wants people to know who they talked to at shows in case they want to follow up and make a purchase.

Px19, 20 and23 contain the tax records of Petitioner and, following their marriage, joint tax records of Petitioner and Mr. Holt-Gleason, from 2013 to 2016, as well as spread sheets from 2013 to 2017 for the Tupperware business. The summaries indicate "Total Retail Sales Year To Date" of $1,030.96 in 2013. This figure reflects the total amount of sales, not the profit. Mr. Holt-Gleason would be entitled to receive 25% of that figure, but noted he also incurs costs such as office supplies, catalogs, product samples and other expenses. The following years reflect total retail sales as follows: $3,951.65 in 2015 (25% of that amount is $987.91) and $724.25 ($181.06). Petitioner and Mr. Holt-Gleason's 2016 joint tax return reflects Petitioner's income was from Social Security in the amount of $14,196.00, and indicates a "loss" in the amount of $10,004.00 regarding Tupperware. In all the years he has sold Tupperware, Mr. Holt-Gleason testified he has not made any money.

Mr. Holt-Gleason has been living with Petitioner since 2003. Prior to Petitioner's injury, he testified he never observed him to have any difficulty with any activities, and to his knowledge Petitioner was able to do all of his work activities. Since Petitioner's injury, Mr. Holt-Gleason testified Petitioner is limited in what he can do. He notices Petitioner cannot sit in one position very long before he has to shift position or get up. When he stands, he notices Petitioner has to move around, shift from hip to hip or relieve himself by sitting down. He notices that Petitioner's lifting is significantly limited versus pre-accident. Petitioner has to lie down during the day and he makes pain complaints. There are times Mr. Holt-Gleason has to take over duties such as laundry or washing dishes when Petitioner is having a bad day.

Rx6 contains entries from Petitioner's Facebook page. It indicates he started working as a Tupperware consultant in November 2013, and has several 2013 posts regarding same. The Arbitrator notes that he has joined multiple groups involved in homebased vendors. Additional Facebook postings regarding Tupperware were included in a surveillance report from 2017 (see Rx9).

Rx7 through Rx11 consist of two surveillance videos and three surveillance reports. The videos of 7/25/14 and 7/26/14 show the Petitioner sitting outside his residence and walking on his porch. He was observed helping spread a tarp over equipment and carrying two pieces of wood to place on the tarp. He picked up a collapsible chair and a light box or bag. He was observed bending to pick up a cell phone, and was observed smoking cigarettes. On 8/9/14 he was filmed assisting with a charity event. He was standing in front of the room with a bowl or bucket shaking up chips so numbers could be pulled. He was then filmed helping to carry a plastic tote and a duffel bag to a car in the parking lot. (Rx7, 10 & 11). Petitioner reviewed the video and testified the plastic tote contained purses and weighed from ten to fifteen pounds. He testified the duffel bag contained Tupperware products and weighed about twenty to twenty-five pounds.

Petitioner was filmed on 2/12/17 at a community center. The video showed the claimant walking outside the center and smoking a cigarette. He was filmed folding up and carrying tables from the center to put in a car. He was filmed wheeling a bag to the car. Petitioner testified the tables are made of plastic and weigh between twenty and twenty-five pounds. They are used in Tupperware displays. He agreed that at one point he carried two large tables at once which would have put the combined weight to forty or fifty pounds. He carried some

smaller tables to the car which weighed about half of the bigger tables. Petitioner testified that bag contained Tupperware products and weighed between twenty and twenty-five pounds. He did appear to walk with a slight limp. (Rx8 & 9). Petitioner testified that when he is at the shows he sits, stands, moves around and talks to potential customers. They can last from anywhere from four to eight hours. Shows require setting up and taking down displays. Petitioner often has help from other people to both sell at the shows and set up and take down displays.

Dr. Kennedy testified he first examined Petitioner on 10/20/04 at the referral of the WC carrier, Sentry Insurance. He placed restrictions on the Petitioner and diagnosed findings compatible with lumbar strain, recommending trigger point injections followed by physical therapy. Following injections performed by Dr. Graham, Petitioner returned to Dr. Kennedy; his symptoms were worse and his clinical picture was compatible with sciatica with leg pain and numbness. Following myleogram testing done on 12/10/04 Dr. Kennedy recommended surgery and a fusion, with rods and screws, was done on 4/15/05 at Missouri Baptist Medical Center. Petitioner was taken off work at that time. Petitioner initially improved but he had an aggravation of pain from lifting while in physical therapy. Petitioner returned to Dr. Kennedy in January of 2006 with ongoing complaints of significant aching pain in the lower back with intermittent tingling in the legs. Dr. Kennedy thought he had reached a plateau and thought a functional capacity evaluation (FCE) should be obtained to determine permanent restrictions. Additional testing was completed in January 2006, and the lumbar CT scan suggested a non-fusion at L5/S1. Dr. Kennedy recommend a revision surgery posteriorly, and if he was non-fused then a follow-up anterior fusion at L5/S1. On 6/22/06, Dr. Kennedy told Petitioner that even with surgical intervention he was not sure his pain would resolve or that he would be able to return to his former level of activity. Based on their conversation Petitioner declined surgery, which Dr. Kennedy thought was reasonable. At that point Dr. Kennedy felt, absent further operative intervention, Petitioner was at MMI. He felt that he was not capable of working in any capacity due to the fact his pain was too severe. (Px7; Px8)

Dr. Kennedy next saw Petitioner on 8/25/10, who reported continued disabling, persistent pain in the back and bilateral legs. Dr. Kennedy had referred him to Dr. Feinberg, but Petitioner did not have any type of improvement with the treatments which included injections, physical therapy and medications. Dr. Feinberg thought he would be a candidate for a dorsal column stimulator which Dr. Kennedy thought was reasonable. Dr. Feinberg did a trial placement of the stimulator on 4/11/11, and given Petitioner's report of substantial pain relief, permanent placement was performed by Dr. Kennedy on 6/7/11. Dr. Kennedy continued the Petitioner off work. Asked if there was a clinical basis to explain Petitioner's complaints, he testified the complaints were consistent with known patterns of pain response with the type of injury that he had. Previous studies showed some soft tissue in the vicinity of the nerve roots, which is a setup for scar tissue or reactive changes around nerve roots. (Px7; Px8).

On 9/20/11, Dr. Kennedy placed permanent restrictions on Petitioner stating that he was not able to sit or stand for more than 15 min a day without changing positions, and that he may need to lie down during the day. He also restricted Petitioner from bending, twisting, stooping or lifting greater than 10 pounds on a permanent basis. Follow up visits with Dr. Kennedy revealed Petitioner was happy with the results of the stimulator and it was giving him good pain coverage. He was still having some bad days but overall was having more good days than bad. Dr. Kennedy noted Petitioner was getting around better, although he still had significant limitations in mobility. On 11/16/11, Dr. Kennedy opined that Petitioner had reached MMI and continued his restrictions. (Px7; Px8).

Dr. Kennedy next saw Petitioner on 11/20/12, with Petitioner reporting a sudden onset of severe back pain in the days preceding that visit. Dr. Kennedy's exam indicated reduced range of motion. Petitioner's leg pain was being covered by the stimulator but his back pain wasn't. Dr. Kennedy ordered an updated lumbar CT scan,

which indicated the fusion appeared to look more solid. On 12/11/12, Dr. Kennedy felt Petitioner would need ongoing treatment under the supervision of Dr. Feinberg for his chronic pain. He did not feel Petitioner was able to work in any gainful capacity because of his disabling back pain. (Px7; Px8).

Petitioner returned for an examination with Dr. Kennedy most recently on 8/2/16. He reported the dorsal column stimulator was working well but that his back pain never went below about a 5 on a 1 to 10 scale and was significantly worse with most activities such that he had to curtail his daily activities. He really wasn't doing much other than sitting most of the day, lying occasionally and little or nothing in terms of physical exertion. Dr. Kennedy reviewed the FCE of 9/18/14 and believed it was legitimate based on appropriate increases in Petitioner's heart and respiratory rates during the study. While it had some value, Dr. Kennedy opined it was limited and didn't tell the whole story about Petitioner's functional capabilities and pain perceptions. Dr. Kennedy testified that FCE's are a starting point for decision making regarding restrictions, and he wasn't sure he agreed with the therapist's conclusion on the FCE. He noted an FCE provides a snapshot of a patient as opposed to an assessment of their ongoing capabilities, and while they are helpful in determining the uppers ranges of abilities, it doesn't mean such range can be sustained over a longer time period. He testified they are useful but not as objective as the report might lead you to believe. Dr. Kennedy noted the FCE appeared to be a valid profile as Petitioner's heart rate increased but some tests had to be discontinued because of pain complaints. He felt Petitioner was giving the best effort he could but there were clear-cut limitations that were determined by his pain. Dr. Kennedy opined Petitioner's medications remained appropriate. He also opined that Petitioner would need to continue with his medications, with adjustments, over a long-term basis, and to supplement with over-the-counter Tylenol. He expected he would need maintenance on the spinal cord stimulator. On physical exam, the doctor found all of Petitioner's back muscles extending from his lower back into the back of his legs were very tight and chronically spasmed. He did not feel he was able to work because he had disabling pain and even with medication and dorsal column stimulator, and it was significantly aggravated by even minimal types of activities such that he had to curtail his activities and needed to lie down during the day at intervals. Dr. Kennedy did not think Petitioner would be able to tolerate work even of a sedentary nature. (Px7).

As to his qualifications to render an opinion about employability, Dr. Kennedy testified that the issue was Petitioner's ability to function, and functional standpoint is a medical determination. Petitioner was not functioning well despite medication and placement of a dorsal column stimulator. Dr. Kennedy thought Petitioner's reported symptoms were valid and his complaints of low back pain and bilateral leg pain were consistent with the injury he had and the resultant treatment he received. Irrespective of his skills or even the work setting, Dr. Kennedy thought the pain itself would prevent him from working in a gainful capacity. The medications would likely impair him as well in terms of memory and concentration. As far as Petitioner's prognosis Dr. Kennedy thought there was not likely to be much improvement. He was going to need access to pain medication over the years and potentially replacement of the generator of his dorsal column stimulator. (Px7).

The deposition of Mr. Stephen Dolan was taken 3/10/162016. Mr. Dolan is a vocational rehabilitation counselor who saw the Petitioner, at his attorney's request, on 6/1/12. Mr. Dolan testified that the only transferable skills the Petitioner has are personal care skills that he got through his training and experience as a nurse's aide but that he could not do that work because of his physical restrictions. In doing his assessment Mr. Dolan relied upon the 9/22/11 restrictions placed by Dr. Kennedy, and he reviewed records regarding the work he had been doing with a rehabilitation counselor in a job search for about a year. He opined that it appeared to be a diligent job search. Petitioner had applied for many jobs either in person or online and had not received many interviews nor had been offered a job. (Px12).

Per Dolan's review of the rehabilitation plan that had been prepared for Petitioner, he was being asked to apply for jobs he had no possibility of getting because he did not have the education, experience or training that would make him eligible for such jobs, or they did not fall within his restrictions. He noted that the vocational counselor was only trying to do job placement within the parameters of the restrictions of Dr. Cantrell and ignoring the treating surgeon's restrictions.
Mr. Dolan reviewed the FCE and didn't think the conclusions matched the testing. As an example, he noted that Petitioner could lift in the medium range but much of the testing had to be stopped because of his complaints of pain. During that testing the Petitioner's heart rate went up and the evaluator determined he was being consistent and was consistently trying to do his best, so while he was able to lift over twenty pounds, he was doing so with pain that caused his heart rate to increase. Mr. Dolan thought the examiner's conclusion that the Petitioner could constantly use stairs (more than two –thirds of the day) since he went up and down five steps, four or five times was ridiculous. Mr. Dolan testified that he did not think Petitioner was employable in the open labor market and there was no reasonably stable labor market for the Petitioner. The main reason for this was a poorly controlled pain problem and the restriction the treating doctor gave him that he may need to lie down during part of the workday, which no employer would likely tolerate. (Px12).

Dr. Feinberg is a board-certified physician in both anesthesiology and pain management and has a rehabilitation based pain management practice. He was initially deposed on 10/17/08. He first started treating Petitioner on 11/1/05 on referral from Dr. Kennedy's referral. Post-fusion, Petitioner had complaints of back spasms, significant pain across his low back and bilateral leg numbness, worse with sitting, standing or walking for a period of time of a half hour or more. Dr. Feinberg diagnosed a post laminectomy syndrome, L5/S1 fusion, lumbar radiculopathy and sacroiliitis. Dr. Feinberg recommended Petitioner undergo a course of physical therapy, medication management and possible injection therapies. That treatment was denied and Dr. Feinberg next saw him on 9/29/06. By that visit, Petitioner had been diagnosed with a non-fusion at the L5/S1 level and was there to discuss medication management and other options for pain relief. Dr. Feinberg made medication management recommendations and began discussions concerning a spinal cord stimulator, which he felt would be Petitioner's best option for pain relief and medication reduction. Dr. Feinberg continued to treat Petitioner with medication and to try to obtain authorization for the spinal cord stimulator. Petitioner was having worsening of pain and difficulty with sleep patterns and had been to the emergency room because of increased pain. Dr. Feinberg further testified that the amount of time that had gone by, the chance of reducing the pain was very low. The spinal cord stimulator over the last couple of years remained the best option to control his pain. (Px9). Following a psychological consultation, authorization was eventually received, subsequent to this deposition.

Dr. Feinberg's second deposition was obtained on 3/7/14. He continued to provide Petitioner with medication, and saw Petitioner on a regular basis because he was still taking a narcotic, in order to manage the medication. Following the 4/11/11 trial implantation, which Petitioner felt was successful, and the permanent 6/15/11 stimulator implantation, Dr. Feinberg continued to prescribe Oxycodone (pain analgesic), Valium (muscle relaxer), Lexapro (adjunct pain reliever) and Ambien (sleep). He testified he continued Petitioner on those medications because, while his pin reduced and activity levels improved, the spinal cord stimulator did not give him a hundred percent relief of his pain and he had pain outside of the distribution of the stimulator. Dr. Feinberg got him to three tablets of Oxycontin rather than four with a five milligram dose which the doctor testified was a very minimal dose. Dr. Feinberg's diagnosed lumbar radiculopathy which is irritation of the spinal nerve roots causing pain, and post laminectomy syndrome lumbar spine, post fusion which is a mechanical and neurologic pain after spinal surgery. As of his January 2013 examination, Dr. Feinberg did not feel the Petitioner could work. (Px10).

Dr. Feinberg testified the minimal Oxycodone dose makes the difference for him to be able to tolerate turning up the stimulator to a level where he gets the maximum amount of stimulation and keeps him at his highest level of activity. Plus, as noted, it covers the areas not covered by the stimulator. Dr. Feinberg testified that he will need to continue with the use of the stimulator and opined that is he not going to be employable due to pain. When he increases his activity significantly over what he is currently doing, his pain level increases as well and he is already maximizing as much as he can tolerate on use of the stimulator. He will maintain activities as best as he can and will need some degree of low-grade medication to be able to help him get the most out of his daily activities with the least amount of discomfort. Due to ongoing Oxycodone use, he also will need to be monitored by a physician monthly. (Px10).

Dr. Cantrell's first deposition was taken on 4/3/14. Dr. Cantrell is board certified and specializes in physical medicine and rehabilitation involving the evaluation and treatment of different musculoskeletal conditions and injuries as well as the treatment of acute, subacute, and chronic pain complaints typically muscular in nature. He initially saw the Petitioner at Respondent's request on 11/8/11. Petitioner reported an approximate 50% pain reduction following implantation of the spinal cord stimulator, but there had not been a corresponding reduction in his medication. Following his evaluation, Dr. Cantrell diagnosed chronic low back pain status post fusion at L5/S1, and recommended reducing the Oxycontin dose from four to two times per day, a corresponding 50% reduction. This was also to keep his total dosage of acetaminophen less than 3,000 milligrams per day, although he agreed on cross examination that it was a bit silly to be arguing about one tablet of Oxycodone a day. Dr. Cantrell didn't find a reason for him to continue taking an anti-spasticity medication because he didn't find evidence of spasm on his examination. He did agree on cross examination that this could be because the medication was working. Dr. Cantrell thought continuing with the antidepressant Lexapro was reasonable and the Ambien on an as-needed basis, but that he should discontinue using the Valium. He opined that Petitioner was at MMI and should have permanent restrictions of lifting less than 25 pounds occasionally, 10 pounds frequently, avoiding repetitive bending, and alternating sitting and standing every two hours as needed. He further opined that an FCE would be helpful to further delineate the limitations Petitioner may have. (Rx2).

Dr. Cantrell was deposed a second time on 5/24/17, following a reevaluation of Petitioner on 4/18/17. Petitioner indicated his pain complaints had remained relatively unchanged, varying from 5/10 to 10/10 levels. He noted Petitioner continued to treat with Dr. Feinberg and saw him monthly. He was taking the lowest dose of Oxycodone three times a day. His Valium had been discontinued and he was now prescribed Gabapentin at night and he took Ambien on an as needed basis for sleep and Wellbutrin. He reported the Gabapentin helped his back spasms but did not provide any significant change in his overall pain complaints. Dr. Cantrell testified that Gabapentin is typically prescribed for nerve pain and is not typically prescribed to address muscle spasms. He did not have any objection to Petitioner continuing to take Oxycodone because he would have pain in other areas not addressed by the spinal cord stimulator, and he saw no indication of abuse or escalation of the medication over time. Dr. Cantrell also thought it helped manage the non-neuropathic pain complaints he has. He did not see a need for the Gabapentin because it hadn't helped Petitioner's pain complaints and the doctor did not note spasms on his examinations. However, he also testified he didn't find a problem with any of the medications, noting that if Petitioner's treating doctor thought Petitioner should continue with the Gabapentin medication it would not be unreasonable. Dr. Cantrell reviewed the FCE and opined the Petitioner should be restricted to lifting less than 35 pounds occasionally and less than 25 pounds frequently, and he did not feel he required any limitations in his sitting or standing tolerances. (Rx3).

Respondent obtained a vocational assessment from Eric Flanagan, a vocational rehabilitation counselor for Encore Unlimited, and he was deposed on 8/31/16. (Rx4). The assessment consisted of a follow-up of job search logs submitted by Petitioner for 3/9/15 through 5/25/15, and the preparation of a Labor Market Survey (LMS). Mr. Flanagan testified that the follow-ups on Petitioner's job log contacts was performed by his

colleague, Mickey Mudhar, while the LMS was prepared by his colleague, Samantha Allen. Mr. Flanagan did not personally speak to or meet the Petitioner, did not make any physical observations of Petitioner and did not discuss Petitioner's past work experience with him. The evaluation was based on the restrictions indicated by Dr. Cantrell based on the FCE, and did not take into account the Petitioner's subjective complaints or the restrictions of Dr. Feinberg or Dr. Kennedy, including the need to lie down during the day, which Flanagan testified was a bizarre restriction he had never seen before. He did review the vocational reports of Mr. Dolan and the records of Dr. Kennedy. (Rx4).

Mr. Flanagan opined that Petitioner had a solid work history with skills, experience, and traits that would move him forward into a number of different areas. He testified the LMS identified jobs, within a one-hour radius from his home, that he thought Petitioner could do with a wage range of approximately $9.00 per hour to $16.83 per hour. He testified it is standard procedure for the person doing the LMS to call the listed employers to see if the job was within the claimant's restrictions, which in this case came from Dr. Cantrell, as well as to see if there could be any reasonable accommodations. (Rx4).

Per Mr. Mudhar's review of Petitioner's job search logs from 3/9 to 5/25/15, Petitioner made 218 contacts over 11 weeks. covering a period of eleven weeks and listing 218 different jobs. It was documented on several occasions the employer Petitioner submitted his application to did not have a copy of his application. There were other instances where Petitioner documented he applied for a position online, but when the employer was contacted, they mentioned they did not accept applications online. Petitioner indicated he submitted an application to St. Elizabeth's Hospital in 2015, but when they were contacted, St. Elizabeth's Hospital indicated they had not received an application from Petitioner since 2013. In another instance, Petitioner applied online at Dunham Sports for a store manager position, but when they were contacted about Petitioner's application, Dunham Sports indicated all management positions had been filled and they had not needed one in a while. Based upon the information obtained, it was Mr. Flanagan's opinion Petitioner did not perform a good faith job search. It was his opinion Petitioner did not apply to jobs appropriately, or indicated he had submitted applications when he did not. It was Mr. Flanagan's opinion Petitioner appeared to attempt to exclude himself from consideration due to the type of job search he performed. It was Mr. Flanagan's opinion Petitioner was employable in the open labor market based upon the restrictions signed by Dr. Cantrell. He also opined Petitioner was employable even based upon the restrictions assigned by Dr. Kennedy, and that Petitioner could find a sedentary position within Dr. Kennedy's restrictions. (Rx4).

Mr. Flanagan agreed on cross exam that many of the employers listed on the logs were called but never responded, and he could not say information Mr. Mudhar may have had other than what was noted on his exhibit. Mr. Flanagan testified that following Mr. Mudhar's checks the inference that can be drawn is that Petitioner's documentation is inappropriate. He was not accurately documenting his job search or what he's doing, and given all of the employers that reported they didn't have an application on file, you can infer Petitioner was not completing the job search appropriately. If he was completing it, he was doing it so poorly that he was not able to get to the actual application stage. It was Mr. Flanagan's opinion that Petitioner had not conducted a good faith job search effort to return to work, and this casts a huge doubt over any of the work he completed in the past and whether that was done in good faith. (Rx4).

On cross examination he acknowledged he could not say for certain what Samantha Allen discussed with the prospective employers, as the LMS itself did not indicate. Mr. Flanagan's reports were not shared with Mr. Gleason nor were they sent to Petitioner's attorney until over a year and two months after they were prepared, and he agreed that it was unlikely that the particular jobs identified on the Labor Market Survey were still available. (Rx4)

On his job log Petitioner indicated he had applied online for a Plaza Tire job in Anna, Illinois. Mickey spoke to the manager "Kenny" from that store who told him applications are only done on paper through the store. It was based upon this assertion that Petitioner's maintenance benefits were cut. On cross examination Mr. Flanagan was shown DepxA which was a copy of a web page for applying to Plaza Tire online and identifying the store you wanted to work at. Mr. Flanagan agreed there was a way to apply to the Anna, Illinois store online. (Rx4; Px18).

Petitioner documented a work-from-home position for DIRECTV. In exploring the lead, Mr. Flanagan testified Mickey wasn't able to find any leads for that company that were work-from-home positions. On cross examination Mr. Flanagan admitted that because they couldn't find it did not mean it did not exist. DepxB showed a printout of website information for Direct TV showing they supported freelance telecommuting and alternate scheduling arrangements. Mr. Flanagan testified they spoke to "Julie" at Red Bud Clinic who said Petitioner applied but to no specific position and that they didn't actually have positions available. Mr. Flanagan agreed he applied but didn't list a specific position which would mean he would not be considered for anything. One of the jobs listed on his log was for a biller position at Rhea Clinic. Petitioner indicated he applied via fax. Mr. Flanagan testified they spoke to an individual and she searched their entire database and did not have Petitioner on file. Mr. Flanagan agreed that just because Rhea Clinic made a search on a database in July for a job applied to in March and could not find one did not mean an application was not made. (Rx4).

Petitioner's logs show multiple positions were applied to online for positions at St. Elizabeth Hospital including a job for a patient account representative, receptionist, unit secretary, patient services rep charge entry and a discharge analyst. Mr. Flanagan testified Mickey spoke to the HR person and was told Petitioner had applications on file but the most recent one was from 2013. Mr. Flanagan testified that since Petitioner's logs were completed during the week of 3/16/15, it could be inferred that he didn't submit an updated application. (Rx4). Petitioner testified at trial that he did apply to those jobs in 2015 on the company website. He said that after his initial applications were made in 2013 you go back in to your profile and reapply adding your electronic signature and changing the date at the bottom. He testified he was never contacted for an interview by St. Elizabeth's nor was he offered a job.

Mr. Flanagan testified Petitioner documented he applied by fax to Synergy Therapeutic Group. He said Mickey spoke to "Christa" at Synergy Therapeutic Group and they could not find a record of him applying. Because this was unverifiable they didn't know if he applied appropriately. He testified that Petitioner documented he made a cold call to Red Lobster to apply for a host position. He said they spoke to the manager, Matt, who told them he couldn't find an application. Matt did say that there was a possibility that it could have been reviewed and removed. Petitioner documented that he applied online to Kay Jewelers. Mr. Flanagan said they spoke to the manager for Kay Jewelers and she said that she did not receive an application from Petitioner. DepxD is a screen shot of the website that show one applies to Kay Jewelers through Sterling Jewelers and the process must first go through Sterling recruiting team before it got to the individual store. Mr. Flanagan agreed on cross examination that it was possible that the manager never received an application because Petitioner never made it past the recruiting team. With Petitioner's Sun Loan application, it was pointed out on cross examination that the application goes through the corporate level and then to the individual store if they make the cut. Mr. Flanagan agreed that just because the application couldn't be found at the individual store could mean Petitioner did not make the cut at the corporate level. (Rx4).

Petitioner documented he applied by fax to Title Cash. Upon checking Mr. Flanagan testified the manager there stated they did not receive an application from Petitioner. On cross examination Mr. Flanagan would not agree that the store may not have kept the application. He thought it likely she would have remembered it. Mr.

Flanagan testified that Petitioner documented he applied online with Hertz for a branch manager trainee position. He testified that when Mickey contacted the number provided it was no longer in service and there was no other contact information. DepxC was a page printed from a website showing a Hertz location at the number listed on the website. Petitioner's attorney had called the number and it was found to be a viable number and business location. Mr. Flanagan testified that Mickey's information regarding this may be a mistake. Petitioner logs reflected he applied online for a telephone sales rep and product info rep for NBTY in Carbondale. Mr. Flanagan's testified that Mickey's search results showed there was no Carbondale location for that company. DepxE was a computer screen capture of a NBTY store with a Carbondale location. It was a negative to Mr. Flanagan that Petitioner applied to Associate Physician Group by a cold call. He does not ask his client to do that as it is a thing of the past. (Rx4).

Petitioner's log indicates he applied by fax for a customer service position at Rend Lake Resort. Mr. Flanagan testified the website instructs that applications are only to be in person so Petitioner was not following instructions. Mr. Flanagan could not direct Petitioner's attorney to any place on the website that said apply in person. Petitioner's logs indicated he applied to a Taco Bell job by fax. Mr. Flanagan thought this surprising because typically specific branches of fast-food chains don't have fax numbers. Mr. Flanagan correctly pointed out that the address Petitioner listed for the Taco Bell did not exist. On cross examination Mr. Flanagan was shown DepxG which is an e-mail note dated July 17, 2015 to Petitioner saying they got his application but he didn't meet their qualifications. Mr. Flanagan thought it raised questions as to what information he was providing on his application because most times one doesn't qualify because they don't have a high school diploma. Petitioner had applied for a manager position. Petitioner indicated he applied at World Finance. Mr. Flanagan testified they were able to speak to an individual who told them Petitioner applied for a manager trainee position online but she does not think they are hiring for a manager trainee position at that location. Petitioner's logs indicated he applied with HSHS Medical Group for a patient service representative position. Mr. Flanagan testified Mickey checked that job and the phone number was out of service. Petitioner's attorney called the phone number before the deposition and spoke to "Kim". The phone number was not out of service and was to Clinton County Rural Health formally known as the HSHS Medical Group. Petitioner's logs indicated he said he applied online for a teller position at Peoples National Bank. Mr. Flanagan testified that when Mickey spoke to "Susan" at the bank she said she could find no record of him applying for work. Mr. Flanagan could not say how they process applications nor could he say how many teller applications the bank would receive. Petitioner logs indicated he applied for a board operator position at W.I.L.Y. Mickey said the phone was disconnected and there was no other contact information. DepxF was a computer screen capture of the business and phone number. Petitioner's attorney said she called that number and spoke to Rachel who confirmed it was a radio station. Mr. Flanagan agreed this would be a viable business. (Rx4).

Petitioner underwent the FCE at NovaCare Rehabilitation on 9/18/14. The evaluator determined that Petitioner tested into the light physical demand level, with some abilities in the medium physical demand category, for 8 hours per day, and was considered an accurate representation of his functional abilities. He showed consistent scores of 20 of 20 performance consistency tests. In combination with physiological responses (heart rate and respiratory rate), movement and muscle recruitment patterns, both aware and unaware of observation, the test results were considered an accurate representation of Petitioner's functional abilities. Based on the job description submitted by the Respondent, the evaluator stated that Petitioner demonstrated the ability to meet the physical demands of a die cast operator. The evaluator determined that Petitioner demonstrated the ability to occasionally lift up to 35 pounds from floor to waist, 30 pounds from waist to shoulder, 30 pounds from floor to shoulder, carrying up to 35 pounds, push/pulling up to 25.4 pounds of force. Petitioner demonstrated the ability to frequently lift up to 25 pounds floor to waist, waist to shoulder and floor to shoulder, carrying up to 40 pounds, and push/pulling up to 20.2 pounds of force. The Petitioner was noted to have terminated many of the noted tests due to pain and/or pulling in his low back. Petitioner testified he had difficulty in doing the FCE

testing and couldn't finish most of the testing requiring lifting, pushing and pulling because of increased pain in his back. He had increased pain in the days after following the FCE testing. (Rx5).

At the time of trial Petitioner was forty-seven years old. He has a high school education and had certified nursing training course following high school. His past work experience including working as a cashier, a fry cook, a certified nursing assistant and factory worker. He owns a computer and uses it for Facebook and doing Google searches. Petitioner has lived in Pinckneyville almost ten years moving there in 2007. Prior to that he lived in Sparta, Illinois.

Petitioner and his attorney met with Patricia Cope of S & H Management on 9/1/11 to interview and initiate vocational services. Ms. Cope helped Petitioner prepare a resume and cover letter and had him sign up on a job search website. She gave him computer classes to take which he finished in the first week even though he was given a month to complete them. She provided job leads and requested he make in-person, telephonic and on-line applications and e-mail potential employers regarding employment opportunities. (Px14). Petitioner's Exhibit 13 is a copy of Petitioner's job search logs. Petitioner and Ms. Cope searched for jobs together when they met and Petitioner developed his own job leads. Ms. Cope followed up with potential employers to see if Petitioner had applied for jobs and found that he applied to multiple places (CMH, Manpower, Garron Foods, Republic of Tea, Radio Shack, Heartland Regional, Hospice of Southern Illinois, McDonalds, Cash Store, Casey's, State Farm, Staples, Spirit Halloween Superstore, Pizza Hut, Christian Homes, Shawnee Health, Titlemax, Panera Bread Company, Mt. Vernon Radiation Therapy, First Southern Bank and Little Caesars). Some of the places eliminated Petitioner because of his physical restrictions or lack of experience (Manpower, Hospice of Southern Illinois, Garron Foods). Others had openings at the time Petitioner applied but filled them with someone else (Spirit Halloween, Superstore, Pizza Hut, Christian Homes, State Farm, Shawnee Health, Titlemax, Panera Bread Company, Mt. Vernon Radiation Therapy, First Southern Bank and Little Caesars). (Px14).

In the first few weeks of his job search Petitioner had interviews with Extra Help, Davita, Select Staffing and Perry County Mental Health but was eliminated from consideration due to his physical restrictions. Ms. Cope encouraged Petitioner to renew his CNA license until it was determined the work would be outside his restrictions. Ms. Cope documented conversations she had with Petitioner in which they discussed his pain complaints and physical abilities. He told her about his difficulty with standing and with muscle spasms and the need to lie down during the day. She noted his emergency room visit on October 31, 2011 and his ongoing pain complaints. Ms. Cope continued to provide job leads and Petitioner tried to develop leads on his own. In reviewing his job leads coving the reporting period of 11/22/11 through 12/6/11, Petitioner applied to 74 jobs and Ms. Cope noted that Petitioner had "essentially contacted all provided job leads and or follow ups in an appropriate time frame." Ms. Cope continued to try to verify employer contacts and found that she couldn't obtain information from many as they were confidential postings. Some employers no longer had positions open and others rejected Petitioner because he did not have the appropriate experience they were looking for (Big River Applebee's, Kohl's) (Px14).

Ms. Cope contacted employers in the Greater Pinckneyville, Illinois area in order to determine physical requirements, job duties and prior skills required and noted some physical requirements were outside Petitioner's restrictions (Hospital Sisters Health System, NBTY, Pinckneyville Community Hospital, Vogler Ford). She found some employers indicating an ability to try to accommodate Petitioner's restrictions. Petitioner and Ms. Cope continued to meet on an ongoing basis. She continued to review his job logs and reviewed his e-mail account. The job logs from 12/3/11 through 1/17/12 documented 81 employer contacts. Her review of the "sent" folder on his e-mail account showed many jobs he had applied to online. She noted responses from potential employers telling Petitioner he did not meet the qualifications of the job (Headway Workforce, Joanne

Fabrics). One employer told Ms. Cope that there were 715 applications for one position (Prairie Cardiovascular). Ms. Cope documented during this reporting period difficulty Petitioner had with getting his pain medication paid for through workers' compensation and that he appeared to be going through withdrawal symptoms. She reported what he told her about his pain complaints, his trouble sleeping and his ongoing muscle spasms. During this reporting period Petitioner had visits with his physician to try to get his medical issues taken care of. (Px14).

In the reporting period of 1/17/12 through 2/17/12, Petitioner documented 61 searches in the job logs. Ms. Cope reviewed his e-mail account and found that many jobs leads she had given him had been applied to that same day or within a couple days. She expressed concerns that he was not making enough in person contacts, and they discussed the difficulty he had doing this because of lack of gas money. Some positions she wanted him to apply to in person he called and mailed the employers his resume (Mary's Laundry, Juvenile Detention Center). Ms. Cope continued to follow up with employers to verify that Petitioner had applied. Multiple employers confirmed they had his resume, some told her they had received several hundred applicants and some told her he was not chosen because of no documented experience. (Px14).

A review of the subsequent Reports filed by Ms. Cope document continuing concerns she had with Petitioner delaying his in-person contacts with potential employers. He appeared to continue to make online applications on a timely basis from leads she provided but he waited to make in person visits, which he indicated was due to trying to economize on his gas by scheduling multiple visits to a certain area of town when he could make multiple visits on one trip. Ms. Cope would note that Petitioner would do follow-ups but criticized him because he would do these at her request rather than on his own. (Px14).

On 11/8/12, she met with Petitioner and his attorney in the attorney's office to discuss concerns she had with him giving his restrictions to some employers, the lack of in-person contact and with an application Petitioner made with Garron Food that raised red-flags with his explicit answers to questions on the application. They discussed his difficulty in making timely in person contacts because of his lack of funds for gas and discussed how to answer questions on applications more professionally without turning off a particular employer. They also discussed his giving his restrictions to employers and Petitioner did not remember doing that with many employers. He did discuss his restrictions with the manager of Auto Credit for a collections position when the manager asked if he had trouble lifting. The manager told him he didn't see a problem with the restrictions but Petitioner did not get the job. (Px14). Petitioner also provided his restrictions along with a second application to Perry County Counseling. Petitioner testified that he did that because he had already been rejected for that job on an earlier application because of the restrictions.

Ms. Cope followed up with prospective employers about applications Petitioner had made or interviews he had received. She noted in her report that on 9/28/2011the Petitioner had found a job lead online with Select Staffing in Mt. Vernon as a general laborer. He had an interview on 10/7/2011, but because of his restrictions, he was not a good fit for the job. They were going to keep him on standby in case a job comes up that fit his abilities. Petitioner had an interview with Extra Help in Marion, IL on 10/5/11, but was not hired due to his restrictions. They said they would keep him in mind if something opens up that he can do. On 9/28/11, Petitioner applied to a confidential posting for mental health staff with Perry County Counseling, listing Danielle Ridgeway as the contact person. Petitioner had an interview for this job on 10/17/11. Ms. Cope reported: "Unfortunately, he did not get chosen for a second [interview] due to restrictions. She said he was very good interview. He used good eye contact. He asked plenty of questions about details of job and only gave out his restrictions when asked. She personally liked him, but the higher up that conducts second interview worried about his restrictions, even though the position is a midnight position." (Px14).

On 10/5/11, Petitioner had an in-person interview for a Life Skills Trainer position at Extra Help, Inc. in Carbondale. They could not hire him because of restrictions. "Stephanie interviewed and said he did fine in the interview, but when asked if he had any physical limitations, they could not consider him for this particular job." On 10/7/11, Petitioner had a phone interview with DaVita for the position of Dialysis Tech. He reported that he could not do the job due to restrictions. Ms. Cope spoke to the interviewing employer who stated that he did very well in the interview process, but they just could not accommodate him due to his restrictions. On 10/24/11, Petitioner called Ms. Cope to inform her that he had called Rend Lake College to see about renewing his CNA license and found out that he would have to take a refresher class, and believed that his restrictions would keep him from renewing. Ms. Cope called Rend Lake College to verify, and indicated the Petitioner was correct, as he would have to be physically able to lift patients and complete clinical to renew his CNA license. (Px14).

On 12/12/11, Petitioner applied for a job as a customer service representative at Cook Sales in Anna, Illinois. According to the follow-up made by Ms. Cope, the employer stated: "that he did look at Petitioner's resume, [and] because of the distance and lack of office experience; and he did not choose him for an interview." On 2/20/12, Ms. Cope provided a lead to Petitioner from Red Top Cab to be a cab driver. On 2/22/12, she provided a lead to Petitioner from South Central Transit to be a part-time driver. Ms. Cope stated that Petitioner did not apply to either job because "he is of the opinion he must turn his Stimulator off while driving." Later in the report, she verified that Petitioner had mailed his resume to South Central Transit for the part-time driver position, and that the employer had received the resume. (Px14).

Beginning with her sixth report (3/16/12), Ms. Cope documented as a "barrier" to his employment that "Petitioner is of the opinion he cannot pursue and accept employment that requires driving as part of the job; however, he can drive to employment in Benton, Illinois or similar distances." Petitioner explained that the manufacturer of the unit recommends turning it off while driving because an "impulse" could cause him to jerk while driving. He explained that he turns off the unit while driving to jobs, then turns it back on when he arrives. Ms. Cope told Petitioner that she would avoid transportation-type jobs. On 7/29/13, Ms. Cope provided Petitioner with a position as a full-time van driver at Brehm Preparatory School. Petitioner applied to be a "transporter" at Hertz on 1/14/12. On 2/20/12, Petitioner applied for a position with Direct Support Personnel through a confidential posting looking for a direct support partner. Ms. Cope supplied the lead for this job and verified his application and interview. She stated: "[Tiffany] said he did very well in the interview. She stated she spoke with her supervisors and because there is a chance of seizures, he would have to bend, squat, and be able to help lower someone to the floor." (Px14).

On 3/20/12, the Ms. Cope flagged the job for Manager of Dollar General as outside Petitioner's experience and physical abilities. On 3/27/12, Ms. Cope flagged the job for Office Manager at Crossroads Hospital in Mount Vernon as outside his experience and physical abilities. On 4/3/12, Mr. Gleason applied to be a guest representative at Holiday Inn Express in Marion, Illinois and had an interview. On 4/10/12, Ms. Cope spoke with the person who conducted the interview, stating: She "informed me that they asked if he could stand for most of the shift with position, Petitioner told them of his restrictions, they were not sure they could accommodate. I did ask if an individual could use a stool, and she said no. She went on to say that they have a seat in the back and if business is slow, they can sit occasionally. They cannot guarantee they will sit every two hours." (Px14).

On 4/12/12, Petitioner applied for receptionist/clerical work at One Hope United. According to Ms. Cope: "The lady who answered said there were no openings for receptionist or clerical at this time, only youth care workers. I asked about the physical requirements of this job. She did say that youth in this category sometimes do become physically aggressive; therefore, I felt this would not be a good fit for Petitioner." On 6/13/12, Petitioner

had an interview with Little Caesars. Ms. Cope spoke with Tony, who conducted the interview. He informed her that "he thought Petitioner was a good person to hire, but he could not guarantee he could sit every two hours." On 10/23/12, Petitioner was provided a job lead for Guardsmark. "Petitioner did not apply; required lifting of 40# fire extinguisher and being able to take a perpetrator down." (Px14).

Petitioner began having more severe complaints around November 2012 and was taken off work by Dr. Feinberg and Dr. Kennedy. During this time, Ms. Cope stopped meeting with Petitioner pending clarification of the medical condition. She continued to do phone calls with Petitioner and provided job leads, mainly sedentary and at home based employment. Per her report of 1/19/13, on 1/16/13, Dr. Feinberg determined that Petitioner "was not able to seek gainful employment in any capacity at this time." (Px14).

Each week from 1/16/13 to 2/3/13, Ms. Cope noted as concerns that Petitioner was "not required at this time to turn in minimum requirements of 15-20 contacts a week while working through medical issues, but could have completed more follow ups and online applications." On 2/6/13, Ms. Cope indicated she would inform Petitioner to continue looking for work outside of home, not just home-based work sticking to mostly desk type positions, and that it was time to return to normal return to work services. On 2/6/13, Ms. Cope gave Petitioner a lead for a telecommunication position at a Sheriff's office in Marion, Illinois. Petitioner made several trips to pick up the application and to take the 3/23/13 testing for the position. There were approximately 187 people there taking the test. He received a rejection email on 3/29/13. Ms. Cope noted that Petitioner's application for jobs as manager at Sun Loan and Assistant Manager of Vitamin World in Carbondale "appear beyond his experiential history." An AM Vets lead was provided by Ms. Cope on 4/8/2013, but on 4/17/2013 she advised him not to apply, as she had determined the job was very part time and based on commission only. Several other noted positions (Pizza Hut Shift Manager, Staples cashier and customer service, Pet Firm) might be beyond his physical limitations. (Px14).

Ms. Cope elicited additional responses from potential employers about their contacts with Petitioner. On 3/19/2012 she spoke with Amy at Family Dental, "who said that he was very nice. He did turn in an application and a resume, but this is a small office, and there are no openings." On 3/19/2012 she contacted the Loos Law Office in Pinckneyville, Illinois – "I spoke with a lady on the phone, who would not give me her name, but she said he was very pleasant and they are a small company and no openings." On 7/3/2012 she called Priority Staffing in Marion, Illinois – "I spoke with Julie, who interviewed Petitioner. She said he was a super nice gentleman, but they do not have any clerical openings at this time." On that same day she spoke with Tony at Little Caesars in Carbondale, Illinois, who said "he seemed like a good person to hire, but he could not guarantee that he can sit every two hours." (Px14).

Ms. Cope identified in-person leads she wanted Petitioner to apply to. For example, on 2/20/12 she asked him to apply to Casey's General Store, Murphysboro for an assistant manager position, which he did that day. He applied that day. A lead was given on 2/23/12 to apply at Wenneman's in Saint Libory, and Petitioner applied in person on 2/28/12. On 4/2/12, Petitioner was asked to attend a job fair in Marion, which he attended on 4/3/12. He attended a job fair at Kaskaskia College in Centralia on 4/18/12. On 4/24/12, Petitioner was asked to apply in person to Pepsi Mid American in Marion for a customer service position, and to Priority Staffing in Marion for a receptionist position. Petitioner had an interview with Pepsi on 5/31/2012, and an interview with Priority Staffing on 6/12/12. On 5/29/12 Ms. Cope asked Petitioner to apply in person to World Finance in Marion, IL for manager trainee position and he did so on 5/31/12. On 6/12/12 he was asked to apply in person to Vic Koenig Chevrolet in Carbondale, IL for a service advisor position and Petitioner submitted his resume in person on 6/13/12. On 7/6/12 he was asked to submit an application in person to Village of Crainville for a water clerk position job, and did so on 7/10/12. He was given a lead to apply in person to the Mr. Vernon Countryside Manor on 8/9/12 and applied in person that day. On 8/19/12 he was asked to apply in person for a

receptionist job at Extremities Hair/Tanning in Carterville, and Petitioner submitted his application in person on 8/23/12. On 5/31/13, Petitioner was asked to apply in person to 7 leads. He was told to "go in person today, 5/31/13, and see if they have any openings and turn in resume/application." That day Petitioner went to Auffenberg, Clintec, Shawnee Christian Nursing, Williamson County Programs for the aging. He attempted to go to River to River, Esse, and Helia, but indicated he could not find these locations and mailed his resume to these locations on 6/6/2013. (Px14).

Ms. Cope's was asked to close her file on 8/7/13, and her last report was issued on that day. A review of Petitioner's Exhibits 13 and 14 indicate that Petitioner applied to approximately 2700 jobs from 9/20/11 through 9/13/16. However, Ms. Cope also notes in her last report multiple "barriers and problems", including limiting and delaying in-person contacts, believing that he cannot accept any job that involves driving despite his ability to drive to surrounding communities, not completing follow ups without being specifically directed to do so, and not applying at all to some contacts. (Px14).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner submitted into evidence a group exhibit of medical bills (Px16). At issue are medical bills from Injured Workers' Pharmacy (IWP) in the amount of $12,124.22 for medication prescribed by Dr. Feinberg. A dispute arose after the implantation of the spinal cord stimulator as to whether Petitioner should continue to take the narcotic medication prescribed by Dr. Feinberg. In additional to the narcotic prescription Respondent questioned whether spasm medical should be prescribed and at one point questioned the prescription of Valium. Respondent stopped paying for certain medications and Dr. Feinberg recommended Petitioner start using IWP. The medications prescribed by Dr. Feinberg appear to be properly managed. The narcotic medication Petitioner takes is the lowest dose possible that can be prescribed. Petitioner is monitored regularly and there has been no indication of misuse, liver problems or toxicity. Dr. Kennedy agreed the medication being prescribed was appropriate. Dr. Cantrell ultimately testified that he really didn't have a problem with anything being prescribed. Respondent is ordered to pay Petitioner $12,124.22 in medical expenses as the Arbitrator finds such charges are reasonable and causally related to his work injury.

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:

Pursuant to Arbitrator's Exhibit 1, the Petitioner seeks TTD benefits from 12/4/04 through 11/16/11, and maintenance benefits from 11/17/11 through the last hearing date of 8/8/17. The parties have stipulated that the Respondent is entitled to a credit against these requested benefits of $182,449.36 based on the prior payment of benefits. Respondent argues that the Petitioner is not entitled to TTD and/or maintenance benefits after 7/15/15.

The Arbitrator finds that the Petitioner is entitled to TTD from 12/4/04 through 11/16/11, and to maintenance from 11/17/11 through 8/8/17, a total of 661-4/7 weeks.

Following his injury Petitioner was placed on light duty restrictions and the Respondent accommodated his restrictions until Respondent fired Petitioner on 12/03/04. When Respondent fired the Petitioner, he was still on light duty restrictions and was not yet at maximum medical improvement. Dr. Kennedy performed his first surgery on 4/15/05 at which time he took Petitioner completely off work. Over the ensuing years Petitioner underwent protracted medical treatment until Dr. Kennedy found him to be at maximum medical improvement on 11/16/11. Petitioner is not entitled to temporary total disability from the date of his injury until he was terminated from his job on 12/3/04 because Respondent provided work to him within his restrictions. Petitioner would have been available to work within his restrictions after that date if Respondent had not terminated him. As Petitioner was not at maximum medical improvement until 11/16/11 he is entitled to temporary total disability payments from 12/04/04 until 11/16/11 for 362 5/7 weeks.

After Dr. Kennedy found Petitioner to be at maximum medical improvement on 11/16/11, Respondent paid maintenance benefits until it terminated them on 7/15/17. The fact that the Arbitrator has determined that the Petitioner's job search was not sufficient enough to support a permanent disability or wage differential award does not automatically mean it was not sufficient enough to support ongoing maintenance benefits. While it appears clear to the Arbitrator that the Petitioner was not doing his best in completing his job search tasks, it is nevertheless true that he made many contacts and was able to get a number of interviews. This Arbitrator has seen numerous cases where the claimants have not been able to even get that far in a job search, and therefore the Petitioner should be given some credit for his efforts. It also cannot be disputed that the Petitioner has some level of medical restrictions which would prevent him from performing all possible jobs. The Arbitrator finds that the effort provided by the Petitioner in the job search process was sufficient to support ongoing maintenance benefits through the date of hearing.

The Respondent is entitled to credit against this award totaling $182,449.36.

The Arbitrator does note that the evidence supports the fact that the Petitioner was, in fact, marketing and selling Tupperware. However, given the records submitted into evidence with regard to income from this task, the Arbitrator believes his involvement was de minimis in terms of the issue of TTD/maintenance.

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

The Arbitrator finds that the Petitioner has failed to prove that he is permanently and totally disabled pursuant to the Act.

The key to this determination involves a recognition that the Petitioner's medical restrictions and medical opinions are significantly, if not completely, based upon his subjective complaints of pain. The Petitioner underwent an April 2005 fusion surgery at L5/S1 with Dr. Kennedy. Initially he improved before suffering a setback, at which time he was diagnosed with a failed fusion. Petitioner opted to decline a second revision procedure based on the odds of success being questionable, and his decision was supported by both Dr. Kennedy and Dr. Bernardi. However, a CT scan obtained shortly thereafter indicated the Petitioner was, in fact, fusing at the surgical site.

Petitioner's subjective complaints of pain appear to the Arbitrator to be credible in terms of their existence, however they also appear to be excessive given the preponderance of the evidence in this case. The surveillance videos are a good example of this. While the Petitioner may have pain, and the Arbitrator acknowledges he even appeared to be limping to some degree in the more recent films (see Rx7 and 8), he nevertheless engaged in significantly greater activity than he indicated to his physicians that he felt capable of. While the activities did

not take place over the course of an entire day, the weights that the Petitioner appeared to be lifting and the ease with which he was bending to lift and carry a number of items do not show a man who is permanently and totally disabled. The Arbitrator believes the weights clearly exceed those which the Petitioner was restricted from by Dr. Kennedy and Dr. Feinberg.

It is also highly relevant to the Arbitrator that Dr. Kennedy and Dr. Feinberg essentially ignored the findings of a valid FCE test and instituted significantly greater restrictions than the testing indicated would be appropriate. Both at times even state that the Petitioner cannot be gainfully employed. While Dr. Kennedy testified that he questioned complete reliance on the FCE findings, and that it was a "starting point" for the determination of restrictions, it appears clear that the restrictions he instituted were based almost solely on the Petitioner's subjective complaints. Given his explanation and the permanent restrictions he supported, it's hard to understand why he even obtained the FCE unless he assumed it would indicate more significant restrictions than it did. Dr. Kennedy indicated that Petitioner reported that he performed minimal physical exertion, which appears to be in opposition to the surveillance video, information in the record that the Petitioner would cut lawns and perform household activities, and the findings of the FCE in terms of his abilities. The testimony of Mr. Flanagan is well taken in terms of the very odd determination that one of the Petitioner's restrictions should be that he should be able to lie down as needed. Such a restriction would clearly bar the Petitioner from numerous jobs, and these does not appear to be any objective basis for such an extreme restriction. Mr. Dolan agreed that the FCE findings, if valid, would put Petitioner into the light/medium work level category.

The Arbitrator also cannot ignore the testimony of Terry Freeman. He testified that the Petitioner advised him to operate a Tupperware business using someone else's social security number to avoid detection by any payor of disability benefits. No evidence was produced which would indicate that Mr. Freeman had a bias against the Petitioner. The Arbitrator believes the actions by Petitioner in this regard are a window into the fact that he was cognizant of how to try to keep his disability benefits going while engaging in income producing activity.

Upon the Arbitrator's determination that the Petitioner has failed to prove a permanent total disability, the next inquiry becomes whether he has shown entitlement to a wage differential award pursuant to Section 8(d)1 of the Act. The Arbitrator finds that the Petitioner has failed to prove this as well. First, there is evidence which supports both that the Petitioner cannot return to his regular employment (Dr. Kennedy and Dr. Feinberg), as well as evidence which indicated he would be able to return to at least a significant percentage of the work duties he performed for Respondent, if not all (Dr. Cantrell, FCE). As noted above, the restrictions that the Petitioner should have been utilizing as part of his job search are also unclear, as the Arbitrator finds that the restrictions issued by Dr. Kennedy appear to be based almost exclusively on Petitioner's subjective complaints. The records of Ms. Cope contain multiple criticisms of how he went about his job search, including revealing of his restrictions when advised not to, not following up consistently with job contacts, and declining any jobs that involve driving despite the fact he does drive and there are no specific restrictions barring him from doing so. The range of possibilities in terms of what the Petitioner could earn based on Mr. Dolan's conclusions make defining a wage differential amount very difficult for an Arbitrator. Overall, the Arbitrator finds that the preponderance of the evidence indicates the Petitioner has failed to prove the required prongs for entitlement to a wage differential award.

This leaves the determination of permanency to be based on a percentage of loss. While §8.1b of the Act requires a number of criteria and factors to be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after 9/1/11, the Petitioner's injury occurred well prior to this date, and thus this section of the Act is not applicable to the case at bar.

While the Arbitrator has criticized some of the Petitioner's actions and the information he has provided in the above analysis, the Arbitrator does believe that the Petitioner sustained a significant injury, underwent a significant surgery involving fusion, had an initial failure of that fusion, and has since had a spinal cord stimulator installed in an attempt to control his pain. The Arbitrator also believes the Petitioner does, in fact, have pain that he has to deal with on a daily basis, and that this does limit his ability to function. Whether one looks at the opinions of either Dr. Kennedy or Dr. Cantrell, the Petitioner requires some level of permanent restrictions. While the Arbitrator noted above that the FCE showed the Petitioner was capable of much of his regular job, it did not indicate he was capable of all of it. The Arbitrator notes that even with Petitioner's nursing background, he would still be at a disadvantage versus the uninjured worker in a stable labor market. The Arbitrator therefore has determined that the Petitioner's situation falls within the loss of trade theory. The time period during which he has remained unemployed has been extensive and is also noted by the Arbitrator with interest in terms of the Petitioner's ability to return to the workforce. It appears highly likely that he is physically deconditioned given this extended vocational absence, and this could be part of his ongoing subjective complaints. The Petitioner also remains a fairly young man at this time. The Arbitrator, again, believes that the Petitioner has valid ongoing significant pain complaints. However, the Arbitrator also believes that the Petitioner's activities, as depicted in the surveillance video, and which the Arbitrator assumes were similar to what he did any time he was out marketing Tupperware, indicate he can do more than what Dr. Kennedy and Dr. Feinberg have stated he can.

Based on 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 the loss of use of 65% of the person as a whole pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (O), IS THE PETITIONER ENTITLED TO MILEAGE EXPENSES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is claiming mileage for office visits with Dr. Feinberg. Petitioner currently resides in Pinckneyville, Illinois and travels to Dr. Feinberg's office in St. Louis in order to obtain prescriptions for his medication. Petitioner testified he has seen Dr. Feinberg 122 times and the mileage is about 170 miles roundtrip.

In addressing this issue in the past, the Commission often looks at whether there was a lack of medical providers in Petitioner's immediate geographic area which could have provided the same treatment. In this case, Petitioner testified his prior primary care physician, Dr. Beckemeyer would no longer see him, but the medical records document Dr. Beckemeyer last saw Petitioner in late 2004. Petitioner acknowledged he is currently seeing a new primary care physician in his hometown of Pinckneyville who is prescribing him medication unrelated to his work injury. Petitioner acknowledged his current primary care physician could also prescribe the same medication Dr. Feinberg is currently prescribing. Further, Dr. Feinberg testified in his deposition Petitioner could get his medications from his primary care physician in Pinckneyville if the physician would agree to prescribe the medication. Finally, Dr. Feinberg testified he encourages patients to do what is convenient when it comes to getting their medication. In fact, Dr. Feinberg testified based on his experience and practice, he thought seeing Petitioner only for medication was overkill, especially when Petitioner can be monitored by his primary care physician in Pinckneyville.

Based on the above evidence, the Arbitrator finds Petitioner is not entitled to the mileage expenses involved in his visits to Dr. Feinberg, as it is clear that the Petitioner could have obtained his prescription medication from his primary care physician in Pinckneyville, and has been encouraged to do so. This is particularly the case based on Petitioner's pain complaints, as his reasoning for continuing to return to Dr. Feinberg for such long

trips when a local option is available makes no logical sense in this case. Having to return for monthly visits for narcotic testing is clearly not something that only Dr. Feinberg could do.

Petitioner also makes a demand for vocational mileage. He claims he is entitled to mileage while conducting his self-directed job search. He claims he drove 3,194 miles while performing his self-directed job search.

Px15 and Px17 contain documentation for the basis of Petitioner's vocational mileage request. However, Petitioner agreed he is not entitled to mileage for trips that were in the Pinckneyville area. These exhibits contain documentation of quite a few job searches in the local Pinckneyville area.

Petitioner testified he did not keep the mileage he drove while undergoing vocational rehabilitation or while performing his self-directed job search. The documentation admitted into evidence was information put together by his attorney. The information put together by Petitioner's attorney, which was admitted into evidence for demonstrative purposes, included mileage to and from locations in Pinckneyville, Illinois. Further, Px15 which was a spreadsheet and affidavit (Note: these were admitted for demonstrative purposes) identified mileage for actual contacts, but also for online applications and resumes mailed or faxed. Px15 documents mileage from Petitioner's home to each employer's location, even if Petitioner saw multiple employers on the same date. For example, 11/1/2013 Petitioner reports seeing four employers in Sparta, Illinois but claims mileage of 19.3 miles for each employment contact.

Based on the documentation submitted and from what can be verified, the Arbitrator finds Petitioner's vocational mileage to be 1,697 miles. There was no evidence presented regarding the rate at which mileage should be paid. In 2011, the rate of which mileage was paid in the State of Illinois was $0.51 per mile. Therefore, Petitioner is awarded vocational mileage in the amount of $865.47.

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

TOM HERNANDEZ,

Petitioner,

vs. NO: 17 WC 13326

DCS MECHANICAL, INC.,

Respondent.

19IWCC0475

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice provided to all parties, the Commission after considering the issues of employee-employer relationship, accident, causal relationship, temporary total disability benefits, medical expenses both incurred and prospective, and average weekly wage, and being advised of the facts and the 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.

As the Supreme Court of Illinois noted in *Roberson v. Industrial Commission*, "the question of whether a person is an employee remains 'one of the most vexatious *** in the law of compensation.' [citation omitted]. The difficulty arises not from the complexity of the applicable rules, but the fact-specific nature of the inquiry." 225 Ill. 2d 159, 174, 866 N.E.2d 191 (2007). As the Arbitrator found and the Commission affirms, the evidence is well-balanced but taken as a whole preponderates in favor of a lack of an employee-employer relationship.

Respondent is in the business of manufacturing and maintaining duct work for air conditioning and heating units. Petitioner performed remodeling work such as drywalling, painting, tiling, and trim work on Respondent's premises. Prior to March of 2017, Petitioner performed such work as an independent contractor under the auspices of Fox Valley Remodeling for which he carried workers' compensation insurance coverage wherein he excluded himself. In March of 2017, this business relationship shifted with Petitioner believing himself to be

employed in a maintenance position whereas Respondent's representative, Mr. Smith testified to a new remuneration package for ongoing remodeling work. While performing the maintenance/remodeling work, specifically painting, Petitioner fell suffering bilateral ankle fractures.

In affirming the Arbitrator's findings, the Commission notes Petitioner was free to perform the remodeling work such as painting in any manner he saw fit. Respondent did not control or supervise the manner in which Petitioner performed his work. See *Bauer v. Industrial Commission*, 51 Ill. 2d 169, 172, 282 N.E.2d 448 (1972) ("inasmuch as an employee is at all times subject to the control and supervision of his employer, whereas an independent contractor represents the will of the owner only as to the result and not as to the means by which it was accomplished. [citation omitted]"). "Moreover, because the theory of [workers'] compensation legislation is that the cost of industrial accidents should be borne by the consumer as a part of the cost of the product, this court has held that a worker whose services form a regular part of the cost of the product, and whose work does not constitute a separate business which allows a distinct channel through which the cost of an accident may flow, is presumptively within the area of intended protection of the act." *Ragler Motor Sales v. Industrial Commission*, 93 Ill. 2d 66, 71, 442 N.E.2d 903 (1982). Respondent is in the business of manufacturing and servicing duct work. Petitioner was not performing work activities which were encompassed by Respondent's general manufacturing activities but was instead performing a separate business service-remodeling. Petitioner failed to prove the existence of an employee-employer relationship.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 15, 2017, as modified above, is hereby affirmed and adopted.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission.

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

DATED: AUG 30 2019

L. Elizabeth Coppoletti

LEC

D: 6/19/19

Stephen Mathis

43

DISSENT

I dissent from the majority Decision and find that an employee-employer relationship existed between Petitioner and Respondent on March 22, 2017.

As noted by the Arbitrator, it was undisputed that the exact terms and conditions of the relationship between Petitioner and Respondent changed as of March 9, 2017. The Arbitrator cited to *Roberson v. Indus. Comm'n*, 225 Ill. 2d 159 (2007), wherein our Supreme Court emphasized the fact-specific nature of the employee-employer issue – and as in any case involving factual questions, it is within 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. *Hosteny v. Ill. Workers' Comp. Comm'n*, 397 Ill. App. 3d 665, 674 (2009). In this instance, I find Petitioner more credible than Respondent's representatives, Ken Smith and Ed Wysocki.

In the case at bar, as was in *Roberson*, the evidence demonstrated elements of both an independent contractor and an employee. Elements of an independent contractor status were limited: Petitioner was paid with a single check with no taxes taken out; this was similar as to when Petitioner operated Fox Valley Remodeler, Inc. and received payment at the completion of his remodeling project. After March 9, 2017, Petitioner continued to use his own hand tools. However, Respondent's shop foreman, Mr. Wysocki, acknowledged having and being required to have his own hand tools.

Conversely, there were significant elements of employee status. Petitioner was now paid $25.00 per hour rather than providing Respondent with a per project contract and invoice. Respondent, not Petitioner, paid for the material used in the shop projects/maintenance with its company credit card. Bigger tools or work items, such as the sprayer and ladder belonged to Respondent. Petitioner further testified to completing an employment application, tax forms, and timesheets; he worked scheduled hours, took his lunch break at the same time as other employees, and he was not free to come and go as he pleased, nor could he choose not to show up for work. Petitioner was also not free to accept other jobs during the time he worked for Respondent.

Another consideration was the nature of Petitioner's work in relation to Respondent's business. The evidence demonstrates that Petitioner did do the same type of remodeling work for Respondent as he had prior to March 9, 2017, but Petitioner also testified to completing duct work and using a "button" or "pinner" machine. Petitioner testified extensively and in detail how to use that specific machine, which Respondent used as part of its duct work manufacturing business. Petitioner testified that he had never done duct work as part of Fox Valley Remodeler and that Respondent had trained him on how to use the machine. Although Mr. Wysocki denied training Petitioner on the machine, he acknowledged that he would have to show a person unfamiliar with the machine how to turn on the switch and where to press the pedal.

Respondent's position against Petitioner's claim is a blanket denial. Mr. Smith denied instructing Petitioner to complete a job application or tax forms, denied informing Petitioner that he would be doing HVAC work or that he had to report to a foreman, denied instructing

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Petitioner when he needed to appear at Respondent's premises for work or when he could take a lunch break, and denied giving Petitioner a work schedule. Similar to Mr. Smith, Mr. Wysocki denied witnessing Petitioner on any of Respondent's machines, or training or supervising Petitioner in any capacity. Most notably, Mr. Smith, Respondent's president and owner absolved himself of any knowledge as to how Petitioner's eventual pay of $1,445.50 was determined, and when Petitioner's attorney asked Mr. Smith how Petitioner could be paid for material when Petitioner had used Respondent's company card to purchase the material, Mr. Smith repeatedly replied, "Time and material" with no further explanation.

Based on the totality of the evidence, I find the testimony of Respondent's representatives to be incredible, self-serving, and at times unresponsive or vague when confronted with Petitioner's testimony and evidence which was credible, logical, and consistent. For these reasons, I must respectfully dissent from the majority Decision and Opinion on Review.

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HERNANDEZ, TOM
Employee/Petitioner

Case# **17WC013326**

DCS MECHANICAL INC
Employer/Respondent

19IWCC0475

On 12/15/2017, 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:

2559 BOWMAN & CORDAY
LANE ALLEN CORDAY
134 N LASALLE ST SUITE 1440
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
JUSTIN SCHOOLEY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF **Kane**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tom Hernandez
Employee/Petitioner

v.

DCS Mechanical, Inc.
Employer/Respondent

Case # **17** WC **13326**

Consolidated cases: **N/A**

19IWCC0475

An *Application for Adjustment 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 **Geneva**, on **October 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 **Hold Harmless**

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FINDINGS

On the date of accident, **March 22, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

On the date of accident, Petitioner was **43** years of age, ***single*** with **2** dependent children.

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

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

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT AN EMPLOYEE-EMPLOYER RELATIONSHIP EXISTED WITH RESPONDENT ON MARCH 22, 2017, PETITIONER'S CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

December 15, 2017
Date

ICArbDec19(b)

DEC 15 2017

Statement of Facts

19IWCC0475

Petitioner Tom Hernandez testified that he is familiar with Respondent DCS Mechanical. He has done work for them since 2015. Respondent does manufacturing of duct work and does maintenance and construction of duct work, air conditioning and heating. He first became familiar with Respondent and Ken Smith, one of its owners, when he worked on their build out in 2015. Respondent needed drywall work done to finish the offices in the building. At that time, Petitioner was operating a business called Fox Valley Remodeler. When he worked as Fox Valley Remodeling, he had a contract for the work. He was paid by the job. He testified that the first job paid about $3,300 to $3,500. Additional work was added. In October, 2015, he finished work in the amount of $14,400. He worked with three employees, his brother Joe Hernandez, Scott Wescott and another guy named Joe. He controlled them and paid them. They did drywall, painting, tile work and installed some trim. The payment was made to Fox Valley Remodeler. PX 39 is the paid contractor's invoice. After that, he went on to other jobs. Petitioner testified that on those jobs, he would pay for material with his company card and submit the invoice at the end.

Ken Smith testified that he is president and an owner of Respondent. Respondent is a heating, air, and ventilation contractor that performs mainly commercial shop fabrication of duct work and some residential work. He testified that shop fabrication employees make duct work; service employees repair issues with HVAC equipment; and field employees perform installation. Respondent also employs personnel employees. Mr. Smith testified that work performed by Fox Valley Remodeler prior to March 22, 2017 included the office build-out, drywall, studwork, trim, tile, painting, and bathroom remodel. While performing that work, Petitioner supplied his own tools.

Petitioner did additional work on a bathroom for Respondent in early March, 2017. He performed plumbing, drywall, ceiling and tile work. He worked with only his brother on that job. He testified that he was paid time and materials. He received a check made out to Fox Valley Remodeler at the end of the job (PX 37). Petitioner testified that at the time he was doing this job, he was closing his business. That was the last job he did. He had Workers' Compensation insurance for Fox Valley Remodelers that ended in June, 2017. He had excluded himself from coverage under that policy.

Petitioner testified he had a conversation with Ken Smith on March 8, 2017 following that job about employment. The conversation took place in the Respondent's shop. Nick, Ken's partner, was also present. Petitioner testified that he asked for a job. His business was slowing down with inconsistent pay. Respondent's location was close to his home. Petitioner testified that Mr. Smith said he had plenty of work here for him remodeling the building. They agreed on $25 per hour. Petitioner testified that he filled out an application for employment and tax forms that Mr. Smith gave him. He put them on the secretary's desk. Petitioner testified it was his impression he was an employee.

Ken Smith testified that Petitioner asked him for a job. He informed Petitioner that he did not have HVAC positions available and could not provide Petitioner with an HVAC job, but indicated that Respondent had additional work including building stairs in the loading dock, doing baseboard trim work, painting a deck and loading dock, and installation and painting of doors as well. Mr. Smith testified that he expected said work to last two weeks. Ken Smith testified Petitioner would be paid $25.00 per hour. He would be paid time and material, meaning he would be paid for time invested on a project at the agreed hourly rate, and then material costs. He testified that he did not tell Petitioner he would be hired as a maintenance man. Ken Smith testified that he did not instruct Petitioner to fill out a job application for tax paperwork. Taxes were not withheld from

Petitioner's pay. He never informed Petitioner that taxes would be withheld from his pay. Petitioner was never put on Respondent's payroll and was never sent a W-2. Mr. Smith did not inform Petitioner to report to a foreman. No one was supervising Petitioner's work. He could come to work, take breaks or leave when he chose. There was no work schedule.

Mr. Smith testified that the March 22, 2017 check was issued to Petitioner personally at Petitioner's request. The request was not made to him. He is not aware of the actual calculation. Petitioner would turn his hours in to Nick. He does not know how it was done.

Petitioner testified he started on March 9, 2017. He was installing some baseboards for 2 to 2 ½ days. He installed a door and painted 3 doors. He used his own tools for these jobs. He testified that he worked on the button machine for about 2 ½ days. This machine fastens the insulation to the inside of the ductwork. He testified Ken Smith told him to do that job. Petitioner worked under the supervision of the shop foreman, Ed.

Petitioner testified he started work at 7:00 AM each day and left after 8 or 9 hours. He took a lunch break with the other guys in the shop. He testified he was not free to come and go as he chose. He showed up every day. He testified that he filled out time sheets that he put on a desk in the shop like the other employees. He did not bring any other employees to work with him. He was given orders by Ken and Ed. Ken did not tell him how to do things because he hired a skilled employee to do those things. He did have his own hand tools.

He received a check on March 22, 2017 made out to him personally (PX 38). Petitioner testified that he expected taxes to be taken out of his check. He fell before he had an opportunity to review the check or question whether deductions were taken out. He also received $600 cash after the accident for the additional three days he worked.

Edward Wysocki testified that he is the current shop foreman at Respondent. His job duties included coordinating shop employees and ensuring that jobs were completed. He testified that he had also previously worked as a shop worker in fabricating and manufacturing HVAC fittings. He was familiar with Petitioner. He testified Petitioner working on improvements in the building. He testified that he did not supervise Petitioner in the performance of those jobs. Petitioner worked by himself. Petitioner had has own gang box of tools. Mr. Wysocki also has his own hand tools. Petitioner never reported to him other than saying "good morning" and "I'm out of here." He came and went at his own time. Mr. Wysocki testified that he never trained Petitioner on how to use any machines at Respondent. He testified that there is no button machine. There is a machine that puts insulation pins on the ductwork called the pinner or Duro Dyne insulation pin machine.

Petitioner testified that on March 22, 2017, Ken asked him to spray paint the loading dock ceiling. He used Respondent's ladder and sprayer. The sprayer was clogged so he needed to purchase some parts. He also needed to purchase some special paint. He used Respondent's company credit card. He closed the area off to other employees. While he was painting, the ladder slipped off the rafters and he fell 17 to 20 feet landing on both of his legs. An ambulance was called and Petitioner was taken to Rush Copley in Aurora.

Petitioner was seen in the Rush Copley Emergency Department. The Registration Form lists Respondent as Petitioner's employer and Petitioner's occupation as painter. X-rays of the left ankle revealed comminuted, displaced and angulated fracture of the mid to distal fibula with complete disruption of the ankle mortise, comminuted fracture of the distal tibia with displacement. The left foot x-rays were also suspicious for fractures of the anterior calcaneus and second metatarsal. X-rays of the right ankle revealed comminuted calcaneal and

a comminuted distal fibular fracture. X-rays of the right foot were also suspicious for fractures of the cuboid and cuneiform and a possible Lis franc injury could not be excluded. Petitioner came under the care of Dr. Weinstein and the surgeon, Dr. Neena Szuch. Dr. Szuch performed an open reduction and of the left ankle and used an external fixator on the Petitioner's lower left leg. Petitioner's right ankle was splinted (PX 19).

Petitioner was transferred to Good Samaritan Hospital where he was hospitalized from March 23, 2017 through April 5, 2017. He came under the care of Dr. Evan Dougherty of Hinsdale Orthopaedics. On March 24, 2017, Petitioner underwent debridement and irrigation of his left open grade three comminuted pilon fracture, removal of the previous external fixator and placement of a new external fixator and antibiotic delivery device (PX 20). On March 27, 2017, Dr. Dougherty performed an open reduction and internal fixation of the anterior portion of the comminuted pilon fracture. The external fixator was adjusted and Petitioner had a complex closure of the open traumatic medial ankle wound (PX 22). On March 30th, Petitioner underwent another open reduction with internal fixation on a plafond fracture, fibular shaft fracture, and the distal tibiofibular

Petitioner testified that he was admitted to a rehabilitation facility, The Tillers, for about a week. Then he went home. On April 26, 2017, Petitioner returned to Good Samaritan for further surgery to his left ankle consisting of debridement and irrigation of the left medial ankle, removal of deep implant from the left distal tibia and removal of the external fixator (PX 25). Petitioner testified that in May, 2017, he saw another specialist at Good Samaritan for wound control. On May 15, 2017, Petitioner had a skin graft to the left ankle (PX 30). Petitioner had follow-up wound care. On June 7, 2017, he reported the skin graft fell off. He was advised to treat this with ointment and bandage. He had continued left foot and ankle pain (PX 31). He began therapy at ATI starting June 19, 2019 through July 20, 2017 (PX 32).

On July 28, 2017, Dr. Dougherty performed surgery to remove the syndesmotic screws from his left ankle (PX 26). On August 14, 2017, Petitioner reported increased pain and swelling in the left ankle. He has been unable to use his walker due to pain. Dr. Dougherty diagnosed a possible infection (PX 32). On August 30, 2107, Petitioner had surgery to remove deep implants from his left tibia and a bone biopsy of the tibia (PX 27). He was placed in a short leg splint. The cultures were positive for Staph. Dr. Dougherty recommended a left ankle fusion (PX 32). Dr. Dougherty performed additional surgery on September 7, 2017 in preparation for the fusion. The surgery consisted of excisional debridement of the distal tibia, proximal tibial corticotomy for planned bone transport and tibiotalar fusion, removal of deep implants, placement of a biodegradable antibiotic delivery device and application of the special frame to the lower extremity (PX 28).

Petitioner testified that at least two more surgeries are planned. He is currently wearing the external fixator. His fiancée must clean every one of his pins daily and adjust them to move the bone inside. These adjustments must be done every morning and again every night. Petitioner cannot bear weight on his left leg. He testified that he tried to use a walker and he got around okay, but he experienced pain and infection set in. Since then, he is wheelchair bound. His treating doctors have authorized him totally off work from March 22, 2017 through his last visit on October 3, 2017 and continuing (PX 1).

Conclusions of Law

In support of the Arbitrator's decision with respect to (B) Employee-Employer Relationship, the Arbitrator finds as follows:

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. *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980). Whether a claimant is classified as an independent contractor or an employee is crucial, for it is the employment status of a claimant which determines whether he is entitled to benefits under the Act. It is undisputed that prior to March 9, 2017, Petitioner, operating as Fox Valley Remodeler, was operating at Respondent's location as an independent contractor. It is also undisputed that the exact terms and conditions of the relationship between Petitioner and Respondent altered as of March 9, 2017. The issue is whether the modified relationship between the parties converted the relationship from that of independent contractor to that of employee-employer at that time.

For purposes of the Act, the term "employee" should be broadly construed. *Ware v. Industrial Comm'n*, 318 Ill. App. 3d 1117 at 1122 (2000). Nevertheless, the question of whether a claimant is an employee remains one of the most vexatious in the law of workers' compensation. *Roberson v. Industrial Comm'n,* 225 Ill. 2d 159 (2007) at 174. The difficulty arises from the fact-specific nature of the inquiry. *Id.* Many jobs contain elements of both an employment and an independent-contractor relationship. *Kirkwood v. Industrial Comm'n*, 84 Ill. 2d 14, 20 (1981). Since there is no clear line of demarcation between the status of an employee and an independent contractor, no rule has been, or could be, adopted to govern all cases in this area. *Roberson*, 225 Ill. 2d at 174-75. An employee is at all times subject to the control and supervision of his employer, whereas an independent contractor represents the will of the owner only as to the result and not as to the means by which it was accomplished. *Bauer v. Industrial Comm'n.*, 51 Ill. 2d 169, 171-172, (1972).

The Supreme Court has identified a number of factors to assist in determining whether a person is an employee. Among the factors cited by the supreme court are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer compensates the person on an hourly basis; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; and (6) whether the employer supplies the person with materials and equipment. *Roberson*, 225 Ill. 2d at 175. Another relevant factor is the nature of the work performed by the alleged employee in relation to the general business of the employer. *Id.*; see also *Ware*, 318 Ill. App. 3d at 1122. The label the parties place on their relationship is also a consideration, although it is a factor of "lesser weight." *Ware*, 318 Ill. App. 3d at 1122. The significance of these factors rests on the totality of the circumstances, and no single factor is determinative. *Roberson*, 225 Ill. 2d at 175. Nevertheless, whether the purported employer has a right to control the actions of the employee is "[t]he single most important factor." *Ware*, 318 Ill. App. 3d at 1122; see also *Bauer v. Industrial Comm'n*, 51 Ill. 2d 169, 172 (1972). The nature of the claimant's work in relation to the employer's business is also an important consideration. *Kirkwood*, 84 Ill. 2d at 21; *Steel & Machinery Transportation, Inc. v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st).

Prior to March 9, 2017, Petitioner was performing work at Respondent as Fox Valley Remodeler. He performed remodeling and carpentry work at Respondent's location. The jobs were priced by the job, not an hourly rate. There was a contract submitted for the work to be performed. Respondent was invoiced per job and paid by check payable to Fox Valley Remodeler. Petitioner did the work on these earlier jobs with

additional employees who were paid by Petitioner. Mr. Smith testified that some materials on these jobs may have been paid for with Respondent's company credit card.

The parties agree that there was a change in this relationship that occurred on March 9, 2017. The Arbitrator notes that Petitioner did not have a gap in his work between the end of the Fox Valley Remodeler relationship which ended on March 8, 2017 and his individual work beginning the next day on March 9, 2017. Petitioner testified that he closed Fox Valley Remodelers at that time. The parties agree that after March 9, 2017, Petitioner was paid $25 per hour for work performed rather than by the job performed. There is no evidence that he personally purchased any materials after March 9, 2017 despite Mr. Smith testifying he was paid "time and material." There was no evidence submitted concerning the purchase of the materials used for baseboards or doors installed. Petitioner purchased parts for the Respondent's spray gun and paint to be used in the dock using Respondent's company credit card. Petitioner testified that he could not bring additional employees to help after March 9, 2017, but the Arbitrator notes that Fox Valley Remodeler was no longer in business and therefore, he did not have any employees. Respondent testified that the projects were all one man jobs. Petitioner presented no evidence that any other Respondent employees or other individuals were used or needed to assist him in performing these projects.

No testimony was presented as to whether Petitioner used any of Respondent's tools such as the ladder and spray gun while performing services as Fox Valley Remodeling. After March 9, 2017, Petitioner used his own hand tools and drill that he kept on Respondent's premises. He used Respondent's ladder and spray gun for the dock painting that he was performing at the time of his injury.

Petitioner concedes that he was not told how to perform the remodeling aspects of his work. He stated that he was a skilled individual. The remodeling work was not related to Respondent's general business of HVAC manufacture, installation and maintenance. Petitioner testified that he was supervised by Ed Wysocki, Respondent's shop foreman. He also testified that he worked a regular day of 8 or 9 hours and left about the same time as the other workers. He testified that he took his lunch and breaks with the other employees. Mr. Smith and Mr. Wysocki both denied that they specified any set work day for Petitioner or provided any supervision or control. The Arbitrator notes that Petitioner's brother worked for Respondent as a delivery driver and assists in the shop. Petitioner taking his lunch with other employees would not be unusual, even if he was not an employee.

Petitioner testified that he did 2 to 3 days of work operating a manufacturing machine for Respondent between March 9, 2017 and the injury. He did not specify which days he performed this work or why he did this work when there was still remodeling work that had not been completed, such as painting the loading dock. He described the machine on which he worked and some detail as to its purpose and operation. Mr. Smith and Mr. Wysocki denied that he performed this work and challenged his designation of the machine as the B Button machine. There was additional testimony as to the difficulty in operating this machine and the need for training to perform this task.

Petitioner was paid a single check made payable to him personally. There were no taxes taken out of this check. The Arbitrator notes this check was drawn on the same account as the previous check to Fox Valley Remodeler and since that company was closed, it would make no sense to make the check payable to that company. Petitioner testified that he filled out a job application and tax forms, a fact denied by Mr. Smith. Petitioner testified he would fill out a time sheet like "other employees" Mr. Smith agreed Petitioner would give his partner a listing of his hours to be compensated, but had no knowledge as to how this was done. Petitioner

also received his last three days pay after the injury in cash. Petitioner testified that he believed he was an employee and listed Respondent as his employer on the Rush Copley Emergency Department Registration Form. Mr. Smith testified that Respondent still considered him an independent contractor after March 9, 2017.

The Arbitrator finds elements of both employment and independent contractor present in the relationship presented. The remodeling work being performed was not in general business of the employer. Petitioner did this work without direct supervision as he was a skilled worker. He used his own tools, but was provided the ladder and spray gun by Respondent. He was paid hourly, but no taxes were taken out. The check he received was not on a payroll account. He was paid the last three days in cash after his accident. Petitioner submitted time records weekly of his time worked. He did not punch a time clock. No example of the time records was offered.

Many of the changes to the relationship between the parties after March 9, 2017 are equally explained by Petitioner's decision to close Fox Valley Remodelers. The closure of this company explains the payments to him personally rather that the company. He did not have employees any more so he would have had to work alone. The full time attendance at Respondent's location is equally explained because he did not have other work. The purchase of materials by Petitioner using the Respondent's credit card is equally explained because he no longer had a business account. His choice of taking breaks with other workers can be explained by a preference for companionship.

The parties also presented conflicting testimony of many element of the relationship. While Petitioner considered himself an employee, the Respondent testified that they did not consider him one. Petitioner testified that he filled out an application and tax forms; denied by Mr. Smith. He testified he was supervised by Mr. Wysocki, disputed by both Mr. Wysocki and Mr. Smith. He testified that he performed manufacturing work for 2-3 days, disputed by Mr. Wysocki and Mr. Smith. He testified he kept a schedule, while Respondent's witnesses testified he could come and go as he pleased.

After reviewing the testimony and exhibits and weighing the evidence against the factors enumerated in the case law, the Arbitrator finds that Petitioner has not proved by a preponderance of the evidence the requisite element of control stated in the case law as the most important element. In reaching this conclusion, the Arbitrator cites *Edward Dzioban v. Joint Management Company*, 2011 Ill. Wrk. Comp. LEXIS 111, 11IWCC 0047, affirmed *Edward Dzioban* v. *Illinois Workers' Compensation Comm'n*, 2013 IL App (1st) 120434WC-U; 2013 Ill. App. Unpub. LEXIS 320; 2013 WL 683053. In particular, the factual recitation of the parties' relationship detailed in the Appellate Court decision tracks similarly to the present case. In that matter, the Petitioner was a painter working full time for a real estate management company performing maintenance work. He was paid hourly without taxes withheld. He turned in time records weekly. He used some of Respondent's equipment including a ladder. He believed he was an employee, while Respondent believed he was an independent contractor.

In *Dzioban,* the Arbitrator, affirmed by the Commission, found an independent contractor relationship existed rather that an employment relationship. The Appellate Court noted the Circuit Court dispute with the Commission's factual findings on the elements evaluated in its confirming of the Commission decision on manifest weight. The Circuit Court found that the evidence illustrated that the work performed by the claimant was "an integral part of the regular business of [the employer]" because the employer's business was to manage and maintain certain properties and the claimant performed tasks maintaining those properties, such as painting, cleaning, and other maintenance tasks. The Appellate Court agreed with the Circuit Court in

describing the factual elements as "well balanced." In a divided decision with two justices dissenting, the Appellate Court affirmed the Commission denial of benefits. See also *Matthew Weimer v. Dream Builders,* 2016 Ill. Wrk. Comp. LEXIS 731; 16 IWCC 547 (Construction laborer found to be an independent contractor).

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that an employee-employer relationship existed with Respondent on March 22, 2017.

In support of the Arbitrator's decision with respect to (C) Accident, (F) Causal Connection, (G) Earning, (J) Medical, (K) Prospective Medical, (L) Temporary Compensation and (O) Hold Harmless, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Employee/Employer relationship, the remaining issues of Accident, Causal Connection, Earning, Medical, Prospective Medical, Temporary Compensation and Hold Harmless are moot.

Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEAH L. LUTZ,

Petitioner,

vs. NO: 15 WC 9163

INDUSTRIAL CONTRACTORS SKANSKA,

Respondent.

19IWCC0476

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 jurisdiction, accident, causal connection, medical expenses, temporary total disability (TTD) benefits, permanent partial disability (PPD) benefits, and penalties and attorney's fees, and being advised of the facts and law, modifies the Arbitrator's Decision 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. 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 (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. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

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The Commission modifies the Arbitrator's Decision and vacates the Arbitrator's finding relative to intervening accident. Instead, the Commission finds that Petitioner's injury on May 8, 2016 did not constitute an intervening injury sufficient to sever the causal chain.

> Under an independent intervening cause analysis, compensability for an ultimate injury or disability is based upon a finding that the employee's condition was caused by an event that would not have occurred 'but for' the original injury. (citation omitted). Thus, when an employee's condition is weakened by a work-related accident, a subsequent accident, whether work related or not, that aggravates the condition does not break the causal chain. (citation omitted). 'For an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition.' (citation omitted). As long as there is a 'but for' relationship between the work-related injury and subsequent condition of ill-being, the . . . employer remains liable. *PAR Elec. v. Ill. Workers' Comp. Comm'n*, 2018 IL App (3d) 170656WC, ¶¶ 62-63.

The Commission first notes that in 2009 and 2010, Petitioner had undergone a capsular plication and a biceps tenodesis in the right shoulder. (PX1). Following the January 6, 2015 work-related injury, Petitioner treated with Dr. Robert Gurtler and Dr. Christopher Glock, who eventually performed a right shoulder subacromial decompression and distal clavicle excision on April 8, 2015. (T.35-36; PX6). Respondent does not dispute liability for this surgery.

At Petitioner's May 14, 2015 appointment with Dr. Glock, Petitioner exhibited full range of motion, but had pain upon palpation of the AC joint, subacromial impingement area, and along the biceps. The record stated, "I shared with her again my feeling that I do not think the biceps is likely the problem because at this point even if it tore loose I cannot imagine that there would be any place that it would go." Dr. Glock, however, stated that if Petitioner continued to be symptomatic after six to 12 months, he would consider re-evaluation of the biceps tendon. At Petitioner's request, Dr. Glock allowed Petitioner to work without restriction commencing May 22, 2015. (T.36; PX4).

Petitioner next followed-up with Dr. Gurtler on December 15, 2015. (T.16; PX1). Dr. Gurtler noted that Petitioner had not proceeded with the recommended right shoulder arthroscopic exam and evaluation of the anterior inferior labrum and open excision of the biceps tendon with release of the biceps tendon; Dr. Gurtler had previously recommended this surgery in February 2015. (T.17; PX1). Dr. Gurtler noted Petitioner's surgery on April 8, 2015 with Dr. Glock, and further noted Petitioner's continued complaints of pain and tenderness in the exact area of her previous tenodesis. (T.17; PX1). Examination of the right shoulder on this date demonstrated normal sensation, but decreased range of motion. Petitioner wanted to hold off on the recommended arthroscopy for now, and Dr. Gurtler found Petitioner's request acceptable. (PX1). As of May 3, 2016, Dr. Gurtler continued to attribute Petitioner's current right shoulder condition to her work duties as a union electrician. (PX7).

On May 8, 2016, Petitioner reported to the emergency department of Carle Foundation Hospital. The history recorded was, "She states that last night she was doing dishes and felt a pop in her shoulder and now has limited motion due to pain. The pain is described as sharp/stabbing in nature, worst over the superior and anterior aspect of the shoulder." (T.41-42; PX8; RX6). Respondent argues that the May 8, 2016 incident was an intervening cause that severed causal connection to the January 6, 2015 work-related injury.

The Commission disagrees with Respondent's position and the Arbitrator's conclusion that this injury represented an intervening accident. The Commission finds that Petitioner's injury to her right shoulder on May 8, 2016 did not completely break the causal chain between the original work-related injury and the ensuing condition. The Commission notes that Petitioner's right shoulder condition had not completely healed as of December 15, 2015, and Dr. Gurtler had not declared Petitioner to be at maximum medical improvement (MMI). Petitioner was symptomatic then and continued to be symptomatic in and around the same area of her right shoulder after the May 8, 2016 accident. On May 10, 2016, Dr. Gurtler's examination demonstrated anterior tenderness and positive impingement. Dr. Gurtler also reviewed x-rays dated May 8, 2016 and an updated MRI of the right shoulder. Although no acute injury was noted, Petitioner was experiencing sharp/stabbing pain, she had limited motion due to pain, and the pain was worse, especially over the superior and anterior aspect of the shoulder. (PX1; PX2; RX7).

The Commission additionally notes that as of May 14, 2015, Dr. Glock indicated that he would consider a re-evaluation of Petitioner's biceps tendon area if she remained symptomatic six to 12 months later. Despite an approximate five-month gap in treatment, the evidence establishes that as of May 14, 2015, the doctors were considering the biceps tendon as a possible explanation for her on-going pain, and Petitioner's right shoulder pain never fully went away. She then sustained a non-work-related injury while doing the dishes at her home. The Commission finds that this incident does not constitute an intervening accident as Petitioner was never placed at MMI or was symptom-free, and the doctors had not ruled out continued issues in the biceps tendon area and right shoulder. Therefore, the Commission finds that Petitioner's current condition of ill-being as to her right shoulder remains causally related to the January 6, 2015 work injury; and, the award for medical bills and TTD is adjusted accordingly.

Respondent had disputed liability for medical bills and TTD benefits after May 8, 2016. The Commission having found continuing causal connection, further finds that Petitioner is entitled to all reasonable and necessary medical bills as detailed in Petitioner's Exhibits 10 through 16, as well as TTD from April 8, 2015 through May 22, 2015, and May 8, 2016 through January 11, 2017. The evidence demonstrates and Petitioner testified that she last treated for her right shoulder on January 11, 2017. (T.44; PX9).

The Commission further vacates the Arbitrator's award of penalties under Section 19(l) of the Act as the Commission finds that a genuine dispute existed between the parties as to the issues of jurisdiction and accident. The remainder of the Arbitrator's Decision is affirmed.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed November 27, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical bills as detailed in Petitioner's Exhibits 10 through 16, pursuant to Section 8(a) of the Act and to be adjusted in accord with the medical fee schedule provided in Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall receive credit for medical bills paid through its group medical plan as provided in Section 8(j) of the Act. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $560.17 per week for 42 weeks, commencing April 8, 2015 through May 22, 2015, and May 8, 2016 through January 11, 2017, 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 $3,441.69 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $504.16 per week for a period of 62.5 weeks, as provided in Section 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 the Arbitrator's award of penalties under Section 19(l) of the Act is hereby vacated.

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 $51,700.00. 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 the Circuit Court.

DATED: AUG 30 2019

D. Douglas McCarthy

Stephen Mathis

DDM/pm
O: 7-3-19
052

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DISSENT

Pursuant to the Illinois Workers' Compensation Act (the Act), Illinois may acquire jurisdiction for injuries sustained by "persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois..." *820 ILCS 305/1(b)2* (West 2013). "A contract for hire is made where the last act necessary for the formation of the contract occurred. [citations omitted]." *Cowger v. The Industrial Commission*, 313 Ill. App. 3d 364, 370, 728 N.E.2d 789 (2000). I find the last act necessary was Respondent's decision to hire Petitioner once she completed the drug testing and safety training all of which occurred in Indiana and not Illinois. Therefore, I respectfully dissent.

"In determining whether an employment contract has been formed, it is appropriate to give consideration to principles of contract law. See *Board of Education v. Industrial Comm'n*, 53 Ill. 2d 167, 290 N.E.2d 247 (1972) (applying principles of mutual assent, consideration, and conditions precedent)." *Cowger* at 370. For a contract to form there must be a meeting of the minds and mutual acceptance by both parties. "As stated in *Rosin v. First Bank (1984), 126 Ill. App. 3d 230, 234, 466 N.E.2d 1245, 1249*, concerning an auction and contract, the court stated: 'To be valid, an acceptance must be objectively manifested, for otherwise no meeting of the minds would occur.'" *Energy Erectors, Ltd. v. Industrial Commission*, 230 Ill. App. 3d 158, 163, 595 N.E.2d 641 (1992). In *Energy Erectors*, the court in reversing the Commission's determination that a contract for hire was made in Illinois highlighted that the claimant was required to report to the job site in order for his employment to commence. The court further quoted Professor Larson

> 'That the place of acceptance is the place of contract, raises the question in some cases whether the claimant's understanding at the time he sets out toward the second state is a true acceptance of a contract or merely an expectation or hope.

> A general statement that if the claimant came to the state he would be given a job * * * has been held to fall short of acceptance of an employment contract in the state where claimant received the message.' *Id.* at 163.

Here, Petitioner testified she was provided a referral by her union for potential employment in Indiana. T. 27. A few days after obtaining the referral, Petitioner travelled to Indiana to the job site where she completed paperwork which included an application for employment at Respondent. T. 28. Petitioner was then required to attend an eight-hour safety course/training. T. 29. The safety training was mandatory and without completion of the training, she would not be allowed onto the job site. T. 33. Once Petitioner completed all the necessary requirements, she was then provided with a unique employee number from Respondent. T. 32. Moreover, Petitioner testified as follows:

> Q. You could be called to a job site and they can reject you?
> A. Yeah.
>
> Q. So when you went to Indiana there was no guarantee that you were – that you were just an applicant showing up on the job site when you appeared in Indiana on July 21, 2014?
> A. Yeah.
> Q. And the company had a right to reject, reject you for, you know, any legitimate, any legitimate reason?
> A. Yes.
> Q. For instance, if you didn't finish your safety training?
> A. Yes.
> Q. Or you didn't pass your drug screening?
> A. Yes. T. 45-46.

Mr. Chris Lamberson, the assistant vice president of operations for the Midwest for Respondent testified as to the hiring protocol. Mr. Lamberson testified as to the International Brotherhood of Electrical Workers' agreement which required Respondent to work with Local 538 to obtain electricians. T. 58. Mr. Lamberson explained an apprentice electrician was required pursuant to the union contract to present for possible employment. T. 63. Mr. Lamberson identified Respondent's Exhibit 4, the labor agreement specifically Section 4.02 which states "the union shall have the sole and exclusive source of referral of applicant for employment." T. 64. Mr. Lamberson

explained, "Once contacted the employee, or the request for manpower for the employees they get a referral. They show up at the date it was requested or within 48 hours of whenever it was requested, and then they go through a series of requirements in order to become an employee of our company." T. 66. Mr. Lamberson confirmed Petitioner's testimony that Respondent had the right to reject Petitioner upon her presentation to the job site. T. 68. Mr. Lamberson also confirmed Petitioner's testimony that she was required to fill-out the necessary paperwork, pass a drug test, and complete the safety training only after which she was provided a unique employee number. T. 68-69.

The majority in finding the last act necessary for the formation of the employment contract to be the call from the referral agent in Illinois ignores both the testimony of Petitioner and Mr. Lamberson that Petitioner was required to present to the job site, complete an employment application, pass a drug test, and complete an eight-hour safety training all in Indiana before she would be hired. In arriving at its decision, the majority relies on *Hunter Corp. v. Industrial Commission*, 268 Ill. App. 3d 1079, 645 N.E.2d 259 (1994), which was subsequently rejected by the Court five years later in *Correct Constr. Co v. Industrial Commission*, 307 Ill. App. 3d 636, 718 N.E.2d 577 (1999), a case which is seemingly directly on point.

In *Correct Constr.*, the claimant, a union pipe fitter received a telephone call in Illinois from his union business agent wherein he agreed to accept a job in Whiting, Indiana. Claimant reported to the job site and was required to complete an application, present his drug screening card, and attend a safety training. Pursuant to the contract, the union was the exclusive referral agent for the employer, and the employer retained the right to reject a referred employee. The Commission found the last act necessary for formation of the employment contract was claimant's acceptance of the offer of employment which occurred in Illinois. *Id.* at 638-640.

The Appellate Court reversed finding the last act necessary was the employer's decision to hire claimant which occurred in Indiana. The Court rejected claimant's argument that the union was the employer's exclusive hiring agent but instead found it to be the exclusive referral agent. The Court noted:

> This language clearly contemplates that the last act necessary for contract formation is the employer's decision to hire the referred Union member. The agreements expressly state that the employer has the "exclusive right to accept or reject persons referred for employment." They also consistently distinguish between a Union member's acceptance of an employment referral and the employer's decision to hire that individual. Additionally, the employer, and not the Union, determines whether a referral is qualified for the available position. *Correct Constr. Co v. Industrial Commission*, 307 Ill. App. 3d 636, 641 (1999).

The Court went on to state:

> Claimant was required to demonstrate that he passed a screening for illegal drug use, verify that he was eligible to work in the United States, fill out various forms, and attend a four-hour safety seminar. If claimant had failed to fulfill any one of these requirements, or if he had not otherwise been qualified, Correct would not have hired him, and he would not have been paid for his time. After determining that claimant was qualified to fill the position, Correct decided to hire him, which was the last act necessary to form the employment contract. As this event occurred in Indiana, Illinois does not have jurisdiction over this matter. *Id.* at 644.

The Court then analyzed the factors relied upon in *Hunter Corp. v. Industrial Commission*, 268 Ill. App. 3d 1079, 645 N.E.2d 259 (1994) and rejected the same. The Court reasoned in *Hunter*, claimant was 1) entitled to 2 hours show-up pay; 2) not required to complete an employment application upon arrival at the job site; and 3) if not hired, a grievance would be filed. "Moreover, it is important to note that in the instant case the relevant agreements were included in the record on appeal. And although there are similarities between Hunter and the instant case, the precise details of the hiring agreements at issue were not provided in Hunter." *Id.* at 645.

In the present matter, the facts are strikingly similar to those presented in *Correct Constr. Co.* The Union Agreement states: "Section 4.02 – Source – The Union shall be the sole and exclusive source of referral of applicants for employment. Section 4.03 –

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Rejection – The Employer shall have the right to reject any applicant for employment." RX4. As in *Correct*, the Union is the exclusive referral agent for Respondent. As in *Correct*, Respondent retains the sole right to hire the referred member. As in *Correct*, Petitioner was required to complete an employment application upon presentation to the job site; pass a drug screening; and complete a safety training course. As in *Correct*, the last act necessary for the formation of the employment contract was Respondent's decision to hire Petitioner which occurred in Indiana. As in *Correct*, Illinois simply does not possess jurisdiction over this matter.

For the reasons set forth above, I conclude Petitioner is not entitled to benefits as no jurisdiction exists under the Illinois Workers' Compensation Act. As such, I would reverse the decision of the arbitrator. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LUTZ, LEAH L
Employee/Petitioner

Case# **15WC009163**

INDUSTRIAL CONTRACTORS SKANSKA
Employer/Respondent

19IWCC0476

On 11/27/2018, 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 2.47% 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:

1551 STOKES LAW OFFICES
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2097 FANNING & OLSEN
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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

Leah L. Lutz
Employee/Petitioner

v.

Industrial Contractors Skanska
Employer/Respondent

Case # **15** WC **9163**

Consolidated cases: **N/A**

19IWCC0476

An *Application for Adjustment 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 **Urbana**, on **6/29/18**. 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. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

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FINDINGS

On **1/6/15**, 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 $**20,166.14**; the average weekly wage was $**840.26**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**3,441.69** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,441.69**.

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

ORDER

Respondent shall pay reasonable and necessary medical services incurred up to 5/8/16, as provided in Sections 8(a) and 8.2 of the Act. Expenses incurred on or after 5/8/16 are 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.

Respondent shall pay Petitioner temporary total disability benefits of $**560.17**/week for **6 3/7** weeks, commencing **4/8/15** through **5/22/15**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**3,441.69** for temporary total disability benefits that have been paid.

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 $**504.16**/week for a further period of **62.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **12.5% loss of use of the person as a whole**.

Respondent shall pay to Petitioner penalties of $**10,000.00**, as provided in Section 19(l) of the Act.

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

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

Michael K. Nowak, Arbitrator

11/20/18
Date

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FINDINGS OF FACT

Petitioner is a union electrician. She is a member of the International Brotherhood of Electrical Workers, Local 538 in Danville, Illinois. Respondent is an Evansville, Indiana based electrical contractor. Local 538 and the National Electrical Contractors Association operate under a Labor Agreement (RX4). Respondent is bound by the Agreement's terms and conditions.

The Agreement provides that employers are required to make contributions to the Illinois Unemployment Compensation Commission, maintain Workers' Compensation Insurance with a company licensed to do business in the State of Illinois, and recognize the Union as the sole and exclusive representative of all employees (RX4). It is considered a material breach of the Agreement for an employer to use any employee not recognizing the IBEW as their representative (RX4, Section 2.10).

Petitioner was an electrician apprentice in July 2014. She worked for Respondent from July 21, 2014 through March 2015 at Duke Energy in Cayuga, Indiana. The normal work schedule was 10 hours per day, six days per week. The Agreement states, "Apprentices shall be hired and transferred in accordance with the apprenticeship provisions of the Agreement between the parties" (RX4, Section 4.20).

Section 3.06 of the agreement provides, in pertinent part, "When men are directed to report to a job and do not start work due to weather conditions, lack of material, or other causes beyond their control, they shall receive one (1) hours pay...." (RX4, Section 3.06). Subpart (b) of section 3.06 provides the only limit to this provision and states "[e]mployees not meeting the employment qualifications of either the Employer of the customer shall not be entitled to show-up pay when either substance abuse or alcohol is involved."

Section 4.03 of the agreement provides "[t]he Employer shall have the right to reject any applicant for employment."

Article V of the Agreement covers Apprenticeship and Training (RX4). The Joint Apprenticeship & Training Committee (JATC) is responsible for training apprentices. Local 538 employed Cathy Porter as the Training Director to oversee training and job assignments. The Agreement states, "...the JATC, as the program sponsor, shall have full authority for issuing all job training assignments and for transferring apprentices from one employer to another" (RX4, Section 5.06). The JATC is to make every effort to honor the request of an employer when the employer requests an apprentice (RX4, Section 5.09).

Chris Lamberson testified on Respondent's behalf. In 2014, Mr. Lamberson was Respondent's Project Manager. Mr. Lamberson testified that Respondent contacted Local 538 to get electricians for the Duke Energy project. He also testified that they could not ask for specific employees and that apprentices do not have a choice where they work once they are contacted by their training director. According to Mr. Lamberson, once the apprentice gets the referral from the union they are making a commitment to go to the location and work for the contractor.

Petitioner testified that she was called by her training director and told to report to Respondent's job site. Upon arrival, she filled out tax forms, took safety training, was issued safety equipment, and went to work. She was paid for the time spent in safety training. Petitioner testified she would have been paid if she reported to the job site and Respondent would not let her work.

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The Arbitrator notes that Respondent's wage records show that Petitioner was paid a full 10 hours on July 21, 2014, the day she first reported to Respondent's job site.

Petitioner' job duties included pulling wires, running conduit, and some material handling. She worked ten hours a day, six days a week. Petitioner is 5'4" and 126 pounds. The majority of Petitioner's work was overhead. Petitioner lifted items that weighed as much as her. While performing her job duties for Respondent, Petitioner began to notice right arm pain. She continued to work, but the pain persisted.

When the pain became too much, she went to see Dr. Robert Gurtler. Dr. Gurtler examined Petitioner on January 6, 2015. Dr. Gurtler ordered a right shoulder MRI (PX1). The January 29, 2015 MRI exhibited a longitudinal tear of the biceps tendon, tendinosis and tears at the insertion of the supraspinatus and infraspinatus tendons, and a torn labrum (PX2).

Petitioner returned to Dr. Gurtler on February 3, 2015. Dr. Gurtler commented that Petitioner did a lot of heavy work and a lot of overhead work (PX1). Dr. Gurtler recommended surgery (PX1). Due to some issues with an old bill, Petitioner was unable to get surgery from Dr. Gurtler.

Petitioner went to Dr. Christopher Glock on February 24, 2015 (PX4). Dr. Glock found a positive apprehension test, positive relocation test, positive speed's test, and pain upon palpation (PX4). Dr. Glock ordered physical therapy (PX4). Petitioner began physical therapy on March 4, 2015 (PX5).

Petitioner returned to Dr. Glock on March 31, 2015. The physical therapy was not helping, so Dr. Glock recommended surgery (PX4). Dr. Glock performed a right shoulder arthroscopy with subacromial decompression and a distal clavicle excision on April 8, 2015 (PX6). Petitioner worked up until the day of her surgery. Petitioner followed up with Dr. Glock on April 15, 2015. Dr. Glock ordered physical therapy (PX4). Petitioner was off work through May 22, 2015. Dr. Glock examined Leah for the final time on September 25, 2015. Petitioner was able to work but was still having right shoulder pain (PX4). Dr. Glock released her from his care.

Respondent sent Petitioner to Dr. Guido Marra on July 21, 2015 for a Section 12 examination. Dr. Marra recommended a MR arthrogram (RX5). Dr. Marra was deposed on April 6, 2018 (RX5). Dr. Marra believed Petitioner's right shoulder condition was work-related (RX5, p.12, 17, 18).

Petitioner returned to Dr. Gurtler on December 15, 2015. Petitioner had decreased range of motion and right shoulder pain (PX1). Dr. Gurtler recommended surgery (PX1). Petitioner continued to work with the right shoulder pain. No additional surgery was performed.

On May 8, 2016, Petitioner went to the emergency room with right shoulder pain (PX8). Petitioner reported that her right shoulder popped while doing dishes (PX8). An x-ray performed the same day did not reveal any acute abnormality (PX2). Petitioner was instructed to see Dr. Gurtler (PX8). Dr. Gurtler ordered a new MRI and restricted Petitioner from work (PX1). The October 18, 2016 MRI revealed postoperative changes and rotator cuff tendinosis (PX2). Dr. Gurtler recommended an injection on October 20, 2016 (PX1). The injection did not help, so Dr. Gurtler recommended a second opinion (PX1).

Dr. Gary Misamore examined Petitioner on January 11, 2017. Dr. Misamore's impression was chronic right shoulder pain (PX9). He did not recommend surgery (PX9). Dr. Gurtler then released Petitioner from his care.

Petitioner continues to work and her right shoulder pain persists. She takes Tylenol to help deal with the pain. She learned to deal with the pain as best as she can.

CONCLUSIONS

Issue (A): Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

The Supreme Court of Illinois held, "...we hold that the place of the contract for hire is the sole determining factor for the existence of jurisdiction over employment injuries occurring outside this state," *Mahoney v. Indus. Comm'n*, 218 Ill.2d 358, 374 (2006).

The facts in this case are strikingly similar to those in *Hunter Corp. v. Industrial Comm'n*, 268 Ill.App.3d 1079 (1st Dist., 1994). In *Hunter*, claimant was a journeyman boilermaker who was injured at a job site in Indiana. *Id* at 1080. The parties' relationship was governed by a labor agreement and the only way for Respondent to hire Petitioner was through the union. *Id* at 1080-1081. The claimant was contacted by the union and told to report to the Indiana job site. *Id* at 1081. The Appellate Court ruled that the contract for hire was made in Illinois. *Id* at 1084. Both the Commission and the Appellate Court in *Hunter* found it significant that if the employee showed up at the job site and was not allowed to work he would be entitled to show up pay of two hours wages. The Arbitrator also notes that the Claimant in *Hunter* also filled out paper work upon arriving at the job site.

In this case Respondent contacted Petitioner's union to request apprentices. Petitioner's training director called Petitioner and informed her to report to the job site in Indiana. The parties are governed by a labor agreement, the only way Respondent could hire Petitioner was by going through the union, Petitioner did not have the ability to turn work down, and the union was Petitioner's exclusive representative.

Respondent was required to have Illinois Workers' Compensation Insurance and pay into Illinois unemployment. Petitioner's union dues were deducted from her pay and sent to her union hall in Illinois. Petitioner's group health plan is based and administered in Illinois.

The Arbitrator finds that as in Petitioner's contract for hire was made when the phone call was placed to Petitioner's union hall in Illinois and Petitioner was given a referral to the job site. The Arbitrator therefore finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act.

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

There is no dispute that Petitioner suffered a work-related injury to her right shoulder while she was employed by Respondent. Respondent's Section 12 examiner related Petitioner's right shoulder injury to her work for Respondent (RX5, p.12, 17, 18). Dr. Gurtler authored a narrative report that concluded Petitioner's right shoulder condition was attributable to her work for Respondent (PX7).

The dispute is whether the May 8, 2016 incident was an intervening cause or a contributing cause. In this case Petitioner had returned to work as an electrician following her release on September 25, 2015. Although Petitioner returned to Dr. Gurtler on December 15, 2015 with shoulder complaints and he recommended surgery there was no surgery and Petitioner continued to work without any additional medical treatment until the May 8, 2016 accident.

Following the May 8, 2016 accident, which Dr. Gurtler referred to as a new injury, Petitioner was restricted from work and began treating actively once again.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds the incident of May 8, 2016 was an intervening accident which broke the chain of causation. The Arbitrator further finds that Petitioner's condition of ill-being up to May 8, 2016 was causally related to the stipulated work accident of January 6, 2015.

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

Petitioner testified she worked ten hours a day, six days a week and that overtime was mandatory. Respondent offered no rebuttal. In fact, Mr. Lamberson testified that Leah made a commitment to work 60 hours a week. Article III of the Agreement makes it clear that all work performed outside the regular working hours shall be paid at the overtime rate (RX4).

Petitioner worked 24 weeks for Respondent before her date of accident. Petitioner's overtime hours were regular and consistent throughout the 24-week period. Petitioner's overtime hours are therefore included at the straight time rate for the purpose of determining the average weekly wage. It is clear from Petitioner's wage records that she earned $20,166.14 in the 24 weeks she worked before the accident (RX3).

The Arbitrator finds Petitioner's average weekly wage is $840.26.

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

Respondent is only challenging liability for the medical bills incurred May 8, 2016 and after. Petitioner's medical bills were admitted into evidence (PX10-16). Based upon the Arbitrator's causal connection finding, Respondent will pay directly to Petitioner the medical fee schedule amounts for any unpaid bills incurred prior to May 8, 2016. Respondent will receive the appropriate 8(j) credit for the bills paid by Petitioner's group insurance and hold Petitioner harmless from any claim of subrogation from the group carrier.

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

Respondent does not challenge liability for the April 8, 2015-May 22, 2015 TTD benefits. They only challenge the TTD benefits from May 8, 2016-January 16, 2017. Respondent eventually paid $3,441.69 in TTD benefits for the first time period. Based upon the Arbitrator's findings on causation above, Petitioner's claim for TTD benefits following May 8, 2016 is denied.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner continues to work as a journeyman electrician. This is a physical and demanding job. Petitioner notices pain while performing her job duties. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 35 years old on the date of accident. Petitioner has a long work life ahead of her in a physically demanding job. 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 there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness.

Petitioner's work involves a great deal of lifting and overhead work. Petitioner testified she still has right shoulder pain when she works. She has learned to work and live with her pain but does take Tylenol to help ease her right shoulder pain.

The medical evidence corroborates Petitioner's complaints. The January 29, 2015 MRI revealed torn tendons and a torn labrum in Petitioner's right shoulder (PX2). Dr. Glock's post-operative notes reveal Petitioner continued to complain of right shoulder soreness, right shoulder, pain, and right shoulder decreased range of motion (PX4). Dr. Gurtler's December 15, 2015 office note mentioned Petitioner had right shoulder pain and decreased range of motion (PX1). Petitioner was still having right shoulder pain, stiffness, and weakness when she saw Dr. Misamore in January 2017 (PX9). The Arbitrator therefore gives *greater* weight to this factor.

Based upon the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

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Issue (M) **Should penalties or fees be imposed upon Respondent?**

Petitioner is seeking 19(l) penalties for Respondent's failure to pay TTD benefits in a timely manner. Respondent failed to present any testimony or provided any reason why they failed to pay TTD benefits until 787 days after Petitioner demanded they be paid. Since Respondent failed to follow the clear language of Section 19(l), Petitioner is entitled to penalties.

The Arbitrator awards Petitioner $10,000 in Section 19(l) penalties.