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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mike McCanna,

Petitioner,

vs. NO: 14WC 22581

Pace Heritage,

Respondent.

20 IWCC0644

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, temporary total disability and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission notes the matter proceeded to arbitration before Arbitrator Falcioni, and by agreement of the parties, a decision was rendered by Arbitrator Seal.

Permanent Partial Disability Benefits

Pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101):

Section 8.1b(b)(i) – level of impairment

Neither party obtained an impairment rating; as such, the Commission assigns no weight to this factor.

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

At the time of the accident, Petitioner was employed as a maintenance mechanic. Petitioner was released to return to work but was unable to return to his pre-accident position due

to an unrelated hearing issue. T. 50. Petitioner tested into the medium-to-heavy job demand range during his functional capacity evaluation of April 8, 2015. PX7. On May 19, 2015, Petitioner was released to return to work with restrictions of no overhead work and a 25-pound lifting restriction. PX2. The Commission notes that overhead work is required for at least a small portion of Petitioner's workday. The Commission finds this factor weighs in favor of an increased permanence.

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

Petitioner was 58 years-old on the date of accident. Petitioner was unable to return to his job for reasons unrelated to the work injury and retired. The T. 50. The Commission finds this factor weighs in favor of a decreased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner provided no testimony regarding his future earning capacity. The Commission affords no weight to this factor.

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

Right Shoulder

Petitioner suffered a right shoulder partial rotator cuff tear which required a shoulder arthroscopy with distal clavicle resection, limited debridement of the glenohumeral joint, subacromial decompression and subpectoral biceps tenodesis. PX2, 6. Petitioner testified his shoulder constantly bothers him as it clicks and hurts throughout the day. T. 44. This is corroborated by the medical records of Dr. Hurbanek which memorialize Petitioner's complaints of pain and stiffness as well as a decrease in range of motion. PX2.

Head

Records from Dr. Gelbort corroborate that Petitioner suffered a traumatic brain injury in the form of a concussion. Dr. Gelbort felt that Petitioner's right cerebral hemisphere was impaired by the injury and recommended cognitive retraining. PX4. Petitioner testified the injury affects his ability to perform mechanical work as he finds himself easily frustrated. T. 42. Petitioner testified he avoids the social interactions which he enjoyed pre-injury, and he experiences increased depression and anxiety. T. 43. Petitioner did not submit treatment records from his counselor, Cosmo Lazano. The Commission finds this factor weights in favor of an increased permanency.

Based on the above, the Commission finds Petitioner sustained permanent partial disability to the extent of 20% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act as a result of the injury to his shoulder.

Additionally, the Commission finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the person as a whole pursuant to section 8(d)2 of the Act as a result of the injury to his head.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2018, as modified above, is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services of $882.10, which consist of the following bills: Silver Cross $321.90, Adult Medical Associates $560.20, as provided in §8(a) and §8.2 of the Act. Respondent shall have credit for all amounts previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay temporary total disability benefits of $639.18 per week for 48-4/7 weeks, commencing June 4, 2014 through May 20, 2015, as provided in Section 8(b) of the Act.

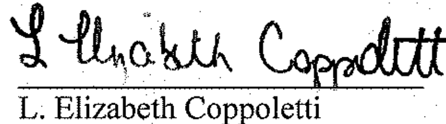
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $575.26 per week for a period of 125 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 25% loss of use of the person as a whole.

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.

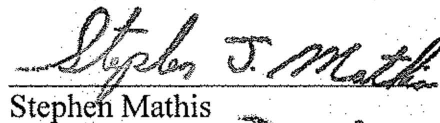
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 5 - 2020

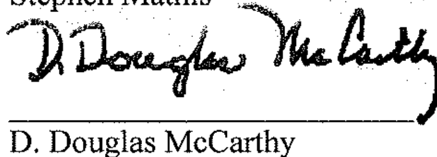

L. Elizabeth Coppoletti

LEC/cak

O: 8.26.2020


Stephen Mathis

43


D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MCCANNA, MIKE
Employee/Petitioner

Case# **14WC022581**

PACE HERITAGE
Employer/Respondent

20IWCC0644

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:

4678 PARENTE & NOREM PC
PARAG P BHOSALE
221 N LASALLE ST
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
900 COMMERCE DR
STE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mike McCanna,
Employee/Petitioner

v.

Pace Heritage,
Employer/Respondent

Case # **14** WC **22581**

Consolidated cases: ______

20IWCC0644

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni** , Arbitrator of the Commission, in the city of **New Lenox**, on **July 11, 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] 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 **6/4/14**, 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 $**49,856.01**; the average weekly wage was $**958.77**.

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

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

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

Respondent shall be given a credit of $**31,958.50** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**31,958.50**.

ORDER

Medical benefits

The respondent shall pay reasonable and necessary medical services of $882.10, which consist of the following bills: Silver Cross $321.90, Adult Medical Associates $560.20, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

The respondent shall pay the petitioner temporary total disability benefits of $639.18/week for 48 4/7ths weeks, commencing 6/04/2014 through 5/20/2015, as provided in Section 8(b) of the Act.

Permanent Partial Disability

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report or opinion was submitted into evidence. Therefore, the Arbitrator 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 the petitioner was employed as a preventive maintenance mechanic at the time of the accident and currently is retired. He is not able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that the petitioner was required to lift materials up to 75 pounds and perform mechanical bus repairs on various parts. Therefore, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that the petitioner was 58 years old at the time of the accident. Because of his age and his retirement, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), the petitioner's future earnings capacity, the Arbitrator notes that the petitioner is unable to perform mechanical duties as a result of his accident, and he retired. Therefore, the Arbitrator gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the petitioner suffered a shoulder injury requiring surgical repair as well as a head injury. Therefore, the Arbitrator gives greater weight to this factor.

Based on all of the above factors, the testimonial and documentary evidence of record taken as a whole, the Arbitrator finds that the petitioner sustained permanent partial disability to the extent of 30% loss of use of the person as a whole pursuant to §8(d) (2) of the Act, 150 weeks compensation at a weekly rate of $575.26.

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 14, 2018
Date

AUG 14 2018

STATEMENT OF FACTS

The parties tried this instant case July 11, 2017, before Arbitrator Robert Falcioni in New Lenox. The parties agreed to Decision of Arbitrator by another Arbitrator based on Transcript of Proceedings on Arbitration and the parties' exhibits and proposed findings. The parties disputed causal connection, medical bills, temporary total disability benefits, and nature and extent of permanent disability. The parties stipulated to accident, notice, and all other issues.

The petitioner was a preventive maintenance mechanic for the respondent for over 20 years. (TA 28-29) His duties included inspecting buses, checking floors, fluids, and looking for things that were worn out. At times, it was his responsibility to repair something on the bus if it was broken. (TA 30) His work duties involving lifting included working on alternators, batteries, tires, and brakes. (TA 32)

On June 4, 2014, the petitioner was working under a bus when a leaf spring blew. (TA 35) Immediately after, he was bleeding from his nose and head. (TA 36) The petitioner was taken to Silver Cross Hospital emergency room. (TA 36)

The petitioner saw Dr. Kamran Khan of Cadence Physician Group June 9, 2014. (PX4) His records indicate that a CT scan of the petitioner's brain was negative for any intra cranial process. Dr. Khan's diagnosis was a head injury resulting in facial contusion.

The petitioner also treated with Dr. Hurbanek at Hinsdale Orthopaedics for complaints of right shoulder pain. (PX2) The petitioner first saw Dr. Hurbanek June 26, 2014. (PX2, pg. 6) Dr. Hurbanek performed surgery on the petitioner's right shoulder on December 5, 2014. The procedures included right shoulder arthroscopy with distal clavicle resection, limited debridement of glenohumeral joint, and arthroscopically assisted subpectoral biceps tenodesis.

(PX6) Post-operatively, the petitioner attended physical therapy and work conditioning. (TA 38) On April 8, 2015, the petitioner completed FCE at ATI Physical Therapy. (PX7) It was noted that his job with the respondent classifies as a medium physical demand level position. (PX7, pg. 1) The FCE indicated that the petitioner's capabilities met and exceeded that level, and that he could work at a medium to heavy physical demand level. During the FCE, the petitioner occasionally was able to lift over 75 pounds. (PX7) Dr. Hurbanek discharged the petitioner from work conditioning on May 11, 2015, signing off on a report placing him at a work level of medium to heavy physical demand. (RX8, pg. 27)

On June 25, 2014, the petitioner saw Dr. Anthony Stevens at Center for Neurological Diseases. He complained of headaches and dizziness. (PX5) Dr. Stevens noted that headaches are symptoms of post-traumatic syndrome and might last months. (PX5, pg. 12) In addition to headaches and dizziness, the petitioner reported a lifelong problem with hearing loss from exposure to noise. (PX5) On August 14, 2014, the petitioner underwent MRI of the brain. The report indicated degenerative changes and age appropriate cortical atrophy. (PX 5 pg. 14) The petitioner returned to Dr. Stevens August 19, 2014. Dr. Stevens noted that the MRI was unremarkable. (PX5)

On December 3, 2014, the petitioner returned to Dr. Stevens. Dr. Stevens noted that the petitioner was depressed and had flat affect. He suggested changing the petitioner's anti-depressant. (PX5) The petitioner then presented for a neuropsychological evaluation with Dr. Gelbort in February and March of 2015. Dr. Gelbort noted that the petitioner suffered a concussion and showed clear indications of depression. (PX5) Dr. Gelbort stated that:

> It appears that Mr. McCanna has suffered a concussion based on these data but his emotional reaction is somewhat extreme and further exacerbates his condition. It may be helpful to reevaluate his mood stabilizing medications to see if his mood cannot be improved upon. It is also highly likely that based on his history of having been gifted mechanically that his non-dominant (likely right) cerebral hemisphere has been impaired by his injury. (PX5)

The petitioner's last appointment with Dr. Stevens was March 31, 2015, at which time Dr. Stevens followed Dr. Gelbort's suggestion and started the petitioner on low dose Depakote as a mood stabilizer. The petitioner was to follow up in three months or as needed. (PX5)

The petitioner testified that prior to June 24, 2014, he worked on his car, motorcycle, and tasks around the house. (TA 41) He testified that after his accident, he does not fix things around the house to the same extent because he gets frustrated and drops things. (TA 42)

The petitioner testified that he continues to treat with a counselor named Cosmo Lazano for anxiety. (TA 48) At completion of treatment with Hinsdale Orthopaedics, the petitioner returned to his position at Pace. (TA 50) On May 26, 2015, he resigned from Pace. (TA 50; RX3)

At the respondent's request, the petitioner attended two separate examinations with Dr. Brian Neal under section 12 of the Act. (RX4) Dr. Neal first examined the petitioner on October 20, 2014, prior to shoulder surgery. (RX4) The petitioner told Dr. Neal that the concussion symptoms would not have prevented him from returning to work. (RX4) Dr. Neal next examined the petitioner on May 11, 2015. He examined medical records, including those from Hinsdale Orthopaedics. He noted that the injection performed by Dr. Hurbanek in April 2015 was an injection to treat arthritis, not symptoms related to an acute shoulder injury. (RX4) That arthritis pre-existed the June 2014 work accident. The petitioner communicated that he only has pain in his right shoulder when he performs activity with his right arm above his head, but that he has no

problems with activity below shoulder level. (RX4) The petitioner also noted that he was not doing the home exercises that he was instructed to by physical therapy. (RX4)

Brian Findlay testified on behalf of the respondent. He was the petitioner's supervisor prior to the June 2014 work accident. (TA 61) He testified that in June 2015, the petitioner returned to Pace to retrieve his personal tool box. (TA 65) The tool box was made of steel, approximately 4½ feet tall and 2½ feet wide. The tool box was filled with the petitioner's tools (TA 66) and weighed about 200 pounds. The petitioner lifted the tool box approximately four feet from the ground with the help of three other people, and they placed it in the back of his truck. (TA 67) The petitioner then loaded cardboard boxes filled with his tools into the back of his truck. (TA 68)

The parties stipulated that the respondent paid $31,958.50 in temporary total disability benefits starting June 5, 2014, and ending May 20, 2015.

CONCLUSIONS OF LAW

The claimant has the burden of proving by the preponderance or the greater weight of the evidence all elements required to establish the liability of the employer, and liability cannot be based upon imagination, speculation, or conjecture. *Illinois Bell Telephone Company v. Industrial Commission*, 265 Ill.App.3d 681 (1994); *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980)

With regard to (F), is the petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds the petitioner's conditions of post-operatively resolved right shoulder partial rotator cuff tear, subacromial impingement, and superior labral tear and resolved concussion to be causally related to the work accident. Dr. Gelbort further opined that:

> It is also highly likely that based on his history of having been gifted mechanically that his non-dominant (likely right) cerebral hemisphere has been impaired by his injury. (PX5)

The parties stipulate that the petitioner suffered an accident arising out of and in the course of his employment. The Arbitrator finds that the petitioner's current condition of ill-being is causally connected to the work injury of June 4, 2014. Prior to his work injury, the petitioner never had a shoulder injury or shoulder pain. He had no medical treatment for his right shoulder. Following the incident, the petitioner began to feel pain in his right shoulder. The Arbitrator finds the petitioner's testimony consistent with and supported by the medical evidence of Dr. Jason Hurbanek. (PX2)

Prior to the work injury, the petitioner occasionally treated for depression; however, he never suffered any head trauma or traumatic brain injury. Following the accident, the petitioner's depression worsened, his anxiety and frustration increased, and he was unable to successfully complete mechanical tasks that he was able to prior to the accident. This is unrebutted.

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 Co. v. Industrial Comm'n,* 93 Ill. 2d 59, 63 That is, if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration. *Schroeder v. Illinois Workers' Compensation Comm'n,* 2017 IL App (4th) 160192WC, ¶ 26. It is well-established that an accident need not be the sole or primary cause – as long as employment is a cause – of a claimant's condition. Id. at ¶28, citing *Sisbro, Inc., v. Industrial Comm'n*, 207 Ill 2d 193, 205 (2003) That there was a preexisting condition with a separate cause is not relevant as long as the accident at issue was a cause of the claimant's condition of ill being. Id. at ¶29

The Arbitrator gives great weight to the fact that the petitioner testified that his frustration and depression have increased, and his ability to do mechanical tasks has deteriorated since his accident. The Arbitrator further looks to the medical records and neurological evaluation of Dr. Anthony Stephens and Dr. Michael Gelbort, respectively. (PX5) The Arbitrator finds that the petitioner's testimony is corroborated by the medical records.

With regard to (J), were medical services provided reasonable and necessary and has the respondent paid all appropriate charges, the Arbitrator finds the following:

The Arbitrator finds that the respondent paid for some of the petitioner's reasonable and necessary charges.

The petitioner claims that the respondent is liable for unpaid medical bills from Silver Cross in the amount of $321.90. (AX1) The respondent asserts that no corresponding medical records were introduced to support this bill amount. The Arbitrator finds that Petitioner's Exhibit 1, the records of Dr. Diana M. Burda, includes records of Silver Cross sufficient to prove the treatment provided as well as causal connection to the petitioner's work injury. The respondent shall pay Silver Cross bill in the amount of $321.90.

The petitioner also claims that the respondent is liable for unpaid medical bills from Center for Neurological Diseases in the amount of $945.00. (AX1; PX9) An invoice from Center for Neurological Diseases dated May 13, 2015, was admitted into evidence as Petitioner's Exhibit 9. However, that invoice conflicts with the billing ledger also contained in Petitioner's Exhibit 9 showing no balance due.

Lastly, the petitioner claims that the respondent is liable for unpaid medical bills from Adult Medical Associates in the amount of $560.20. (AX1; PX9) The respondent shall pay Adult Medical Associates bill in the amount of $560.20.

With respect to (K), what temporary total disability benefits are in dispute, the Arbitrator finds the following:

The parties stipulated, and the temporary total disability benefit payment screens admitted into evidence as Respondent's Exhibit 1 show, that the respondent paid temporary total disability benefits from June 4, 2014, through the date that the petitioner was able to return to work with the respondent, May 20, 2015, for the total amount of $31,958.50.

With respect to (L), what is the nature and extent of the injury, the Arbitrator finds the following:

According to Section 8.1b(b) of the Illinois Workers' Compensation Act, permanent partial disability is to be determined by:

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. 820 ILCS 305/1 et seq. (West 2012)

Shoulder

(i) There was no impairment rating given in the instant case; therefore, the Arbitrator gives this factor no weight.

(ii) The petitioner, as discussed above, was a preventative maintenance mechanic. He had to work with alternators that weighed up to 75 pounds and batteries that weighed 50 pounds. Additionally, the petitioner testified to having to lift those himself, as often there was no room for two individuals to lift those items in the small work area. Additionally, the petitioner testified to having to work on and inspect buses in a pit, or on a jack, requiring him to work with his arms over his head for a majority of his day.

The respondent's witness, Brian Findlay, testified that that was incorrect, that the petitioner would need to work overhead only for an hour. But, Mr. Findlay testified on cross-examination that at no time was he the petitioner's direct supervisor. He did not supervise the petitioner or what he did all day. In fact, Mr. Findlay and the petitioner did not work the same shifts. Mr. Findlay never held the petitioner's position of or performed the duties of preventive maintenance mechanic. He did not know or understand the daily requirements of the petitioner's job. The Arbitrator gives some weight to this factor.

(iii) The petitioner was 58 years old at the time of the accident. He was employed by the respondent for over twenty years. The petitioner had only held jobs in the mechanical maintenance or repair fields. He testified that he had attempted to return to work after Dr. Hurbanek released him after his shoulder surgery. He was required to take a physical exam with a company doctor in order to determine if he was able to return. The Arbitrator gives greater weight to this factor.

(iv) Upon the petitioner's return to work, he needed to undergo a physical examination for the respondent to allow his return to duty. He was found unable to return to work with the respondent due to his hearing – an issue that he had long before his June 2014 work accident and had passed prior fit for duty examinations. He had been able to work full duty without issue prior to June 2014. The petitioner being determined unfit to return to work forced him to retire, thereby adversely affecting his earning capacity. The Arbitrator gives this factor greater weight.

(v) The petitioner testified that his shoulder still constantly bothers him. This is corroborated by the medical records. Dr. Gelbort indicates that the petitioner's shoulder pain disrupts his sleep at least 3-4 times a week. (PX5) The petitioner testified that as he was sitting in court his pain was at a 3; however, when he tries to do things at home, it can get up to a 9.

Dr. Bryan Neal examined the petitioner at the respondent's request pursuant to section 12 of the Act in October 2014, prior to the shoulder surgery, and then subsequently, post-surgery in May 2015. (RX4) The Arbitrator gives this factor greater weight.

Head Injury/Trauma

(i) There is no impairment rating given for the traumatic brain injury in the instant case; therefore, the Arbitrator gives this factor no weight.

(ii) The petitioner worked as a mechanic. He had a talent for repairing things such as cars, buses, motorcycles, among other things. The petitioner testified that he excelled in those areas in school and that he has been in the field his whole life and even brought that home with him by working on cars and motorcycles, repairing whatever else needed fixing around the house. He testified that he no longer is able to do these tasks due to increased depression, anxiety, frustration, and difficulty concentrating. The Arbitrator gives this factor greater weight.

(iii) The petitioner was 58 years old at the time of the accident, and now he is retired. While he no longer needs to use his mechanical talents at work, the petitioner is unable to use them in his personal life. The Arbitrator gives this factor some weight.

(iv) The petitioner suffered a shoulder injury as well as a head trauma. Upon being released to return to work, he had to pass a fit for duty examination for the respondent. He was unable to return to work due to issues with his hearing – issues which predated his June 2014 work accident. Prior to June 2014, the petitioner always had been found fit to work. Because he now was found unfit to return to work – for the first time – the petitioner was forced to retire. The arbitrator gives this factor greater weight.

(v) Both the petitioner and Mrs. McCanna testified that when he does attempt to fix things or work on cars, he ends up making the situation worse and even breaking them. Mrs. McCanna testified that she never needed to call a mechanic to fix any car issues or things around the house prior to June 2014. The petitioner now lets her call for repair help because he no longer is able to perform these tasks.

His inability to perform these tasks as he once did has also caused continually more severe frustration, anger and depression. Both the petitioner and Mrs. McCanna testified about social situations and how the petitioner tries to avoid them at all costs. He even stopped attending his "Munchie Group" because of his increased depression and anxiety in social situations.

The respondent's section 12 examiner is an orthopedic surgeon. As such, he is not qualified to provide expert opinion regarding the petitioner's mental, emotional, or psychological state. Dr. Gelbort opined as above and is competent to do so. The Arbitrator finds that the testimony of the petitioner and Mrs. McCanna correlate with and are supported by the

petitioner's medical records, especially those of Dr. Stephens and Dr. Gelbort. Therefore, the Arbitrator gives this factor greater weight.

Based on all of the above factors, the testimony and documentary evidence, the Arbitrator finds that the petitioner sustained permanent partial disability to the extent of 30% loss of use of the person as a whole pursuant to section 8(d) (2) of the Act, 150 weeks compensation at a weekly rate of $575.26.

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

Alita Jones-Richard,

Petitioner,

vs. No. 97 WC 39437

Chicago Board of Education,

Respondent.

20 IWCC0645

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County, which reversed much of the Commission's March 28, 2016 decision. The Commission now vacates its March 28, 2016 decision in accordance with the Circuit Court's order, and affirms and adopts the February 11, 2015 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).

On June 4, 1997, Petitioner, then a 40-year old physical education teacher, was pushed down a flight of six stairs by a 3rd grade student. She sustained injuries to both feet and knees, among other body parts. Following a July 3, 2014 arbitration hearing, the Arbitrator, in a February 11, 2015 decision, expressly found that: Petitioner's current condition of ill-being of her knees and feet were causally related to her work accident; Petitioner had not reached MMI; and although Petitioner failed to prove she was an "odd-lot" permanent total or was entitled to a wage differential award under §8(d)1, it was not appropriate at that time to make a determination as to Petitioner's permanent disability. The Arbitrator awarded Petitioner $10,531.25 for medical services,

$581,485,14 in TTD benefits,[1] and prospective medical care for her left foot, including a surgical consultation with Dr. Kelikian and a re-evaluation by Dr. Hill.

The Commission, in its March 28, 2016 Decision and Opinion on Review, modified the Arbitrator's decision. The Commission reversed the Arbitrator's finding that Petitioner's current bilateral foot and right knee conditions were causally related to her June 4, 1997 accident, and reversed the Arbitrator's finding that she had not reached MMI for her work-related injuries. The Commission found that Petitioner had reached MMI by November 30, 1998. The Commission reduced Petitioner's TTD and medical expense awards,[2] and reversed the Arbitrator's award of prospective medical care. Finally, Commission found that the Arbitrator erred by not awarding Petitioner permanent disability because Petitioner had stipulated that nature and extent was an issue to be decided. The Commission awarded Petitioner 20% body as a whole under §8(d)2 for permanent partial disability.

Petitioner filed an appeal of the Commission's decision to the Circuit Court of Cook County. That court, in a May 3, 2019 order, granted much of the relief sought by Petitioner. It set aside the following portions of the Commission's March 28, 2016 decision:

> "the Commission's (1) November 30 termination of Temporary Total Disability, (2) its reduction of Alita's benefits, (3) its reduction of the awards for medical bills/prospective care, (3) its finding that she was ineligible for maintenance payments, and (4) its reversal of the arbitrator's determination that Alita's disabling condition has not reached permanency."

The Circuit Court then remanded the cause back to the Commission, "for determination as to the benefits due to Alita and for any further proceedings consistent with this order."

The Circuit Court concluded that Petitioner did prove her bilateral foot and right knee conditions were causally related to her June 4, 1997 accident. The Circuit Court found the Commission's reliance upon the opinions of Dr. Kornblatt was against the manifest weight of evidence. The Circuit Court also found the Commission erred, as a matter of law, in construing Dr. Hill's November 30, 1998 letter to have been a release to return to work.

Respondent filed an appeal of the Circuit Court's order to the Workers' Compensation Commission Division of the Appellate Court. In a Rule 23 order dated March 27, 2020, the Appellate Court found that while Petitioner's appeal of the Commission's March 28, 2016 decision to the Circuit Court had been timely, the Circuit Court's May 3, 2019 order was interlocutory, because it explicitly directed the Commission to make a determination as to benefits due the

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[1] The Arbitrator's awarded Petitioner 836-3/7 weeks of TTD (7/1/97 to 9/4/97; 7/1/98 to 9/4/98, and 10/31/98 to 7/3/14 (date of arbitration hearing). The Arbitrator also awarded Respondent a credit in the amount of $396.247.20 for TTD benefits it had paid.

[2] The Commission reduced the Arbitrator's TTD award to 23-2/7 weeks (7/1/97 to 9/4/97; 7/1/98 to 9/4/98, and 10/31/98 to 11/30/98) and reduced Petitioner's medical expenses award to $4,112.00.

claimant on remand. The Appellate Court found it had no jurisdiction to decide the remaining issues, and dismissed the appeal for lack of jurisdiction.

The Commission now reconsiders this matter, pursuant to the directive of the Circuit Court to set aside its findings that Petitioner's current right knee and bilateral foot conditions were not causally related, that Petitioner had reached a state of permanency, and that Petitioner did not require prospective medical care. The Commission now finds that Petitioner's current right knee and bilateral foot conditions are causally related to Petitioner's June 4, 1997 accident; that her conditions have not reached a state of permanency, and that she is in need of prospective medical care. The Commission – having reviewed the Commission's prior decision and the record, and following the opinion and mandate of the Circuit Court – now concludes that the decision of the Arbitrator was correct, for the reasons stated in that decision.

In accordance with the Circuit Court's order, the Commission now vacates it's March 28, 2016 Decision and Opinion on Review. Because Petitioner had not reached MMI and is in need of prospective medical care, the Commission remands this case back to the Arbitrator for a determination of those issues.

IT IS THEREFORE ORDERED BY THE COMMISSION that it's March 28, 2016 Decision and Opinion on Review in this matter is hereby vacated, and the Decision of the Arbitrator, issued February 20, 2015, is hereby affirmed and adopted.

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

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

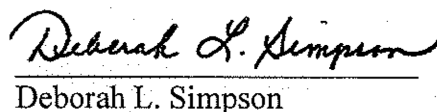
IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a notice of intent to file for review in the Circuit Court has expired without the filing of such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

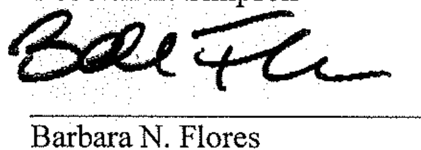
There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

20 I WCC0645

DATED: NOV 5 - 2020
o-2/24/16
MP/mcp
68

Marc Parker


Deborah L. Simpson


Barbara N. Flores

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES-RICHARD, ALITA
Employee/Petitioner

Case# **97WC039437**

CHICAGO BOARD OF EDUCATION
Employer/Respondent

20IWCC0645

On 2/13/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0559 CHICAGO BOARD OF RDUCATION
RACHEL M GARCIA
125 S CLARK ST SUITE 700
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

ALITA JONES-RICHARD,
Employee/Petitioner

Case # **97** WC **39437**

v.

Consolidated cases: **N/A**

CHICAGO BOARD OF EDUCATION,
Employer/Respondent

20 I W CC0645

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **July 3, 2014 and August 5, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other (1) **Prospective Medical Care**
(2) **Dismissal/Reinstatement of Claim**

FINDINGS

On **June 4, 1997**, 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 $**54,225.60**; the average weekly wage was $**1,042.80**.

On the date of accident, Petitioner was **40** years of age, *married* with **1** dependent child.

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 $**396,247.20** for TTD benefits, $**0** for maintenance benefits, and $**0** for other benefits, for a total credit of $**396,247.20**.

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

ORDER

Temporary total disability benefits

Respondent shall pay Petitioner temporary total disability benefits of $**695.20**/week for **836-3/7** weeks, commencing **7/1/1997** through **9/4/97**, **7/1/1998** through **9/4/1998**, and **10/31/1998** through **7/3/2014**, as provided in Section 8(b) of the Act.

Credit

Respondent shall be given a credit of $**396,247.20** for temporary total disability benefits that have been paid.

Medical Bills

Respondent shall pay reasonable and necessary medical services of $**10,531.25**, as provided in Section 8(a) and subject to Section 8.2 of the Act, as applicable.

Prospective Medical Care

Respondent shall authorize and pay for a surgical consultation for Petitioner's left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

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

February 11, 2015
Date

FEB 1 3 2015

ILLINOIS WORKER'S COMPENSATION COMMISSION

ALITA JONES-RICHARDS,)
)
Petitioner,)
vs.) No. 97 WC 39347
)
CHICAGO BOARD OF EDUCATION,)
)
Respondent.)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter having come before the Arbitrator for hearing on July 3, 2014 and August 5, 2014, the Arbitrator, having heard the testimony of the parties and considered the exhibits admitted into evidence, makes the following findings in support of his award:

I. Findings of Fact

Petitioner filed an Application for Adjustment of Claim alleging she sustained injuries in the course of her employment with the Chicago Board of Education on June 4, 1997. At the time of the accident, Petitioner was 40 years of age and was employed as a physical education instructor.

Petitioner testified that she holds a Bachelor of Science Degree in physical education and health as well as a Masters Degree in school administration. She has never been employed in the area of school administration, but has worked many years as a physical education instructor. Petitioner's Illinois teaching certificate was received into evidence as Petitioner's Exhibit 38. The certification confirms the Petitioner's certificate was valid for special K-12 teaching, physical education. The subsequent teaching certificate, which was issued in June 1995, indicates it was valid for administrative K-12.

Petitioner testified that her position as physical education instructor requires her to be on her feet the entire day, requires her to demonstrate the various physical education activities to her students and requires lifting and pulling for such items as wrestling mats. Petitioner testified she was able to perform all these duties prior to the accident of June 4, 1997. Immediately prior to that date, she was not under the care of a doctor nor did she have treatment for any knee complaints. Petitioner did testify she had seen a foot doctor prior to the date of her accident, but that her foot condition was in good control for at least a year prior to the accident.

Petitioner testified that on June 4, 1997, as she was descending a flight of stairs in the school where she taught, a student pushed her, which caused her to fall forward and strike the floor after she went down approximately six steps. Petitioner described the steps as being of a hard material. A picture of the stair steps was admitted as Petitioner's

Exhibit 20. As Petitioner lay where she fell, the same student descended the stairs and stomped on her left thigh, which caused her leg "to move."

Petitioner testified that immediately following the assault, she noticed pain in her left thigh as well as pain in her neck, shoulders, arm and generally everywhere. Another employee of the Board of Education assisted Petitioner following the accident.

Petitioner completed an Employee Accident Report in which she identified the parts of the body that she injured: "BOTH ARMS, LEGS, KNEES, + BACK, BOTH ELBOWS, + NECK." She also wrote that she had a bruise on the following body parts: "ARMS, LEGS, BOTH KNEE (sic) + ?". She wrote that she had a sprain of her LEFT ANKLE and scratches to BOTH KNEES. She wrote that she had a fracture of her FINGER RGT, but also indicated that she had a broken finger prior to being pushed. *PX 1*

Following the accident, Petitioner underwent extensive medical treatment, particularly for pain in her ring finger, her left and right knees and her left and right feet. Petitioner was initially seen by her doctors at Advocate Meyer Medical. *PX 4* X-rays were ordered and were taken of her right fourth finger, left knee and left ankle and foot on June 4, 1997. *PX 4*

Petitioner then followed up with Dr. Herbert White on June 10, 1997. Petitioner testified she went to Dr. White because a relative had received treatment from him and had recommended him. Petitioner treated with Dr. White for, among other body parts, her ankles and feet. Petitioner has continued to treat with Dr. White to the present. During his treatment, Dr. White ordered a number of diagnostic studies, which included a September 26, 1997 MRI of the right knee, a June 26, 1998 order for an MRI of the right knee, a June 19, 2006 order for an MRI of the lumbar spine and left knee and a June 30, 2005 order for a MRI of the left foot. The primary treatment rendered by Dr. White has been medication for pain and swelling as well as multiple courses of physical therapy. Such therapy has included, at various times, swim therapy, massage therapy and acupuncture. *PX 6B*

The deposition of Dr. Herbert White was taken on September 30, 2009 and was admitted into evidence as Petitioner's Exhibit 6.

At the request of Respondent and pursuant to Section 12 of the Act, on June 8, 1998, Dr. Mitchell I. Krieger examined Petitioner's knees. Upon examination, the doctor found, *inter alia*, ½ inch atrophy of Petitioner's left calf when compared with her right calf. He diagnosed chondromalacia of the patella bilaterally, ordered an MRI of the right knee. If such MRI were negative, he would declare Petitioner to be at MMI. He would then order an FCE to determine whether she could return to work as a physical education teacher. Dr. Krieger further opined: "There does appear to be a significant amount of subjective complaints with minimal objective findings." *RX 9*

At the request of Respondent and pursuant to Section 12 of the Act, on July 13, 1998, Dr. Edward J. Goldberg examined Petitioner's lumbar spine. Dr. Goldberg did not find any focal neurological change to indicate that the slight atrophy in Petitioner's left calf is from her lumbar spine. Dr. Goldberg opined: "It is possible that she has been

favoring the left lower extremity due to the fact that she did have the arthroscopic surgery and had the injury to that knee." He recommended one month of formal physical therapy for her low back while she receives PT for her left knee. After that, he would find her to be at MMI for her lumbar spine and capable of returning to work as a physical education teacher. In that regard, Dr. Goldberg continued, he would defer to Dr. James Hill, who performed the arthroscopy on Petitioner's left knee. *RX 10*

The records of Meyer Medical reflect that on June 19, 1998, Petitioner complained of heel pain. On July 24, 1998, Petitioner returned to Meyer Medical. Among her subjective complaints, the physician wrote the following:

> "Hx Heel spurs – Using orthotics x 11 YR. C/O↑ heel pain x 4 mos. -
> Notes Trauma 1/98 to Lt Knees 1 YR ago - Jan 98 had arthroscopy –
> Notes cartilage damage – Walking differently." *PX 4*

Upon examination, the physician noted bilateral tenderness to the heels, but no edema. The physician assessed Petitioner with heels spurs and ordered x-rays of bilateral heels with copies of the x-rays to be given to Petitioner. He also referred Petitioner to a podiatrist. *PX 4*

On August 12, 1998, Petitioner visited the offices of Dr. Dominic Andriacchi DPM. The Progress Note for this date indicates: "Pt. is picking up X-rays – she says she is taking them to another Dr. who did surgery on her knee." *PX 19, Resp. Dep. Ex. #3* Just above the August 12, 1998 Progress Note is a July 31, 1995 Progress Note that states:

> "Pt has x-rays – Pt had "knot" on left foot for approx. 3 mos. –
> has disappeared. Primary doctor stated pt. has heel spurs.
> Sensitivity on heels. Plantar Fasciitis. X-rays show heel spurs.
> Pt. to have ort's made. RTO PRN." *PX 19, Resp. Dep. Ex. #3*

After Petitioner's visit to the offices of Dr. Andriacchi on August 12, 1998, she returned to him on August 27, 1998. The Progress Note for this date indicates:

> "Pt. here to pick-up letter w/Diagnosis. Letter is for work. Also,
> here to inquire about Orthotics.
> S/ Pt. wants letter stating that states her heel pain is from accident.
> P/ Spoke c̄ Pt's lawyer – advised him that she had heel pain in '95
> before the accident. She's to cont. c̄ current tx. RTC PRN
> *PX 19, Resp. Dep. Ex. #3*

Although Dr. Andriacchi did not personally treat Petitioner until sometime in 1999, he and his colleagues have treated Petitioner for her foot problems from August 1998 to the present. The records reflect that following Petitioner's accident, Dr. Andriacchi provided various forms of treatment, including left ankle bracing, orthotics, biofreeze, cortisone injections on multiple occasions, diagnostic ultrasound examinations and surgery. Following his evaluation of Petitioner, Dr. Andriacchi diagnosed her with aggravation of her bilateral heel spurs, plantar fasciitis and a neuroma. *PX 14, PX 18, PX 19, Resp. Dep. Ex.#1, #3 and #4*

The deposition of Dr. Dominic Andriacchi was taken on August 4, 2009, and was admitted into evidence by this Arbitrator as Petitioner's Exhibit 19.

Dr. White referred Petitioner to Dr. James Hill for treatment of her knee complaints. Dr. Hill performed left knee arthroscopic surgery on Petitioner on January 27, 1998. He found Grade III chondromalacia of the patella and Grade II changes to the lateral tibial plateau. The doctor's treatment did not resolve Petitioner's problems and she remained on work restrictions from Dr. Hill. Dr. Hill then proceeded to perform right knee arthroscopic on Petitioner on February 23, 2001, at which time he found Grade II chondromalacia of the patella. *PX 15, Deposition Exhibits*

The records reflect that on March 12, 2007, Dr. Hill offered to perform a second surgery on Petitioner's left knee, but Petitioner declined additional surgery at that time. *PX 15, Deposition Exhibits*

Petitioner testified that Dr. Hill, on various occasions, recommended she proceed with foot surgery to help her with her knee pain. Such recommendations appear in his records, including April 16, 2004. In addition to the surgical treatment to the knees, Dr. Hill prescribed various periods of physical therapy, home exercise and activity restrictions.

The deposition of Dr. James Hill was taken on August 20, 2009, and was admitted into evidence by this Arbitrator as Petitioner's Exhibit 15. At this deposition, Dr. Hill opined that if Respondent could find a job for Petitioner that is within the restrictions Dr. Hill had imposed on her, she could probably perform such job. *PX 15, pp. 31-32*

Petitioner received physical therapy from Health South from October 6, 1998 through October 14, 1998, but had to transfer to another facility due to an allergy to pool chemicals used at that facility. Petitioner received additional physical therapy at Health South from August 5, 1999 through August 21, 1999 for treatment of her foot pain and received more physical therapy from Health South in Palos Heights in August of 2001 for treatment of her knee pain. *PX 40*

On June 1, 2006, Petitioner presented to the emergency room of John Stroger Hospital with complaints of foot and knee pain. She followed up with injections to the left knee and with an offer of left knee surgery, which Petitioner again declined. *PX 30*

Petitioner testified she continued to complain of pain and has had continuous pain from the date of accident to present. The pain is most notable in her knees and feet. As a result, she uses a cane if she has to walk any significant distance. She also notes that she moves more slowly and is unable to participate in any of the sports she used to do, which previously included running, basketball and racquetball. Petitioner has not returned to work since the date of her accident.

Petitioner testified she has not received any offers of employment within the limitations imposed by her doctors. Petitioner did receive a notice to return, admitted into evidence as Petitioner's Exhibit 37. The notice to return to work was dated September 14, 2009, but erroneously referred to her medical release to return to work from her physician. As her doctors have testified, she was not released to return to work at that

time. Even if she had a release to return to work, Respondent informed her, through the notice, that her prior position had been closed and no other positions were offered to her.

Petitioner looked for work in school administration. Documentation of the Petitioner's attempt to look for administrator positions are reflected, not only in her testimony but in Petitioner's Exhibit 46, which documents an application for a position advertised in the Board of Education personnel bulletin.

The records reflect Petitioner was assigned to vocational rehabilitation with Rehabilitation Works, Inc. Petitioner testified that she only recalls one meeting with the vocational rehabilitation specialist. The reports of Susan J. Rosenberg, the vocational rehabilitation consultant hired by Respondent, were admitted as Petitioner's Exhibit 17. Ms. Rosenberg performed an initial vocational assessment in November 1998, with a recommendation to Respondent to conduct a Labor Market Survey and to work with Petitioner to develop job skills. In January 1999, Ms. Rosenberg completed a Labor Market Survey with a plan to meet with Petitioner to discuss transferable skills and to develop a rehabilitation plan. However, following the development of the Labor Market Survey, the vocational rehabilitation consultant was instructed to put a hold on additional vocational services. *PX 17*

In September of 1999, Respondent restarted vocational services, with two meetings between the vocational specialist and Petitioner. The vocational rehabilitation consultant, Ms. Rosenberg, noted that the jobs identified for Petitioner would pay her in the range of $6.50 to $10.00 per hour. Per the records of Rehabilitation Works, Inc., Petitioner refused to attend a job interview with a prospective employer. Such job was within her restrictions. Respondent then terminated rehabilitation services. *PX 17*

Rehabilitation Works, Inc., reopened the file on April 22, 2000, but then closed it on June 2, 2000 in order to seek clarification of Dr. White's off-work opinion. *PX 17*

On November 25, 2009, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner submitted to an examination by Dr. Ira Kornblatt. Dr. Kornblatt specifically examined Petitioner's knees and feet. Following the examination, Dr. Kornblatt provided the following answers to specific questions:

1. Diagnosis of the patient's current condition is early degenerative arthritis, patellofemoral region, bilateral knees. With respect to her feet, she has complaints of foot pain without evidence of significant objective findings to substantiate her ongoing subjective complaints. With respect to her knees, on exam, there is no evidence of significant disability, and her subjective complaints are far in excess of the findings of the x-ray and on physical exam.

2. With respect to the question regarding whether the diagnosis of her feet is related to the work injury, it is my opinion that there is no relationship at all between her foot symptoms and the injury as described. It is my opinion that she did have documented plantar fascial symptoms and spurs prior to the injury, which she admitted to, and it is my opinion that it is not likely that the injury

as described resulted in any aggravation of her pre-existing foot problem.

3. Is any further treatment required to cure the injuries/conditions caused by the work-related injury? No.

4. Has the employee reached maximum medical improvement from this injury? With respect to permanent partial impairment, I find no evidence of significant permanent partial impairment.

5. Not applicable.

6. Does the employee have any permanent work restrictions? No.

7. Do you believe all the medical treatment to date has been necessary and directly related to the injury? No, I do not. I believe that the claimant likely reached maximum medical improvement approximately 6 months following the surgery of the left knee. It is my opinion that the surgery which was carried out of the right knee was not related to the work injury, and it is my opinion that she likely could have returned to work back in 1998. *RX 11, Dep, Ex. 2*

The deposition of Dr. Ira Kornblatt was taken on March 24, 2010 and was admitted into evidence as Respondent's Exhibit 11.

Petitioner's Exhibit (Group) 16 is a compilation of off-work slips from June 5, 1997 through February 14, 2014.

II. Conclusions of Law

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (F) "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?", THE ARBITRATOR FINDS:

Petitioner described the June 4, 1997 accidental injury. She described walking down a flight of stairs, with a group of students, at the school where she worked as a physical education instructor. As she was descending the stairs, she was pushed by a student, which caused her to fall forward down half a flight of stairs. As she lay at the bottom of the stairs, the same student that pushed her descended the stairs and stomped on Petitioner's left leg.

Petitioner has had an extensive history of medical treatment, primarily from her occupational medicine physician, Dr. Herbert White; from her orthopedic surgeon, Dr. James Hill; and from her podiatrist, Dr. Dominic Andriacchi. Throughout the records of these doctors, Petitioner consistently relates her pain as starting from the date of her accident and further describes fairly constant and consistent reports of pain in her bilateral knees and bilateral feet. Given the nature of the accident, her complaints of pain are consistent with the description of the accident.

As to Petitioner's bilateral knee complaints, the Arbitrator notes that she was seen by Dr. Herbert White on June 10, 1997, which was within one week of the accident. At that time, she was complaining of pain in her ankles, knees, elbows, shoulder, neck, back, ribs and hand. *PX 6, p. 13.* Dr. White treated Petitioner after the initial visit, made various referrals to specialists and ordered an MRI of the left knee. He reported a working diagnosis as of September 26, 1997 of left knee torn cartilage and right knee pain, among other diagnosis. He therefore referred Petitioner to Dr. James Hill, an orthopedic surgeon. *PX 6, p. 19; PX 15, p. 7.*

Dr. Hill initially examined Petitioner on August 26, 1997, and offered a causal connection opinion between Petitioner's left knee condition and the June 4, 1997 accident. *PX 15, p. 12.* He performed surgery on the left knee and gave a post-operative diagnosis of chondromalacia of the patella and the lateral tibial plateau. The operation did not alter Dr. Hill's opinion that the left knee condition was causally related to the accident. Dr. Hill also treated Petitioner for her complaints of right knee pain. As of August 12, 1998, Dr. Hill diagnosed her with chondromalacia of the right knee. This treating orthopedic surgeon opined that the right knee pain was also causally related to the accident as Petitioner had an altered gait and favored her left knee. *PX 15, p. 16.* Dr. Hill continued to treat Petitioner for bilateral knee pain and ordered an MRI in 2000 that showed patella tendinitis and chondromalacia. *PX 15, p. 19.* The doctor subsequently performed arthroscopic surgery on Petitioner's right knee Petitioner on February 23, 2001. At that time, he excised the medial plica. *PX 15, p. 20.* Dr. Hill testified that since he initially evaluated Petitioner in August 1997, he has seen Petitioner regularly for her ongoing complaints of bilateral knee pain, left greater than right.

Dr. Hill offered no causation opinion with regard to Petitioner's feet.

Dr. Herbert White, who continued to treat Petitioner on a non-surgical basis, causally related Petitioner's complaints of left and right knee pain to the accident of June 4, 1997. *PX 6, pp. 19, 22, 26 and 29.*

To the extent that Respondent's Section 12 physicians have expressed differing opinions, this Arbitrator finds the explanations and foundation for opinions expressed by Dr. Hill to be more persuasive. In addition, the treating doctors have had the benefit of years of treatment and frequent contact with Petitioner to evaluate her condition and form opinions. It is therefore the finding of the Arbitrator that Petitioner's current condition of ill-being related to her right and left knees is causally related to the accident of June 4, 1997.

At trial, Petitioner continued to complain of bilateral foot pain. The record reflects she had complaints of left heel pain prior to her accident of June 4, 1997 and was seen by a podiatrist at Dr. Andriacchi's office on July 31, 1995. At that time she was diagnosed with heel spurs. She was only seen on one occasion. She did not return to Dr. Andriacchi's office for treatment until approximately 1 year after the accident.

Post-accident, Petitioner voiced complaints of foot pain to Dr. White. On May 27, 1998, Dr. White recorded complaints of worsening bilateral heel pain. Dr. White testified that Petitioner sustained an aggravation of her heel spurs. *PX 6, pp. 68-69* Dr. White further opined that Petitioner had an abnormal gait due to knee pain and back pain

that caused an aggravation of her foot pain resulting in plantar fasciitis. *PX 6, pp. 36-37* The Arbitrator accepts these opinions given the minimal treatment Petitioner received for heel pain in 1995 and the nearly two-year period prior to the accident during which she did not seek medical attention for heel or foot pain.

Petitioner returned to see Dr. Andriacchi, a podiatrist, who noted ongoing complaints of heel pain from August 1998, when his office first saw her, to the date he testified by deposition. He treated her with multiple injections, medications, orthotics and a heel brace. Dr. Andriacchi opined that this condition is causally related to the accident. *PX 19, pp. 22, 27-28*

In March 1999, Dr. Andriacchi further found the onset of plantar fasciitis, which he noted was secondary to heel trauma. *PX 19, pp. 25-6.* On September 24, 2004 Dr. Andriacchi performed surgery for treatment of the left foot plantar fasciitis. The left foot pain continued, even after surgery, and resulted in an additional diagnosis of a neuroma, which he measured to be approximately 1 cm.

Dr. Andriacchi concluded that the left and right foot conditions, for which he treated Petitioner, were causally related to the accident, and continue to be causally related as of the date he testified. *PX 19, p. 46.*

In 2009 and 2010, Dr. Kornblatt opined that neither the condition of Petitioner's right knee nor her feet are causally related to the accident of June 4, 1997. Moreover, Dr. Kornblatt opined that Petitioner was capable of returning to her job of physical education teacher.

The Arbitrator recognizes that payment of TTD benefits is no admission of liability. Yet, after Respondent had paid nearly 12-1/2 years of TTD benefits, Dr. Kornblatt examined Petitioner on one occasion, did not review all of Petitioner's treating records and rendered a 2-1/2-page report.

The Arbitrator finds the opinions of the treating physicians, in particular, Dr. Hill, to be more persuasive than those of Dr. Kornblatt. Dr. Hill is a Professor of Orthopedic Surgery at Northwestern University Feinberg School of Medicine and has a 13-1/2 page curriculum vitae. Dr. Hill performed surgery on each of Petitioner's knees.

As the Arbitrator finds Dr. Kornblatt's opinions unpersuasive with regard to Petitioner's right knee and her ability to return to her job of physical education instructor, he gives little weight to his causation opinions with regard to Petitioner's feet.

The Arbitrator puts great weight on the opinions of Dr. Hill.

Given the mechanism of injury, Petitioner's altered gait, the consistency of her complaints and the opinions of Doctors Andriacchi and White, the Arbitrator finds Petitioner's current condition of ill-being of her feet to be causally related to the accident of June 4, 1997.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (J) "WERE THE MEDICAL SERVICES PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY? HAS THE RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICE?", THE ARBITRATOR FINDS:

The Arbitrator has found Petitioner's bilateral knee complaints and bilateral foot complaints causally related to the accident of June 4, 1997. She received diagnostic and therapeutic services for her bilateral knee condition at St. James Hospital and Health Center, underwent an MRI on June 29, 2008, participated in physical therapy and visited Dr. White. These services fall within reasonably and necessarily prescribed services as follows:

1. June 29, 2008 MRI billed in the amount of $ 950.00;
2. February 10, 1998 through November 30, 1998 physical therapy billed in the amount of $4,112.00;
3. Various office visits with Dr. White billed in the amounts of $24.00, $262.50, $131.25, $370.50 and two visits of $182.00.

Petitioner presented to the emergency room of John Stroger Hospital on June 1, 2006 with complaints of foot and knee pain. She received an injection to her left knee from the hospital. This complaint and treatment is consistent with her complaints to Dr. James Hill and are reasonable and necessary in the billed amount of $2,407.00.

In addition to the treatment for her knee injury, Petitioner saw Dr. Dominic Andriacchi for care of her bilateral foot pain, which the Arbitrator has found to be causally related to her accident of June 4, 1997. The Arbitrator finds the unpaid balance of $1,910.00 was for reasonable and necessary treatment.

The Arbitrator orders the above medical bills to be paid, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Finally, while Respondent paid for the surgery to Petitioner's foot, they claim a credit for their payments, which is addressed below. The Arbitrator finds the surgery, as described by Dr. Andriacchi in his deposition, to be reasonable, necessary and related treatment.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (K) "WHAT TEMPORARY BENEFITS ARE IN DISPUTE? (TTD)", THE ARBITRATOR FINDS:

Petitioner testified she was off work following the accident of June 4, 1997 through the date she testified. She testified that Respondent employed her as a physical education instructor. She found this to be a physically demanding job. Petitioner testified that she is required to demonstrate physical education activities to her students, which include basketball, volleyball, running and other physically demanding activities. In addition, she is responsible for setting up the facilities for the students, which would include pulling and placing wrestling mats.

All three of Petitioner's treating physicians following this accident, Drs. Hill, White and Andriacchi, testified she could not return to work as a physical education instructor. The Arbitrator finds this is significant as the opinion of inability to perform work as a physical education instructor comes from three, independent doctors.

Dr. James Hill, the orthopedic surgeon, testified that he took Petitioner to surgery on January 27, 1998 for her left knee. As of March 28, 1998, he kept her off work to help build her leg muscle. *PX 15, p. 15.* He continued Petitioner's treatment and testified that as of December 10, 1998, he still had not released her to work duties. *PX 15, p. 18.* Dr. Hill continued his treatment plan, including home exercise program and a second surgery, this time to the right knee, on February 23, 2001. The doctor testified that as of March 21, 2007, he continued her off work as a physical education instructor and imposed permanent restrictions of no prolonged standing, walking, kneeling, squatting, bending and no lifting over 25 pounds. *PX 15, p. 23.* The doctor reiterated these permanent restrictions as of November 3, 2008. *PX 15, p. 24.* Given the physical nature of Petitioner's job, these restrictions rule out her ability to perform her occupational duties from the date of her accident until the date this case was tried.

Dr. White, who followed Petitioner on a non-surgical basis, also limited Petitioner from returning to her occupational duties. When Dr. White saw Petitioner in June 1997, he certified her off work. *PX 6, p. 16.* He continued her off work through June 26, 1998. *PX 6, p. 26.* He further confirmed he held Petitioner off work continuously from June 10, 1997 through February 23, 2001. *PX 6, p. 33.* The doctor testified the off work status continued through July 2009, with the exception of one unsuccessful attempt to return to work. *PX 6, pp. 38-39.* On the date of his deposition, Dr. White concluded Petitioner continued to be unable to return to work as a physical education instructor. *PX 6, p. 41.*

Dr. Dominic Andriacchi also opined Petitioner could not work as a physical education instructor. His medical records reflect ongoing off-work certifications confirmed by his testimony. His treatment recommendations include the use of orthotics, rest, elevation of the feet and the use of compression stocking. *PX 19, p. 44.*

Since Dr. Hill, Dr. White and Dr. Andriacchi testified to their opinions in 2009, each of them has issued numerous "off work" slips. There are no "light-duty" work releases in this exhibit. *PX (Group)16*

Based on the complaints of pain in both her knees and feet, and on these off-work slips, the Arbitrator finds that has been temporarily, totally disabled from the date of her accident to the present.

The parties stipulated to payments received for full salary and TTD benefits. Based on contractual obligations, Respondent paid Petitioner her full salary for the periods of June 5, 1997 through June 30, 1997; September 5, 1997 through June 30, 1998; and September 5, 1998 through October 30, 1998. Petitioner was disabled and did not work during this period, but was entitled to full salary pursuant to the collective bargaining agreement. Petitioner is entitled to payment of TTD benefits from July 1, 1997 through September 4, 1997; from July 1, 1998 through September 4, 1998; and October 31, 1998 through July 3, 2014, the date Petitioner testified, representing a period

~~of 836-3/7 weeks. Respondent is entitled to a credit for TTD benefits they have paid in~~ the amount of $396,247.20.

IN SUPPORT OF HIS DECISIONS WTH REGARD TO ISSUES (L) "WHAT IS THE NATURE AND EXTENT OF THE INJURY?", AND (O) "OTHER: PROSPECTIVE MEDICAL CARE", THE ARBITRATOR FINDS:

Based on the testimony of Petitioner and the deposition testimony of Drs. Hill and White, Petitioner sustained a traumatic injury to her left knee resulting in an aggravation of a degenerative knee condition. Dr. Hill further found Petitioner sustained an aggravation of her right knee degenerative condition as a result of an altered gait resulting from her left knee pain.

Both Dr. White and Dr. Andriacchi causally related the condition of Petitioner's feet to the accident of June 4, 1997.

The accident also resulted in the sprain of Petitioner's left fourth finger. While Dr. White felt there was a fracture, Dr. Suk found a sprain, which Petitioner reported continues to bother her.

As a result of the knee injuries, Dr. Hill, on March 21, 2007, imposed activity restrictions on Petitioner that limit her standing, walking, stooping, kneeling and lifting (to 25 lbs.). Dr. White testified in 2009 that if Petitioner were allowed undergo surgery for the neuroma on her foot, she might be able to return to some work. The later off-work slips of Doctors White and Andriacchi have simply limited Petitioner to no return to work. *PX 16 (Group)*

The Arbitrator finds that Petitioner failed to prove that she is an "odd-lot" permanent total. No doctor or vocational rehabilitation counselor has specifically opined that Petitioner is permanently and totally disabled. Moreover, Petitioner did not introduce evidence of a job search or any evidence to show that no stable job market exists for any of her services and thus failed to meet her burden that she was not capable of obtaining gainful employment.

The Arbitrator notes that Petitioner is well educated. Petitioner is not taking prescription pain medication. Under Dr. Hill's March 21, 2007 restrictions, to which he referred at the August 20, 2009 deposition, Petitioner was capable of performing, at the very least, sedentary work. At the February 11, 2014 hearing of the motion to reinstate, Petitioner stated that she has been looking after her mother during her mother's long illness.

Petitioner has also failed to prove that she is entitled to a wage differential award. Although Respondent provided vocational rehabilitation services from November 25, 1998 through May 23, 2000, the vocational consultant questioned Petitioner's motivation to return to work. Furthermore, Petitioner refused to attend an interview with a prospective employer that the consultant had arranged on November 10, 1999. The Labor Market Survey conducted in early 1999 indicated that Petitioner would likely suffer a wage loss. However, such data is 15 years old. No recent Labor Market Survey

or recent opinion of a vocational specialist was offered into evidence. No evidence was introduced to show the amount Petitioner is able to earn in some suitable employment or business. No evidence was introduced to show what Petitioner would be able to earn in the full performance of her duties in the occupation in which she was engaged at the time of the accident.

On August 20, 2009, Dr. Hill opined that if Respondent could find a job for Petitioner within the restrictions he had imposed on her, that Petitioner could probably perform such job. Thereafter, he issued no return to work slips and recommended further treatment for her foot. Petitioner's Exhibit (Group) #16 is a compilation of off-work slips, produced by Dr. Hill, Dr. White, Dr. Andriacchi, and Dr. Gormley. The first off-work slip was authored by Dr. Gormley and dated June 5, 1997. The rest of the off-work slips are authored by the other three treating physicians, which begin on February 13, 2008 and end on February 15, 2014.

Dr. Hill continues to keep Petitioner off work and has recommended that Petitioner seek a surgical consultation regarding her left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

Based on Dr. Hill's recommendation, the Arbitrator finds that Petitioner has not yet reached MMI. Consequently, a determination as to Petitioner's permanent disability is not appropriate at this time.

Therefore, the Arbitrator orders Respondent to authorize and pay for a surgical consultation for Petitioner's left foot with Dr. Kelikian, followed by a re-evaluation of Petitioner by Dr. Hill.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (M) "SHOULD PENALTIES AND FEES BE IMPOSED ON RESPONDENT?", THE ARBITRATOR FINDS:

Respondent introduced reports of physicians hired by them to perform Section 12 examinations. Respondent was entitled to rely on the opinions of their physicians, even though the Arbitrator has found the opinions of the treating doctors, to the extent they conflict with those rendered by Doctors Krieger and Kornblatt, to be more persuasive. No penalties are due Petitioner on this record.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (N) "IS RESPONDENT DUE ANY CREDIT?", THE ARBITRATOR FINDS:

Respondent claims a credit for the payment of Petitioner's foot surgery. However, the Arbitrator finds that both Dr. Herbert White and Dr. Dominic Andriacchi opined that Petitioner's foot condition was causally related to the accident. In this regard, the Arbitrator adopts his findings of fact and conclusions of law as to the issue of causation. Respondent was liable for the foot surgery pursuant to Section 8(a) of the Act and is not entitled to a credit against the award herein.

IN SUPPORT OF HIS DECISION WITH REGARD TO ISSUE (O) "OTHER: DISMISSAL/REINSTATEMENT OF CLAIM", THE ARBITRATOR FINDS:

The Arbitrator made detailed findings and entered a written Order for the reinstatement of the instant case. The Arbitrator finds no reason to disturb his findings and Order. The reinstatement of this case shall stand.

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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVEN SPINA,

Petitioner,

vs. NO: 16 WC 38621

STATE OF ILLINOIS,
DEPARTMENT OF TRANSPORTATION,

Respondent.

20 I W CC0646

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 benefit underpayment and permanent disability, and being advised of the facts and law, corrects the Decision to properly reflect the parties' stipulations, 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.

Corrections

A. Temporary Total Disability

The parties stipulated Petitioner was temporarily and totally disabled from November 30, 2016 through November 5, 2017. It was likewise stipulated Respondent paid $45,961.48 toward its Temporary Total Disability benefit obligation. The Arbitrator's decision awarded Respondent's credit but failed to award Petitioner the associated Temporary Total Disability benefits. Therefore, the Commission corrects the decision to award the stipulated Temporary Total Disability benefits from November 30, 2016 through November 5, 2017.

B. Medical

The parties stipulated there are unpaid medical expenses of $167.75 for services rendered by Dr. Krcik, and Respondent is liable for same. The Order indicates medical services have been "provided" but does not acknowledge this charge remains outstanding. The Commission corrects the decision to reflect medical services have been "provided, in part," and award the undisputed medical expenses.

Permanent Disability

The Commission observes the Arbitrator misapplied the Section 8.1b(b) factors and his analysis is contrary to law. The Commission strikes the permanent disability determination and substitutes the following to satisfy the requirements of Section 8.1b. *820 ILCS 305/8.1b* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101.

Section 8.1b(b)(i) – §8.1b(a) impairment report

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), the Commission will assess Petitioner's permanent disability based upon the remaining enumerated factors.

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

Petitioner is a highway maintainer; his job duties include road construction, drainage, snow and ice removal, and litter/debris removal. The Commission observes Dr. Krcik released Petitioner to return to work "without restrictions outside of wearing ACL brace" (PX3), and Petitioner resumed "doing the job I was doing before," though he is nervous and approaches tasks with caution. The Commission finds Petitioner's successful return to "full activities with work" is indicative of reduced permanent disability.

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

Petitioner was 38 years old on the date of his accidental injury. Petitioner is a relatively young individual and will therefore experience his residual complaints for an extended period. The Commission finds this factor weighs in favor of increased permanent disability.

Section 8.1b(b)(iv) - future earning capacity

The Commission notes Petitioner returned to his pre-injury job, and there is nothing to suggest his base salary was adversely affected. Further, while Petitioner testified that following his return to work, he did not receive a merit bonus as he had on one occasion in the past, we observe no specifics were offered as to the metrics considered when determining who represents the top 25% of employees. Moreover, that bonus came from a program initiated by then-

Governor Rauner, and there is no evidence corroborating that the program still exists. As such, the Commission finds no reliable evidence was offered to prove the injury had an adverse impact on Petitioner's future earning capacity, and this factor weighs in favor of reduced permanent disability.

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

After diagnostic imaging revealed a torn anterior cruciate ligament and impaction fractures of the lateral femoral condyle, Dr. Krcik performed a left knee ACL reconstruction with hamstring autograft, chondroplasty of the patella, and suprapatellar spica excision. Post-operatively, Petitioner underwent an extended course of physical therapy followed by work conditioning. On November 3, 2017, Dr. Krcik released Petitioner to return to work full duty with the caveat that he wear his ACL brace; Dr. Krcik further reinforced the importance of Petitioner knowing his limits and continuing with the home exercise program, and warned there may be tough days and Petitioner may experience occasional swelling requiring anti-inflammatories and icing. The Commission notes Dr. Krcik's records are consistent with Petitioner's description of his residual complaints. Petitioner testified he continues to wear his knee brace while working as well as whenever a situation presents a risk to his knee. He further testified his ongoing knee pain has resulted in activity modification: "...I was always able to do like coach my son's soccer team. I can't run and play soccer with him no more. I was also working - - not working. I was also with a church hockey team. I can't play hockey no more. Little things like riding my bike with my son, I can't do no more." T. 16-17. The Commission finds Petitioner had a positive surgical outcome but nonetheless has residual deficits. The Commission finds this factor weighs in favor of increased permanent disability.

Based on the above, the Commission finds Petitioner sustained permanent partial disability to the extent of 25% loss of use of the left leg under Section 8(e)12.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 2019, 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 $1,099.70 per week for a period of 48 5/7 weeks, representing November 30, 2016 through November 5, 2017, that being the stipulated period of temporary total incapacity for work under §8(b). Respondent shall have credit of $45,961.48 for payments already made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $167.75, that being the undisputed outstanding charge for Petitioner's treatment with Dr. Krcik, for reasonable and necessary medical expenses as provided in Section 8(a), subject to Section 8.2.

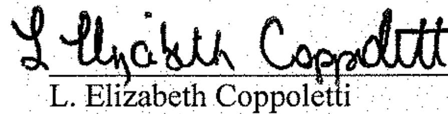
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 53.75 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 25% loss of use of the left leg.

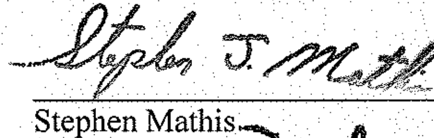
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

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

DATED: NOV 6 - 2020


L. Elizabeth Coppoletti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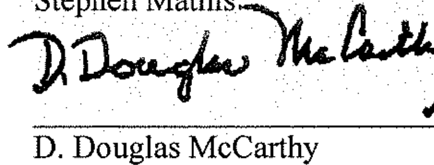

D. Douglas McCarthy

LEC/mck

O: 9/15/2020

43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SPINA, STEVEN
Employee/Petitioner

Case# **16WC038621**

STATE OF ILLINOIS/IDOT
Employer/Respondent

20IWCC0646

On 2/19/2019, 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:

0320 LANNON LANNON & BARR LTD
PATRICIA LANNON KUS
200 N LASALLE ST SUITE 2820
CHICAGO, IL 60601

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

FEB 19 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0646

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
NATURE AND EXTENT ONLY

Steven Spina
Employee/Petitioner

v.

State of Illinois/IDOT
Employer/Respondent

Case # **16** WC **38621**

Consolidated cases: ______

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **November 16, 2018 and December 17, 2018**. By stipulation, the parties agree:

On the date of accident, **November 29, 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 $**85,776.71**, and the average weekly wage was $**1649.55**.

At the time of injury, Petitioner was **38** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**45,282.28** for TTD, $**0** for TPD, $**0** for maintenance, and $**679.20** for other benefits, for a total credit of $**45,961.48**.

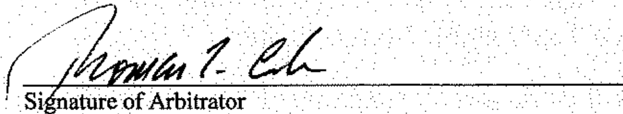
After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$775.18**/week for a further period of **43** weeks, as provided in Section **8e** of the Act, because the injuries sustained caused **permanent partial disability to the extent of 20% loss of a leg.**.

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

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



Signature of Arbitrator

2-19-19
Date

FEB 19 2019

Steven Spina v. State of Illinois/IDOT, No. 16 WC 038621

Preface

The parties proceeded to hearing November 16, 2018, and December 17, 2018, on a Request for Hearing indicating ultimately, the sole issue was what is the nature and extent of the injury. Arbitrator's Exhibit 1. A transcript was not ordered.

Findings of Fact

Steven Spina (Petitioner) a 38 year old male, testified he was working in highway maintenance with the State of Illinois since 2003. He testified that on November 29, 2016, while working in the Wilmington/Braidwood area on I-55, a beaver dam was blocking a drain pipe and his supervisor instructed him to remove the dam. Based on Petitioner's testimony and his medical records, it appears he waded into the water, his legs were submerged in mud in the water, and when he tried to move, his knee twisted, and he felt a pop, falling into the water. Petitioner's Exhibit 1 (unpaginated); Petitioner's Exhibit 2 (unpaginated).

Petitioner testified he sought treatment at Bolingbrook Hospital. Those records of November 30, 2016, indicate Petitioner complained of left knee pain. An x-ray revealed no acute fracture. He was diagnosed with a knee sprain and placed in a knee immobilizer and given crutches. Petitioner's Exhibit 1.

Petitioner also testified he sought treatment from Dr. James Krcik. The records of Dr. Krcik, from both Integrity Orthopedics and Mercy Health Systems, indicate Petitioner had an MRI of his left knee December 14, 2016. It revealed a complete tear of the anterior cruciate ligament and impaction fracture of the terminal suicos of the lateral femoral condyle and the posterior aspect of the lateral tibial plateau. Petitioner had surgery February 7, 2017, a left knee ACL reconstruction with hamstring autograft, a left knee chondioplasty of patella, and a left knee suprapatellar plica excision. Petitioner's Exhibit 2 (unpaginated).

Petitioner participated in months of physical therapy and work conditioning. By November 3, 2017, Dr. Krcik indicated Petitioner felt ready to return to full activity and denied swelling or issues with his knee. The unstable sensation with his knee had been resolved. Petitioner felt he could return to any type of activities without any concerns. Dr. Krcik noted Petitioner would return to full activities November 6, 2017, and wear a knee brace when he had to. On Petitioner's last visit to Krcik, April 27, 2018, he noted Petitioner worked out on a regular basis and had no limitations or restrictions at work. Petitioner's Exhibit 2 (unpaginated); Petitioner's Exhibit 3 (unpaginated).

Conclusions of Law

The sole issue here is the nature and extent of the injury. Petitioner suffered a complete tear of his ACL, which required surgery and extensive therapy and work conditioning. He was released to full duty and is working at his job again. Here, permanent partial disability is established using the criteria found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, the Arbitrator finds as follows.

Regarding subsection (i) of Section 8.1b(b), this Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. However, I have considered Dr. Krcik's comments on April 27, 2018, that Petitioner, on occasion, will feel a bit of discomfort on the anterior aspect of his knee, as a factor in the evaluation of Petitioner's permanent partial disability. I give this factor some weight in determining the level of disability.

Regarding subsection (ii) of Section 8.1b(b), the occupation of the injured employee, the record indicates that at the time of the accident, and currently, Petitioner was working in highway maintenance for IDOT in Teamsters Local 330. He was released to full duty and had no limitations or restrictions at work. I note in Petitioner's Exhibit 2, Petitioner's occupation required physical demands in the heavy level of work. Thus, this factor is not relevant, and I give it no weight in determining the level of disability.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, the parties stipulated Petitioner was 38 years old, and as he must live with his condition for some time, coupled with the comments of Dr. Krcik, this factor is relevant, and I give it weight in determining the level of disability.

With regard to subsection (iv) of Section 8.1b(b), the employee's future earnings capacity, this Arbitrator notes the absence of evidence Petitioner's earnings capacity was adversely impacted by the accident. Petitioner is a member of a union with a guaranteed base pay. Any discussion of potential bonuses is too speculative to be of consideration. Thus, I give this factor no weight in determining the level of disability.

Regarding subsection (v) of Section 8.1b(b), evidence of disability corroborated by the treating medical records, this Arbitrator notes the records of Dr. Krcik indicating there may be days that it may be tough, and on occasion Petitioner will feel discomfort in his knee. Petitioner testified to having to wear a brace and the impact of the accident on his current performance. I give this factor weight in determining the level of disability.

Based on the above factors, and the record taken as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 20% loss of leg.

Arbitrator

2-19-19

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 [down- regarding left arm]	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIJUANA GIBSON,

Petitioner,

vs. NO: 18 WC 09635

CITY OF CHICAGO,

Respondent.

20IWCC0647

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, 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.

After reviewing the totality of evidence, the Commission modifies the Section 8.1b(b) analysis. This section provides:

> §8.1b(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.

The Commission finds the following:

(i) Neither party submitted an impairment report so this factor is given no weight.

(ii) Petitioner is employed as a traffic enforcement aide for the City of Chicago, Department of Finance. Some weight is given to this factor.

(iii) Petitioner is 52 years old and has a moderately significant amount of work life remaining due to her age. Some weight is given to this factor.

(iv) Petitioner is earning the same as she did prior to the accident. There is no evidence of wage loss sustained as a result of the accident therefore no weight is given to this factor.

(v) Petitioner suffered multiple injuries when she was struck by a motor vehicle traveling at 30 mph. Petitioner sustained significant injury to her left arm and underwent an ORIF procedure. Petitioner sustained significant injury to her right arm/shoulder with dislocation, rotator cuff tear and tendon retraction and underwent arthroscopic surgery. Petitioner sustained a facial orbit fracture and a nasal septal dislocation that required surgical intervention to correct the deviation and help with her breathing. Significant weight is given to this factor.

The Commission notes the history of the accident is well documented along with her extensive injuries to her arms, shoulder, face, and some injuries to her legs. There is no question of the severity of her injuries and extensive medical care for her left arm including ORIF surgery with hardware, dislocation of the right shoulder requiring arthroscopic surgery, nasal septum deviation and surgery, and an orbit fracture. Petitioner underwent physical therapy for both arms/shoulders post surgeries. Petitioner's subjective complaints are well supported with objective findings and the operative reports. Petitioner still has some weakness and pain and limited ROM.

Petitioner has since returned to her normal work duties. She is required to carry two devices, a printer and ticket writing device, which she states are not that heavy. Petitioner stated she used to bowl, be able to carry groceries and clean her house. Petitioner stated when it hurts she takes Advil for pain or she exercises. She indicated that she cannot wash her back with one arm because it gets very stiff. Petitioner testified it is difficult to go to the doctor because, when they use the blood pressure cuff, it hurts her arm. Petitioner testified that she experiences daily discomfort and problems due to her accident

The Commission finds that Petitioner suffered a significant left arm injury resulting in a displaced fracture of the humerus and requiring ORIF surgery. Petitioner's testimony of ongoing difficulties is fully supported by the medical records. Petitioner testified of pain and discomfort and difficulties with her left arm. Physical therapy notes at discharge indicate Petitioner has good days and bad days and she experiences some decreased ROM right more than left. The Arbitrator's award of 40% loss of use of the left arm, however, is considered excessive, and, considering the factors in §8.1b(b) noted above, the Commission herein, modifies the award to find Petitioner sustained 30% loss of use of her left arm, as more appropriate and fully supported by the evidence and Petitioner's testimony.

The Commission affirms and adopts the decision of the Arbitrator as to the permanent partial disability award of 30% loss of use of a person as a whole for injuries to Petitioner's right arm and nasal/facial fractures.

All else is affirmed and adopted.

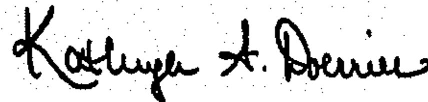
IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $665.28 per week for a period of 225.9 total weeks, as provided in §8(e)(10) and 8(d)(2) of the Act, for the reason that the injuries sustained caused the 30% loss of use of her left arm (75.9 weeks) and 30% loss of use of Petitioner's person as a whole (150 weeks).

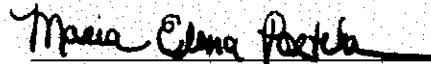
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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: NOV 6 - 2020
o-10/6/20
KAD/jsf


Kathryn A. Doerries


Maria E. Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GIBSON, TJUANA
Employee/Petitioner

Case# **18WC009635**

CITY OF CHICAGO
Employer/Respondent

20IWCC0647

On 1/7/2020, 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 1,52% 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:

0314 KUMLIN & FROMM LTD
MARK L FROMM
205 W RANDOLPH ST SUITE 1030
CHICAGO, IL 60606

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
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

TJUANA GIBSON
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # **18** WC **09635**

Consolidated cases: ____

20 I W CC0647

An *Application for Adjustment 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 and Elaine Llerena**, Arbitrators of the Commission, in the city of **Chicago**, on **December 12, 2019**. After reviewing all of the evidence presented, the Arbitrators hereby make 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 19, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**57,815.77**; the average weekly wage was $**1,108.80**.

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

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

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

To date, Respondent has paid $**36,960.00** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

Respondent shall be given a credit of $**36,960.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**36,960.00**.

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

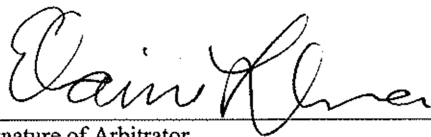
ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $665.28 per week for 101.20 weeks, because the injuries sustained caused the 40 % loss of the left arm, as provided in Section 8(e)10 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $665.28 per week for 150 weeks, because the injuries sustained caused the 30 % loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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



Signature of Arbitrator

12/26/2019
Date

JAN 7 - 2020

STATEMENT OF FACTS

On March 19, 2018, while performing her job a traffic enforcement aid for the City of Chicago, Petitioner was struck by a car while crossing the street at 47th street. Petitioner testified that she was struck on the right side of her body. The blow knocked Petitioner into the air and caused her to land on her left side and hitting her face on the ground. Petitioner testified that she felt immediate pain in her left arm, right shoulder and face and had blood coming out of her nose.

Petitioner testified that she was transported by paramedics to Mt. Sinai Hospital where she was seen in the emergency room. At the emergency room, Petitioner complained of pain in her left upper arm, right shoulder, face and nose. (PX1) Petitioner was examined by medical personnel, underwent diagnostic testing and was diagnosed as having a left humeral fracture, dislocation of the right shoulder joint, fracture of the right inferior orbit and transverse fracture through the nasal septum. (PX1) Petitioner was admitted to Mt. Sinai Hospital that same day and underwent an open reduction and internal fixation of the right humeral shaft fracture, performed by Dr. Mason Milburn, and placed in a long arm cast on her left side and in a shoulder immobilizer on the right. (PX1) As a result, Petitioner had difficulty dressing, bathing, toileting, eating and taking care of personal grooming. (PX1) Petitioner was discharged from Mt. Sinai Hospital on March 30, 2018. (PX1) Petitioner testified that due to balancing problems and her inability to take care of herself, she was transferred to Manor Care Rehabilitation Center for occupational therapy. Petitioner testified that she was at Manor Care Rehabilitation Center for about a week and, because she was still unable to return to her own apartment and care for herself, moved in with her cousin.

Petitioner continued to follow up with Dr. Milburn and on April 4, 2018, Dr. Milburn ordered physical therapy for Petitioner's left arm and referred Petitioner to his partner, Dr. Luis Carrilero, for consultation regarding her right shoulder injury. (PX4) Petitioner began physical therapy at ATI Physical Therapy on April 10, 2018 and underwent evaluation by Dr. Carrilero on April 18, 2018. (PX3) Dr. Carrilero recommended surgery for Petitioner's right arm. (PX4) On May 25, 2018, Dr. Carrilero performed a right shoulder arthroscopic debridement, biceps tenodisis and labrum repair. (PX1) Dr. Carrilero's post-surgical diagnosis was right shoulder full thickness and retracted tear of the supraspinatus tendon; full thickness tear of the infraspinatus tendon; partial tear of the subscapularis tendon; medial sublaxation of the long head of the bicep tendon with interstitial tear; moderate to large joint effusion with joint loose bodies; post traumatic dislocation associated with displaced bony Bankart fracture, labral tears and comminuted Hill-Sachs deformity; and adhesive capsulitis. (PX1) Petitioner was once again placed in the right shoulder immobilizer and instructed to avoid motion of the shoulder and weightbearing activities with the right arm. (PX1) Petitioner continued to follow up, post-operatively, with Dr. Carrilero regarding her right shoulder. (PX3) Dr. Carrilero ordered physical therapy. (PX3)

On February 26, 2019, Dr. Carrilero noted that Petitioner reported improvement regarding her range of motion and muscle strength. (PX3) Dr. Carrilero felt it was reasonable to allow Petitioner to return to work with the understanding that she perform work activities as tolerated and that she could discontinue her work activities if any symptoms or complaints arose. (PX3) On March 26, 2019, Petitioner returned to Dr. Carrilero and reported that she had been discharged from physical therapy and was working full duty. (PX3) Petitioner reported ongoing pain and restricted range of motion. (PX3) Dr. Carrilero encouraged Petitioner to continue her home exercise program and to follow up if any new problems arose. (PX3)

On August 8, 2018, Petitioner saw Dr. Michael Friedman, and ear, nose and throat ("ENT") physician at Illinois Masonic Hospital, regarding her nasal septal fracture and deviated nasal septum. (PX5) During that visit, Petitioner reported that she had trouble breathing, which was painful, and trouble sleeping. (PX5) Dr. Friedman performed a nasal endoscopy in his office and confirmed that there was a septal deviation to the left, bilateral

valve collapse and edematous turbinates'. (PX5) Dr. Friedman concluded that the septum deviation could be causing nasal obstruction and recommended surgery to correct the injury. (PX5)

On September 14, 2018, Dr. Friedman performed a nasal septoplasty on Petitioner at Illinois Masonic Hospital. (PX2) Petitioner continued to follow up with Dr. Friedman monthly over the next three months, during which she complained about tenderness, congestion and problems sleeping. (PX5) At each follow up visit, Dr. Friedman performed a nasal endoscopy to deal Petitioner's ongoing nasal issues. (PX5) On December 13, 2019, Dr. Friedman declared Petitioner to be at maximum medical improvement ("MMI"), cleared Petitioner for work from an ENT perspective and discharged her from his care. (PX5)

Petitioner testified that prior to the accident, she did not have any problems with her left arm, right shoulder, nose or face. She further testified that she did not have any difficulty performing her job as a traffic parking enforcement aid or performing activities of daily living. Petitioner testified that, following the accident, she has noticed problems while performing her job duties. Petitioner testified that she experiences pain while using and carrying two devices required to carry out her job. Petitioner explained that it was difficult for her to handle the devices along with paper and envelopes due to her pain and upper extremity mobility issues. Petitioner testified that cold weather causes her pain and discomfort in her arms. Petitioner also testified that she continues to have problems with reaching behind her back, overhead reaching and carrying heavy objects, such as trash cans and grocery bags, as well as pain when she cleans her home. Petitioner further testified that she used to bowl, but is unable to do so anymore. Petitioner testified that when she experiences pain and discomfort, she takes Advil and continues her home exercises. Petitioner also testified that she continues to have difficulty breathing.

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

Petitioner testified that she did not have any problems with her upper extremities, nose and face prior to the March 19, 2018 accident. Her testimony regarding how the accident occurred is consistent with the history she provided at the hospital on the day of the accident, as well as during her visits with Dr. Milburn, Dr. Carrilero, Dr. Friedman and her initial physical evaluation at ATI Physical Therapy. (PX1, PX3, PX4, PX5 & PX7)

Based on the medical records and Petitioner's undisputed testimony, the Arbitrator finds that Petitioner's left arm, right shoulder, nose and face injuries are causally related to the work accident of March 19, 2018.

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

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

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

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

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

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

The Petitioner is employed as a traffic parking enforcement aid. She continues to be employed in this capacity. The Arbitrator gives some weight to this factor.

The Petitioner is 53 years old. The Arbitrator gives some weight to this factor in that Petitioner has remaining years in the work force.

Petitioner's future earning capacity has not been affected by this accident. Petitioner testified that she is still employed at her pre-injury capacity. The Arbitrator gives some weight to this factor.

The Arbitrator finds that as a result of Petitioner's March 19, 2018 work accident, Petitioner sustained causally related injuries to her left arm, right shoulder, nose and face. Petitioner initially treated her left arm humerus fracture with open reduction internal fixation surgery on March 22, 2018. She then continued with physical therapy as an in-patient and out-patient. She also continued taking medication for her pain and discomfort for over one year after the accident. Petitioner continues to experience pain and discomfort, limitation with her daily living activities, as well as with carrying and lifting at work. No evidence has been presented by Respondent to dispute Petitioner's testimony or her medical records presented into evidence. The Arbitrator gives greater weight to this factor.

Based on the foregoing, the Arbitrator finds that Petitioner sustained 40% loss of use of the left arm pursuant to Section 8(e)10 of the Act as a result of the work accident of March 19, 2018.

With regards to the right shoulder injury, the Arbitrator notes that Petitioner underwent surgery on May 25, 2019, performed by Dr. Luis Carrilero at Mt. Sinai Hospital. Petitioner sustained a full thickness and restricted tears of her rotator cuff, including the subscapularis, supraspinatus and infraspinatus, with medial sublaxation of the long head of the bicep tendon. Petitioner also sustained labral tears and bony Bankart fracture as well as the Hill-Sachs deformity related with her shoulder dislocation. Following the surgery, Petitioner's shoulder was placed in an immobilizer and eventually physical therapy was prescribed. Petitioner continued with out-patient physical therapy at ATI through March of 2019. She still continues to perform home exercises due to her continued limitations and discomfort. Petitioner testified she still continues to have difficulty reaching overhead, reaching behind her back, lifting and washing and styling her hair. She also has difficulty with opening doors, lifting items from the floor, sustained repetitive movement using her right arm and pushing and pulling tasks. These limitations are confirmed in the discharge summary from ATI Physical Therapy dated March 19, 2019. Petitioner also sustained a fractured orbital to her face and a fractured and deviated septum to her nose. She underwent surgery to correct the injury to her nose on September 14, 2018 and continued to treat for those injuries for the next four months. During that time, Petitioner had difficulty with breathing, congestion and sleeping. The Arbitrator gives greater weight to these factors concerning her right shoulder and nose.

Based on the foregoing, the Arbitrator finds that Petitioner sustained 30% loss of the person as a whole, pursuant to Section 8(d)2 of the Act, as a result of the right shoulder and facial injuries she sustained on March 19, 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 JEFFERSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rhonda Gibson,

Petitioner,

20 IWCC0648

vs.

NO: 18 WC 5779

State of Illinois, Department of Rehabilitation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability 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, with the changes made below.

While affirming and adopting the Decision of the Arbitrator, the Commission writes additionally on the issue of temporary total disability (TTD) benefits. The decision of the Arbitrator delineates the procedural history relating to her initial §19(b) hearing, as well as the facts relating to the issues and Petitioner's medical treatment, in particular, in detail.

The Commission notes that it previously affirmed the Arbitrator's initial §19(b) ruling awarding medical expenses, prospective medical care, and temporary total disability benefits from January 18, 2018 through the initial §19(b) hearing date of April 10, 2018. After remanding the case, a second hearing was held on December 4, 2019 at which time Respondent stipulated to liability for TTD benefits for the period from January 18, 2018 through September 14, 2018. Respondent further stipulated that there had been a TTD underpayment. The Arbitrator's decision awarded permanent partial disability benefits but was silent on the issue of temporary disability. Now comes Petitioner on appeal seeking review of both temporary disability and permanent disability awards.

The law in Illinois holds that "an employee is temporarily totally incapacitated from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill.2d 107, 118 (1990). "To establish entitlement to TTD benefits, a claimant must demonstrate not only that he or she did not work, but also that the claimant was unable to work." *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759 (2003). "The dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement." *Id.* Moreover, Parties are bound by the stipulations made at the time of trial. *Walker v. Industrial Comm'n*, 345 Ill.App.3d 1084, 1087 (2004).

Respondent stipulated to liability for the claimed TTD period on the Request for Hearing form. Petitioner stipulated that Respondent was entitled to a credit in the amount of $2,598.10. Moreover, the record reflects that following the initial §19(b) hearing through September 14, 2018, Petitioner was either under work restrictions that Respondent could not accommodate or placed off work completely. The restrictions were not accommodated by Respondent and remained in place until May 30, 2018 when Petitioner was taken off work completely due to her cervical disc replacement surgery. Subsequently, Petitioner was not released to full duty until September 14, 2018.

Thus, the Commission finds that Petitioner is entitled to TTD benefits from April 11, 2018 through September 14, 2018 as stipulated by the parties and supported by the record. Accordingly, the Commission changes the Arbitrator's decision to include such benefits. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week (minimum TTD rate) from April 11, 2018 through September 14, 2018, a period of 22 and 3/7ths 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 the Respondent shall receive a credit in the amount of $2,598.10 for TTD benefits it already paid.

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

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

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

DATED: NOV 6 - 2020
o: 10/8/20
BNF/wde
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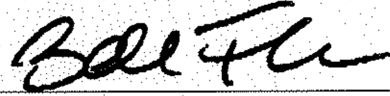
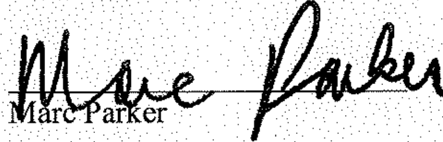

Barbara N. Flores

Deborah L. Simpson


Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0648

GIBSON, RHONDA Case# **18WC005779**
Employee/Petitioner

ST OF IL/DEPT OF REHABILTATION
Employer/Respondent

On 1/28/2020, 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 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY & CHAPPELL P
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

6147 ASSISTANT ATTORNEY GENERAL
CORI STEWART
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

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 28 2020

Brendan 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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Rhonda Gibson
Employee/Petitioner

Case # 18 WC 05779

v.

Consolidated cases: n/a

State of IL/Dept. of Rehabilitation
Employer/Respondent

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 Mt. Vernon, on December 4, 2019. By stipulation, the parties agree:

On the date of accident, January 17, 2018, 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 $14,285.04; the average weekly wage was $274.71.

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 $2,598.10 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $2,598.10.

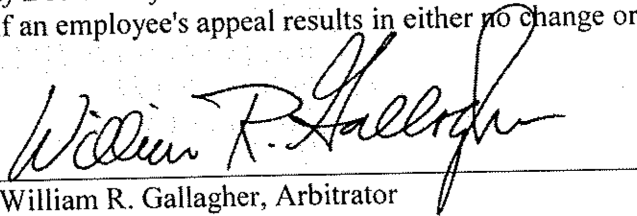
After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $220.00 per week for 75 weeks because the injuries sustained caused the 15% loss of use of the person as a whole as provided in Section 8(d)2 of the Act.

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

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



William R. Gallagher, Arbitrator

January 23, 2020
Date

JAN 2 8 2020

Findings of Fact

Petitioner filed an Amended 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 January 17, 2018. The Amended Application alleged Petitioner was assisting a client and sustained an injury to her right shoulder, neck and body as a whole (Arbitrator's Exhibit 2).

This case was previously tried in a 19(b) proceeding on April 10, 2018. The Arbitrator's Decision was filed with the Commission on May 9, 2018, in which he awarded payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent filed a review of the Arbitrator's Decision and the Commission affirmed and adopted the Arbitrator's Decision on January 14, 2019, and remanded the case to the Arbitrator for further proceedings (Petitioner's Exhibit 13). When this case was tried on December 4, 2019, the only disputed issue was the nature and extent of permanent partial disability (Arbitrator's Exhibit 1).

As noted in the Decision of the Commission/Arbitrator, Petitioner was treated by Dr. Matthew Gornet, an orthopedic surgeon, for a cervical spine injury. When Dr. Gornet evaluated Petitioner on May 10, 2018, he recommended Petitioner undergo disc replacement surgery at C5-C6 (Petitioner's Exhibit 5).

Dr. Gornet performed surgery on May 30, 2018, and the procedure consisted of disc replacement at C5-C6. Following surgery, Petitioner was seen by Dr. Gornet on June 14, July 16 and September 11, 2018. When seen on September 11, 2018, Dr. Gornet authorized Petitioner to return to work without restrictions on September 14, 2018 (Petitioner's Exhibit 5).

At trial, Petitioner testified that following surgery she did not receive any physical therapy or perform any exercises at home. Petitioner did not return to work for Respondent; however, Petitioner obtained a job at a group home where she takes care of disabled individuals. Her job duties are essentially the same as those she performed while employed by Respondent. Further, Petitioner also obtained a job as a cashier at a Big Lots store.

Petitioner last saw Dr. Gornet on May 30, 2019. At that time, Dr. Gornet opined Petitioner was at MMI and provided her with medications. Petitioner was to follow up as needed or in one year (Petitioner's Exhibit 5).

At trial, Petitioner testified her neck condition improved following surgery, but she still experiences soreness in her neck especially at the end of a work shift. Petitioner stated she applies ice or takes Tylenol on an as needed basis.

Conclusion of Law

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

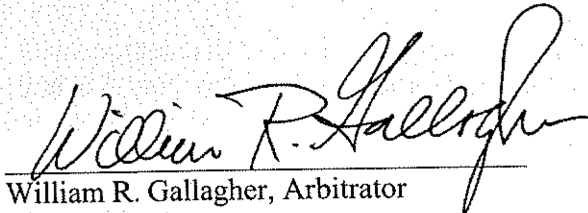
Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

Petitioner worked for Respondent has a health care assistant. While Petitioner did not return to work for Respondent, she obtained a job for another employer in which she does essentially the same tasks she did while employed by Respondent. Petitioner also obtained a job as a cashier. The Arbitrator gives this factor significant weight.

Petitioner was 45 years old at the time of the accident and will have to live with the effects of this injury for the remainder of for 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 injury, Petitioner underwent disc replacement surgery at C5-C6. Petitioner's condition improved following surgery and she did not receive physical therapy or do home exercises. Petitioner still has complaints of neck soreness consistent with the injury she sustained. The Arbitrator gives this factor significant weight.



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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EVERARDO ZUNIGA,

Petitioner,

20 IWCC0649

vs. NO: 18 WC 15628

CALUMET CARTON COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. Findings of Fact

Petitioner was a baler/operator with job duties that included tying bundles of paper, shredding paper, and removing plastic from the paper. For the 20 years he worked for Respondent, Petitioner tied bundles of paper by putting wire around them, tying them down with great strength, and spinning the wire five or six times to secure them down. The wire Petitioner wrapped around each bundle had to be pulled hard in a rowing motion toward his body to keep the bundle tight. For each bundle, Petitioner made the rowing motion five times, because there were five wires. On direct examination, Petitioner testified that he tied approximately 15 to 20 bundles of paper with wires each day and spent eight hours per day tying the bundles with the exception of his breaks and lunchtime. On cross examination, Petitioner testified that he wrapped the bundles for seven hours per day and would tie eight to ten bundles on a regular shift and 16 to 20 bundles on a busy shift, although the number of bundles per hour varied.

Robert Byrne, Respondent's plant manager, agreed that Petitioner tied an average of 16 to 20 bundles per day. Mr. Byrne further identified RX 1 as the job description and physical demand worksheet for Petitioner's position. RX 1 indicated that the balers/operators use their hands for repetitive use such as grasping for 0.75 hours a day and turning with grasping for 0.25 hours a day. Mr. Byrne testified that RX 1 stated that no fine manipulation for either hand was involved.

On April 23, 2018, Petitioner felt his right arm pop as he was pulling a wire tight around a bundle. Petitioner promptly stopped working and reported the accident to Brian Beckman, who then drove Petitioner to Ingalls Clinic. An employee report of injury was also filled out and signed by Petitioner on the accident date. In the report, which was admitted in RX 2, Petitioner stated that he was tying a bale and pulling the wire when he felt pain in his right hand that tingled in his fingers. In a management incident investigation report also included in RX 2, Brian Beckman wrote that Petitioner felt right wrist pain while pulling bale wires on April 23, 2018. Mr. Beckman noted that the pain continued to worsen with Petitioner experiencing tingling in his fingertips. Mr. Byrne testified that although Mr. Beckman was Respondent's department manager and not Petitioner's direct supervisor, RX 2 also included a supervisor's investigation report completed by Petitioner's direct supervisor, David Miller, on April 24, 2018.

Petitioner presented to Ingalls Clinic on the accident date with complaints of pain and tingling, as well as decreased mobility, in his right hand. Petitioner informed Christy Davis, a nurse practitioner, that he had been diagnosed with rheumatoid arthritis two years prior and took Humira for that condition. It was also noted that Petitioner had an overuse history at work associated with hand-tying wire around bales. On exam, Petitioner had positive Phalen's and Tinel's tests, TTP over all aspects of his right wrist and forearm, and pain with flexion, extension, inversion, and eversion. X-rays of the right wrist and forearm were negative. Nurse Practitioner Davis diagnosed Petitioner with right carpal tunnel syndrome and wrist pain. She ordered a Medrol Dosepak to cover a possible rheumatoid arthritis flare-up from an overuse injury as well as any carpal tunnel symptoms. Petitioner was also given a wrist splint and light duty restrictions, including a two-pound lifting and carrying limitation and no repetitive motions for the right hand.

Petitioner returned to work the day after the accident with his light duty restrictions in an accommodated position. Petitioner testified that he did not miss any time from work as a result of the April 23, 2018 accident.

On April 27, 2018, Petitioner returned to Ingalls Clinic with unchanged right hand tingling. Nurse Practitioner Davis indicated that although Petitioner's symptoms were consistent with carpal tunnel syndrome, the diagnosis needed confirmed by an EMG. She also noted that Petitioner had overexertion from prolonged static or awkward postures. She recommended physical therapy, naproxen, and continued work restrictions.

Petitioner continued to follow up with various nurse practitioners, as well as with Dr. Patrice Burch, from May 4, 2018 to June 6, 2018. Throughout this period, Petitioner was kept on medication and light duty restrictions for his right hand. He was also advised to continue physical therapy, wear a splint, and rest the extremity to avoid further symptom aggravation. At the May 4, 2018 and May 11, 2018 office visits, it was noted that Petitioner's problem was related to his

work activities. Also on May 11, 2018, Jennifer Schnell, a nurse practitioner, stated that Petitioner's positive Phalen's and Tinel's test with pain and tenderness in the medial forearm was highly likely due to tendinitis and cumulative trauma from 19 years of doing the same job.

On June 13, 2018, Petitioner alleged a second work injury to his left upper extremity from pushing a dust mop. This second accident corresponds with 18 WC 20666, which was consolidated with the present case. In a separate Decision issued for 18 WC 20666, the Commission found that Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment on June 13, 2018.

On the same day as the alleged second accident, Petitioner presented for a right upper extremity EMG. The EMG found: demyelinating sensory and motor median entrapment mononeuropathy with severe axon denervation affecting the median innervated muscles consistent with a severe proximal right medial neuropathy at the forearm suggestive of pronator syndrome; demyelinating sensory ulnar neuropathy with early motor demyelination and severe axonal features consistent with a severe proximal right ulnar neuropathy; and a greater that 0.4 difference in median to ulnar mixed NCS consistent with a median entrapment mononeuropathy supporting right carpal tunnel syndrome. Dr. Michael Spence, who conducted the EMG, indicated that a lower trunk right brachial plexopathy also could not be ruled out. Nevertheless, there was no evidence of cervical radiculopathy or peripheral polyneuropathy.

On June 18, 2018, Dr. Amy Allegretti of the Ingalls Clinic found that the EMG was consistent with carpal tunnel syndrome, pronator syndrome, and ulnar neuropathy. She diagnosed Petitioner with right carpal tunnel syndrome and right ulnar and median nerve lesions. Dr. Allegretti provided an orthopedic referral and continued to recommend NSAIDs, a splint, and light duty restrictions. Shortly thereafter, on June 20, 2018, Respondent stopped accommodating Petitioner's light duty restrictions due to new restrictions placed on Petitioner's left hand related to his second alleged accident. Mr. Byrne testified that Respondent did not have any accommodations that fit within restrictions for both the right and left hands.

Petitioner next saw Dr. Daniel Bakston at Ingalls Clinic on June 25, 2018. Dr. Bakston added a diagnosis of overextension from prolonged static and awkward positions, put Petitioner's therapy on hold, and requested an orthopedic referral. Petitioner then presented to Dr. John Kung of Illinois Premier Orthopaedic and Hand Center on July 2, 2018. Dr. Kung's right upper extremity exam revealed tenderness in the lateral forearm and over the ulnar nerve with positive Phalen's and Tinel's tests. He diagnosed Petitioner with right carpal tunnel syndrome and lesions of the right ulnar and radial nerves. Dr. Kung administered a right carpal tunnel injection and right radial tunnel injection.

When Petitioner followed up on July 11, 2018, Dr. Kung recommended a repeat right upper extremity EMG. On August 7, 2018, a left upper extremity EMG with limited comparison on the right revealed bilateral median neuropathies at or distal to the wrists, such as seen in carpal tunnel syndrome, with slightly more involvement on the right than left. When Petitioner returned on August 15, 2018, Dr. Kung diagnosed Petitioner with left carpal tunnel syndrome in addition to the diagnoses he already made for Petitioner's right upper extremity. At that time, Dr. Kung indicated that the repeat EMG he ordered for Petitioner's right arm was still pending. Dr. Kung

then noted that Petitioner understood he may need surgery, but it was not clear whether Dr. Kung was referring to Petitioner's right or left side.

Upon referral from Dr. Kung, Petitioner presented to Dr. Kenneth Ham of the Bone and Joint Specialists on August 31, 2018. Dr. Ham reported that Petitioner presented with bilateral hand numbness and tingling from pulling wires and tying bales with a repetitive wrist motion. After considering Petitioner's EMGs, Dr. Ham diagnosed Petitioner with bilateral carpal tunnel syndrome, right pronator syndrome, right cubital tunnel syndrome, and a right ulnar nerve lesion. He recommended carpal tunnel releases, a pronator release, and a cubital tunnel release. On November 16, 2018, Dr. Ham stated that Petitioner's surgery for his work-related condition was pending workers' compensation approval. He advised Petitioner to return once medically cleared.

At Respondent's request, Dr. Sam Biafora of the Hand to Shoulder Associates performed a §12 examination on February 7, 2019 and authored a corresponding report on February 11, 2019. Dr. Biafora's diagnosis for the right upper extremity was diffuse pain complaints with electrodiagnostic evidence consistent with right pronator syndrome, cubital tunnel syndrome, and carpal tunnel syndrome. However, Dr. Biafora indicated that Petitioner's diagnoses did not explain why his diffuse pain and tenderness did not follow any anatomic pattern of distribution. Dr. Biafora found no causal connection between Petitioner's right upper extremity complaints and the electrodiagnostic findings or the work accident.

Following a bifurcated §19(b) hearing on the consolidated matters, the Arbitrator found that both the alleged accidents on April 23, 2018 and June 13, 2018 arose out of and in the course of Petitioner's employment and that the current condition of Petitioner's right upper extremity and left wrist were causally related to said accidents. Although the Arbitrator issued two separate Decisions for the consolidated matters, the Decision for 18 WC 15628 still made findings and awarded benefits that relate to Petitioner's June 13, 2018 accident covered by 18 WC 20666. Specifically, the Arbitrator awarded a total of $3,453.00 in medical expenses under §8(a) for both claims, which broke down to $1,280.00 for 18 WC 15628 and $2,173.00 for 18 WC 20666. The Arbitrator also awarded temporary total disability benefits from February 1, 2019 through May 14, 2019, prospective medical care, and §19(l) penalties and fees related to the June 13, 2018 accident covered by 18 WC 20666.

II. Conclusions of Law

Following a careful review of the entire record, the Commission affirms the Arbitrator's findings that the April 23, 2018 accident arose out of and in the course of Petitioner's employment and caused the current condition of his right upper extremity.

Although there was some question as to the exact amount of time Petitioner spent performing repetitive hand motions, the record does not indicate that Petitioner was claiming a repetitive trauma injury. Instead, Petitioner testified that on April 23, 2018, he felt his right arm pop as he was pulling one of the wires tight around a bundle. Petitioner's testimony as to this specific incident is consistent with the descriptions of the accident given in RX 2's accident reports and the accident histories that Petitioner gave to his treating doctors. Both Petitioner and Mr. Byrne agreed that Petitioner's job duties included tying bundles of paper and that he could average

16 to 20 bundles per day. As Petitioner's testimony, the accident reports, and the histories in the medical records all indicate that Petitioner's injury occurred as he was performing his job duty of tying a paper bundle, the Commission finds that the April 23, 2019 accident arose out of and in the course of Petitioner's employment.

However, for reasons delineated in its separate Decision for 18 WC 20666, the Commission does not find that Petitioner's second alleged accident to his left upper extremity on June 13, 2018 also arose out of and in the course of his employment. As such, the Commission modifies the Decision of the Arbitrator to deny all compensation that was awarded for the June 13, 2018 accident and only awards benefits as it relates to the April 23, 2018 accident. Thus, the Commission denies prospective medical care regarding Petitioner's left wrist for the June 13, 2018 accident and awards only $1,280.00 for medical expenses pursuant to §8(a) for the April 23, 2018 accident. No additional medical expenses are awarded for the June 13, 2018 accident.

The Commission further reverses the Arbitrator's award of §19(l) penalties and fees. Although it falls under 18 WC 20666, the Arbitrator nevertheless included the award of §19(l) penalties and fees in the Decision for 18 WC 15628. The Decision did not specify the amount or period of §19(l) penalties that related to the June 13, 2018 accident. Nevertheless, since the Commission found that Petitioner's left hand injures are not causally related to the June 13, 2018 accident, §19(l) penalties and fees are hereby denied.

Lastly, the Commission awards no temporary total disability benefits as it relates to the April 23, 2018 accident. Petitioner returned to light duty work the day after the accident in an accommodated position, which Respondent was able to provide until additional restrictions were placed on Petitioner's left upper extremity from the June 13, 2018 accident. Petitioner testified that he did not miss any time off work as a result of the April 23, 2018 accident, and the parties stipulated at the hearing that the issue of temporary total disability was not applicable under 18 WC 15628. Therefore, the Commission awards no temporary total disability benefits under 18 WC 15628. Additionally, to the extend that 18 WC 15628 conveys an award of benefits for 18 WC 20666, the Commission also denies temporary total disability benefits for the June 13, 2018 accident, as Petitioner failed to prove he sustained a work-related accident on that date.

The Commission again notes that it has issued a separate Decision detailing its reasoning in Petitioner's companion case of 18 WC 20666 regarding the alleged left upper extremity injury. Although the Commission finds Petitioner's right upper extremity injury sustained on April 23, 2018 compensable, the Commission modifies the Decision of the Arbitrator to deny any finding or award made as related to Petitioner's June 13, 2018 accident, which falls under 18 WC 20666.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated February 24, 2020 is modified as stated herein. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner for reasonable and necessary medical services of $1,280.00 pursuant to §8(a) of the Illinois Workers' Compensation Act for Petitioner's right upper extremity injuries sustained on April 23, 2018. The Commission awards no medical expenses for Petitioner's left upper extremity injuries as related to the June 13,

2018 accident.

IT IS FURTHER ORDERED that Respondent shall authorize and provide payment for the reasonable and necessary prospective medical care as prescribed by Dr. Kung and Dr. Ham as it relates to Petitioner's right upper extremity only. The Commission awards no prospective medical care for Petitioner's left upper extremity injuries.

IT IS FURTHER ORDERED that Petitioner is not entitled to any temporary total disability benefits as related to the April 23, 2018 accident.

IT IS FURTHER ORDERED that penalties and fees pursuant to §19(l) of the Act are hereby denied.

IT IS FURTHER ORDERED that the Decision of the Arbitrator is modified to deny any findings or awards made as related to Petitioner's June 13, 2018 accident that falls under 18 WC 20666. The Commission notes that it has issued a separate Decision for 18 WC 20666.

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.

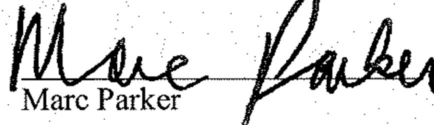
IT IS FURTHER ORDERED that Respondent shall receive a credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 6 - 2020

Deborah L. Simpson

Barbara N. Flores



Marc Parker

DLS/met
O: 9/17/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

20IWCC0649

ZUNIGA, EVERARDO
Employee/Petitioner

Case# **18WC015628**

18WC020666

CALUMET CARTON CO
Employer/Respondent

On 2/24/2020, 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 1.51% 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
DANA DJOKIC
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT E HARRINGTON JR
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

20IWCC0649

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)

EVERARDO ZUNIGA
Employee/Petitioner

v.

CALUMET CARTON CO.,
Employer/Respondent

Case # **18** WC **015628**

Consolidated cases: **18 WC 020666**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Tiffany Kay**, Arbitrator of the Commission, in the city of **Chicago**, on **May 14, 2019 and July 15, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

M. [x] Should penalties or fees be imposed upon Respondent?

N. [x] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS **20 I W CC0649**

On the date of accident, **4/23/18**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**52,298.48**; the average weekly wage was $**1,005.74**.

On the date of accident, Petitioner was **51** 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 $**21,455.68** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**21,455.68**.

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

ORDER

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries that arose out of and in the course of his employment by Respondent.

Respondent shall pay Petitioner for reasonable and necessary medical services of $1,280.00, as provided in Section 8(a) of the Act.

Penalties and attorney's fees are awarded as provided in Section 19(l) of the Act in regards to the 18wc20666/June 13, 2018 accident.

Respondent shall authorize and provide payment for reasonable and necessary prospective medical care as prescribed by Dr. Kung and Dr. Ham and any reasonable and necessary rehabilitative care needed, as provided in Section 8(a) of the Act.

The parties have stipulated that Respondent paid to Petitioner $21,455.68 in TTD for which Respondent shall be given a credit.

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.

02/20/2020

FEB 24 2020

PROCEDURAL HISTORY

This case has been consolidated with Case No. 18WC020666.

This matter was pursued under Section 19(b) of the Illinois Workers' Compensation Act (hereinafter "Act") by Mr. Everardo Zuniga (hereinafter "Petitioner") who is seeking relief from Calumet Carton Co. (hereinafter "Respondent"). This matter was heard on May 14, 2019 and July 15, 2019 in Chicago, Illinois before Arbitrator Tiffany Kay (hereinafter "Arbitrator Kay"). This matter was tried, the submitted records examined and a decision rendered by Arbitrator Kay.

The parties proceeded to hearing with disputed issues as to whether Petitioner sustained an accident that arose out of and in the course of his employment with Respondent, whether his alleged condition of ill-being is causally connected to his injury, and whether Respondent is liable for Petitioner's unpaid medical bills. In addition, whether Petitioner is entitled to prospective medical care and if Respondent is entitled to a credit for a temporary total disability overpayment. (Arb.X1)

The parties stipulated that Respondent was operating under the Illinois Workers' Compensation Act (hereinafter "Act"), that the Petitioner and Respondent had a relationship of employee and employer, that notice was given within the time limits stated in the Act, Petitioner's average weekly wage was $1005.74, 51 years old, and Petitioner was married with 0 dependent children. (Arb.X1)

SUMMARY OF TESTIMONY AND FACTS

Petitioner testified he has been employed by Calumet Carton Co. for 20 years. (T.13). He testified that his duties were to tie up bundles of paper through the use of a lot of force in order for him to tie them down tightly. (T.14). He testified he also had to shred paper in the shredder that was collected from all over the company and at times he had to remove plastic away from the paper. He testified he did this all day. (T.14). He testified that the bundles of paper weigh approximately 1,500 pounds but those were lifted with a forklift. (T.15). He testified that he worked 40 hours per week but sometimes over 40 hours. (T.15).

Mr. Zuniga testified that he would have to put wires around the bundles of paper and then tie them down with a lot of strength, then spin the wire five or six times in order to tie it down. (T.16). He testified he did those duties for the 20 years he was with the company. (T.16). He testified he had to use both hands and spent eight hours a day doing that. (T.16). He testified he had two breaks that were 10 minutes and 15 minutes. (T.17). The first break is for lunch and the other is just a break. He testified he typically started at 6:00 a.m. (T.17) and his workday ended typically at 2:00 p.m. (T.18). He testified that he did the tying duties by himself. He explained that first he has to wrap the bundles of paper because they come under pressure. The wire has a ring and a tip which is put through. Then he has to pull really hard to be able to keep the bundle tight. (T.18). He motioned how he has to grab the wire and pull it really tight. (T.18). He testified that he had to pull toward his body, as in a rowing motion. (T.19). Mr. Zuniga testified that while it depended on production, he had to tie approximately 15-20 bundles of paper per day. (T.20). He testified it took him the whole working day, except for breaks. (T.20).

He testified that on April 23, 2018, he was pulling one of the wires really tight and felt his right arm pop. (T.20). He testified he **felt pain in his right arm** at that time and reported it to his supervisor, Brian Beckman. (T.21). He testified that Brian drove him to Ingalls in South Holland, Illinois. (T.21). He testified that Brian did not wait with him and somebody came and picked him up later. (T.22). He testified that at Ingalls they took some x-rays and he was given medication. (T.22). He could not remember the medication but testified that it

was some sort of Cortisone medication. (T.22). He testified that he completed physical therapy at Ingalls, which addressed his right arm and wrist. (T.23). He was given restrictions which were accommodated by the Respondent when he returned to work the following day. (T.24). Mr. Zuniga did not miss any time from work as a result of the April 23, 2018 injury. (T.24). He testified that he was then referred to a specialist, Dr. Ham. (T.25).

Mr. Zuniga testified that as an accommodation to his restrictions, he cleaned floors using his left arm, and sometimes did sorting and inventory at the warehouse with boxes. (T.25). He recalled his restrictions on the right arm and hand being 10 pounds of lifting. (T.25-6).

June 13, 2018 accident

Mr. Zuniga testified that on June 13, 2018, he injured his left arm. (T.26). He testified that the whole day he had been cleaning the floor with a dust mop just using his left arm and the floor was really wet. (T.27). He testified he had to use more strength and felt pain in his arm that moved all the way up to his shoulder. (T.27). He testified that he wanted to report it to Robert Byrne, but because he wasn't there, he reported it to another supervisor named Dave Miller. (T.27). He testified that he explained to him how the accident happened and that he had pain in his [left] arm moving all the way up to his shoulder. (T.28). He testified that Mr. Miller sent him to Ingalls. (T.28). He testified that Mr. Miller drove him to Ingalls and dropped him off. (T.29). X-rays were taken and he was given a prescription. (T.29). He testified he returned to work the next day with a five-pound restriction. (T.30). He testified that he was also prescribed physical therapy and but only attended two sessions. (T.31-3).

Mr. Zuniga testified that he felt pain, tingling and loss of strength in his right arm. He testified he had pain and tingling in his left arm and his shoulder hurt as well. (T.33). He was wearing braces on each arm at the hearing and testified that a doctor at Ingalls had prescribed those. (T.33-4). He testified that he has not had surgery on either arm but that carpal tunnel surgery was recommended for the right arm and a surgery for his elbow. (T.34). He testified that carpal tunnel surgery was also recommended for his left arm as well as a surgery for his left shoulder. (T.36). He testified that he had EMG testing on both arms. (T.36). He testified that he wants to have both surgeries because he wants his hands to be "fine" and wants to recover strength so that he can continue work. (T.37).

He testified that he currently experiences loss of strength in each hand and cannot lift a lot of things, and experiences pain and tingling in each. (T.37). He testified that no surgeries are scheduled. (T.39). He testified that he worked another seven days after June 13, 2018 and stopped on approximately June 21, 2018. (T.40). He testified he has not received any TTD in 2019 and has been unable to work. (T.42). He testified he is not currently working anywhere and has not worked anywhere since he last worked at Calumet Carton Company. (T.43). He testified he is still under work restrictions. (T.43).

On cross-examination, Mr. Zuniga testified he is right-handed and injured his right wrist and forearm on April 23, 2018. (T.44). He testified he was seen at Ingalls Occupational clinic and x-rays were taken. (T.44). He testified he had told the doctor that he had been diagnosed two years earlier with rheumatoid arthritis. (T.45). He also told the doctor he had been taking Humira for that condition. (T.45). He testified he was given a wrist splint for the right wrist and released to restricted duty. (T.45). He testified that from April 24, 2018 through June 20, 2019 he worked light duty for the Respondent. (T.45-6). He testified he then injured his left arm on June 13, 2018 while pushing a dust mop which he did all day. (T.46). Counsel for Respondent showed Mr. Zuniga incident reports from Calumet Carton Co. (T.47, R.X.2). Mr. Zuniga confirmed for Counsel that there is a diagram of the human body on one page where Mr. Zuniga marked the right wrist and hand as referring to his injury on April 23, 2018. (T.48, R.X.2).

Counsel for Respondent then showed Mr. Zuniga an Employee Report of Injury for the June 13, 2018 injury and Mr. Zuniga confirmed that he completed it. (T.50, R.X.3). He confirmed for counsel that there is a diagram of the human body on one page where Mr. Zuniga marked the left forearm as referring to his injury of June 13, 2018 with the time of injury being 6:30 a.m. (T.50, R.X.3). Mr. Zuniga testified that his shift began at 6:00 a.m. (T.50). Mr. Zuniga confirmed that the date of the report is June 14, 2018. (T.51). Mr. Zuniga testified that he reported the incident of June 13, 2018 on the same date, but that Mr. Miller did not have time and told Mr. Zuniga to report it to him the following day. (T.52). Mr. Zuniga testified that he completed the report on June 14, 2018 but verbally notified Mr. Miller on June 13th. (T.52).

Mr. Zuniga testified that on June 13, 2018, he had a previously scheduled EMG with Dr. Michael Spence in Munster, Indiana for his right arm. (T.55). He testified that he made no complaints relative to his left arm to Dr. Spence on that date. (T.55). He testified that he did not remember dates of treatment at Ingalls, when given various dates by Counsel for Respondent. (T.57-58). When asked if, as a baler/operator he would only bundle one or two bundles of paper an hour, Mr. Zuniga denied that as being true. (T.58). Asked differently, Mr. Zuniga admitted that on average he would bundle eight to 10 bundles of paper on a regular shift and maybe up to 16-20 on a busy shift for the entire day. (T.59). Mr. Zuniga explained that it may not be just one to two bundles per hour but could be about three to four per hour, dependent on production. (T.59). He agreed with Counsel for Respondent that the bundles have to be unloaded from a truck with a forklift before he can bundle them and other things that have to be done. (T.60).

Mr. Zuniga testified that as part of his duties, he also had to collect all the scrap from around the premises, grind them on the grinder in the shredder, that he had to remove by hand all the pieces of plastic that the cartons may have on them, sometimes bring back five or six skids loaded from the warehouse, all by hand. (T.60). Mr. Zuniga testified that he would have to tie up the bundles. (T.61).

On re-direct examination, Mr. Zuniga testified that he was diagnosed with rheumatoid arthritis in regard to his toes and the pinky finger on his left hand. (T.61). He testified that prior to April 23, 2018, he did not have any problems with his right or left hand. (T.62). He testified that he could not remember the dates he had treatment at Ingalls in 2018. (T.62). He testified that he did not complain to the EMG doctor about his left arm, because only his right arm was being tested. (T.63). He reiterated that he reported his left arm injury to Dave Miller on June 13, 2018 and that neither he nor Mr. Miller filled out an accident report on that date. (T.63).

Mr. Zuniga clarified that on June 13, 2018, he started work at 6:00 a.m. (T.65). He clarified that he had been sweeping with his left arm for approximately two months before June 13, 2018. (T.65). He testified that he started feeling symptoms when he first began sweeping prior to June 13, 2018. (T.65). He testified that he did not report it prior to June 13, 2018 because it was a light pain until it became stronger on June 13, 2018. (T.66). Mr. Zuniga again testified that he signed a report on June 14, 2018 indicating that he had an accident on June 13, 2018 at 6:30 a.m. (T.67).

Robert Byrne's Testimony at Hearing

Mr. Robert Byrne testified at the hearing on behalf of the Respondent. He testified that he is employed by Respondent and had been so for over 10 years. (T.69). He testified his current job title is plant manager and it was so since "the beginning." (T.69). He testified he knows Mr. Zuniga because he has worked with him for the 10 years he has been with the company. (T.70). He testified he is familiar with Mr. Zuniga's job title as a baler/operator and that he is familiar with the job duties of such a title as they existed in April and June of 2018. (T.70). Mr. Byrne identified a job description and physical demands worksheet for a baler/operator. (T.71, R.X.1). Mr. Byrne testified about the job description worksheet indicating an employee uses both hands for

repetitive use. (T.72-3, R.X.1). He testified that between the words "light" and "firm" on the worksheet, the word "firm" is circled and specifies that the repetitive use is for .75 hours in a day. (T.72, R.X. 1). He testified that for "grasping" with both hands, the word "firm" is indicated for .75 hours per day. (T.72-3, R.X.1). He testified that for "turning" and "grasping," the word "firm" is again indicated as well as .25 hours per day. (T.73). He testified that as far as "fine manipulation" for either hand, the worksheet indicates "no." (T.73, R.X.1).

Mr. Byrne testified that he heard Mr. Zuniga's testimony as to the motions involved in tying a bale. (T.74). He testified that the tying or bundling is done with wire. (T.74). He testified that Mr. Zuniga was correct when he demonstrated a rowing motion with both hands toward his chest when describing the tying and bundling. (T.74-5). He testified that he agreed with Mr. Zuniga's testimony that a baler/operator would on average tie between 16-20 bundles a day. (T.75). He testified that that is not the same amount per hour. (T.75). He testified that the company has three operate [sic] balers that fill up at different rates, depending on how the machines are running and what machines are running. (T.75-6). He testified that the business has "seasonality" where the volume of work fluctuates. (T.76). He testified that he agreed that Mr. Zuniga also did other tasks, as well as shredding the corrugated boxes. (T.76). He testified that the corrugated boxes are accumulated and then put into a machine that shreds. (T.77). Mr. Byrne testified that baler/operators would go to other departments and retrieve waste carts on a forklift and take them to the baler area to do the shredding. (T.77).

Mr. Byrne testified that he worked on April 23, 2018. (T.77). He testified that Mr. Zuniga reported that he had hurt his right hand. (T.78). He further testified that Mr. Zuniga made an incident report to his supervisor that he had pain in his right hand and asked for medical attention. (T.78). Mr. Byrne testified that the reporting process at Respondent, is for employees to report all accidents ideally immediately, but as soon as practical after an event takes place. (T.78). After the accident is reported, the supervisor as well as the employee, would be required to fill out an accident report. (T.78). Mr. Byrne identified the employee report of injury for April 23, 2018 reflecting a time of injury of 8:20 a.m. (T.79, R.X.2). He testified that the report reflects David Miller as the supervisor and Brian Beckman as the person the incident was reported to on April 23, 2018. (T.80, R.X.2). Mr. Byrne confirmed the accuracy of Mr. Zuniga's testimony that Mr. Beckman took Petitioner to the clinic. (T.80). He confirmed that the only body part listed and indicated on the human body diagram on the April 23, 2018 report is the right hand. (T.81, R.X.2).

Mr. Byrne identified that it was part of the company's investigative process to do a follow-up. (T.81). In that regard, Mr. Byrne identified a third document in Respondent's Exhibit No. 2, called a Supervisor's Incident Investigation Report. (T.82, R.X.2). He testified that the report was completed by David Miller, Mr. Zuniga's direct supervisor. (T.82, R.X.2). He testified that the date of that report is April 23, 2018 which mentions the April 23, 2018 incident. (T.82, R.X.2). He testified that Respondent accommodated restrictions placed on Mr. Zuniga's right hand by the clinic doctor. (T.83). He testified that Mr. Zuniga worked until June 20, 2018. (T.83). He testified that Mr. Zuniga was transferred into a forklift operator position and assisting the regularly scheduled forklift operator doing inventories. (T.84). Mr. Byrne testified that Mr. Zuniga's restrictions changed throughout time but the company would adapt his duties to fit within the restrictions. (T.84). He testified that Mr. Zuniga was no driving a forklift in the beginning, but was helping with inventory, helping put away corrugated [boxes]. (T.84). Mr. Byrne testified that some of Mr. Zuniga's responsibilities got added on later as restrictions got lighter. (T.85).

Mr. Byrne testified that Mr. Zuniga reported an incident occurred on June 13, 2018. (T.85). Mr. Byrne identified an employee report of injury signed by Mr. Zuniga on June 14, 2018 showing an injury occurred at 6:30 a.m. (T.86, R.X.3). He testified that Mr. Zuniga's shift on June 13, 2018 started at 6:00 a.m. (T.86). Mr. Byrne read the description on the report of injury. (T.86):

"I was cleaning the floor with a dust mop and the floor in warehouse 8 was damp. I started to push. At putting more pressure with my left hand, I started to feel pain from my wrist to my elbow." (R.X.3).

Mr. Byrne testified that the report indicated injury from the wrist to the elbow and the left forearm was circled on a diagram of the human body. (T.87, R.X.3). He testified that the report indicates Mr. Zuniga reported the accident on June 14, 2018, and it was signed by Mr. Zuniga. (T.87, R.X.3). Mr. Byrne testified that the second page of R.X.3 is a supervisor's incident investigation report completed by David Miller on June 14, 2018. (T.88, R.X.3). The report indicated a date and time of accident being June 13, 2018 at 6:30 a.m. (T.88, R.X.3). Mr. Byrne read the description written by Mr. Miller stating, ". .while pushing a dust mop, he felt pain in his left arm." (R.X.3).

Mr. Byrne testified there was no reference to the right arm. Mr. Byrne testified that Mr. Zuniga continued to work for Respondent for about six more days, with his last day being June 20, 2018. (T.89, R.X.3). He testified that on June 20, 2018, Mr. Zuniga was seen at Ingalls clinic for the injury and returned with a restriction for five pounds on his left hand. (T.89). Mr. Byrne testified that there was already in place a restriction on the right hand so they had no light-duty that fit within both hands being restricted. (T.89-90). Mr. Byrne testified the company was no longer able to accommodate Mr. Zuniga's light-duty restrictions. (T.90).

Mr. Byrne testified that security camera footage in the area of the reported injury showed Mr. Zuniga pushing the dust mop. (T.90-1). He testified that security cameras were throughout the whole facility. (T.91). Mr. Byrne testified that upon viewing the footage, he saw Mr. Zuniga pushing the dust mop with both hands, and did not see in the video that the floor at the warehouse was wet, as Mr. Zuniga had testified. (T.91). Mr. Byrne testified that the video was taken on June 13, 2018 and the floor, made of polished concrete, looked dry on the video. (T.91-2). Mr. Byrne testified that the mop was a standard dust mop with a rectangular bottom, and that Mr. Zuniga was using both hands in the video. (T.92).

On cross-examination, Mr. Byrne testified that the wire used for tying bales was made out of an aluminum type material – flexible steel. (T.95). He testified he had never done any type of tying of bales. (T.95). He testified that he has watched Mr. Zuniga working. (T.95). He testified he has watched Mr. Zuniga working for "minutes," yet he was familiar with what Mr. Zuniga did in a day. (T.96). He testified that over the course of 10 years, he has observed all the tasks Mr. Zuniga did. (T.96). He testified that the weight of the dust mop was approximately two pounds – fairly light. (T.96). He testified that Mr. Zuniga's use of both hands while pushing the dust mop would have violated "the restriction" despite having a restriction of five pounds on each hand. (T.96-7).

When asked to explain how the restriction was violated by using both hands, Mr. Byrne testified he could not speak for the condition, but that it depended on how Mr. Zuniga was using and lifting the dust mop. (T.97). He admitted that Mr. Zuniga did not have a restriction on his left hand until June 20, 2018, but actually was not really sure if using his right hand with the dust mop violated any restriction. (T.97-8). Mr. Byrne testified that the video is 30 seconds long and the floor appeared dry. (T.98). He testified that it is possible the floor could have been wet, other than for the 30 seconds in the video. (T.98). He testified that the video captured and timeframe that Mr. Zuniga described being hurt in the report of injury. (T.98). Mr. Byrne testified that David Miller is a shift supervisor and that an employee can report an incident to him. (T.98).

On re-direct examination, Mr. Byrne testified that the time-stamp on the video was around 6:30 a.m. and that Mr. Zuniga's shift started at 6:00 a.m. (T.99-100). He testified that the video shows the truck bay where trucks back into and that there was not any water in the truck bay. (T.100). He testified that it is possible for trucks to come into the warehouse between 6:00 a.m. and 6:30 a.m., but there is no indication of puddles or

wet floor anywhere from what he could see in the video. (T.100). Mr. Byrne identified the security video disc dated June 13, 2018. (T.102).

Petitioner – rebuttal witness testimony

Petitioner testified that June 13, 2018 was a very humid day in the morning, so the floor was damp and had some exposure from the outside because of the approximately six docks that are always open. (T.105). He testified that the docks had a mesh protecting them. (T.105). He testified that Respondent had mops that were two or three pounds. (T.105). He agreed that at times he used both hands to do the mopping which was within his restrictions. (T.106).

Petitioner, on cross-examination testified that there were five or six docks in the bay and that the overhead doors were open the majority of the time. (T.106). He testified that the docks were open always, especially if it is humid or hot and that people open the doors to get air in (T.106-7). Finally, Petitioner testified that he did not know if the temperature was usually cooler at 6:00 a.m. than at noon. (T.107).

Medical Records

On April 23, 2018, Petitioner went to Ingalls Occupational Health ("Ingalls"). It is noted that he is an employee of Calumet Carton Company who is right-handed. He reported that while at work on April 23, 2018, he was pulling and twisting wires that were around a bale and started having pain and tingling with decreased mobility in the right hand. He reported that the pain seemed to be intermittent and made worse by performing work-related activities, yet improved with rest. He reported that he had no previous injury to his right hand. He advised that he was diagnosed with rheumatoid arthritis approximately two years earlier and was taking Humira for it. Mr. Zuniga also complained of tingling in the second, third and fourth fingers. An examination by nurse practitioner Christy Davis (hereinafter "Ms. Davis") revealed tenderness to palpation over all aspects of the right wrist and forearm. Phalen's and Tinel's tests were positive indicating carpal tunnel syndrome. X-rays of the right wrist and forearm done on the same date were negative. The diagnosis was carpal tunnel syndrome in the right upper limp and pain in the right wrist. Ms. Davis explained that Mr. Zuniga had an overuse history at work associated with hand-tying wire around bales. (P.X.3).

A Medrol Dosepak was prescribed to cover a possible rheumatoid arthritis flare-up that is also associated with an overuse injury as well as carpal tunnel syndrome. Petitioner was prescribed a wrist splint and a home exercise program. Ms. Davis discussed physical activities and work activities that would aggravate the problem. A restriction of two pounds maximum lift and carry was placed on the right hand. A drug screen was negative for alcohol and narcotics. (P.X.3).

On April 27, 2018, Petitioner returned to Ingalls for a follow-up appointment. He reported that he felt his pain was improving or "just about gone" as he was on his last day of the Medrol Dosepak. However, it is noted he had been working light duty – checking off inventory, using a pen – which he felt exacerbated his pain. Ms. Davis again explained to Mr. Zuniga that he had an overuse history at work associated with hand tying wire around bales. Mr. Zuniga was prescribed naproxen. After an exam, the diagnosis was the same as before – carpal tunnel syndrome in the right upper limb and pain in the right wrist. Ms. Davis opined that Mr. Zuniga's symptoms were consistent with carpal tunnel syndrome, but that that needs to be confirmed by EMG. Ms. Davis prescribed physical therapy, continued use of the wrist splint, and continuation of the home exercise program. She increased the lift/carry maximum to five pounds with the right hand. (P.X.3).

On May 4, 2018, Petitioner had another follow-up at Ingalls on with a different nurse practitioner. It is noted that pain, tingling and decreased mobility began in his right hand on April 23, 2018 while pulling and

twisting wires around a bale at work. While he reported a pain level of 0/10 at the visit, he also reported that this was true when his right hand was not in use, but that pain and weakness returned with increased use. He also reported tingling in his right hand and increased pain while sleeping which woke him up. He had completed two sessions of physical therapy with little relief. Phalen's and Tinel's tests were still positive on the right. The diagnosis was the same as at previous visits and carpal tunnel syndrome was discussed. Ms. Lewis-Buchanan noted that carpal tunnel syndrome would be confirmed through an EMG so the plan was to have that done and for Mr. Zuniga to continue physical therapy, use of the wrist splint, and home exercise program. Ms. Lewis-Buchanan wrote in her visit note that "[t]he cause of this problem is related to work activities." She continued the prior five-pound restriction. (P.X.3).

On May 11, 2018, Petitioner returned to Ingalls for a follow-up. He reported having minimal to no pain when his right hand was not in use, but worse pain when performing work-related activities and writing with a pen. He reported that the pain was in the volar aspect of his forearm with tingling into the second, third and fourth digits of the right hand. He reported that he was experiencing pain and weakness with increased use, and increased pain and tingling while sleeping, which awakened him. Nurse practitioner Jennifer Schnell's (hereinafter "Ms. Schnell") examination revealed tenderness over all aspects of the right wrist and forearm. She was able to reproduce pain with flexion, extension, inversion and eversion of the right wrist. Ms. Schnell noted that Phalen's and Tinel's tests were positive with pain and tenderness still in the medial aspect of the forearm and highly likely due to tendinitis and cumulative trauma from 19 years of doing the same job. She opined that an EMG/NCV of the right upper extremity would be a good test to confirm carpal tunnel syndrome and wrote an order for that. She noted it was imperative that Mr. Zuniga rest the tendons and muscles of his right forearm, continue using the wrist splint, and continue physical therapy to focus on the reduction of inflammation. (P.X.3).

Ms. Schnell recommended that Mr. Zuniga have a blood sugar test performed. She also wrote in her visit note that "[t]he cause of this problem is related to work activities." She increased the lift, carry maximum to 10 pounds with the right hand. (P.X.3).

Petitioner was doing physical therapy at Ingalls Center for Outpatient Rehabilitation in South Holland, Illinois. (P.X.3).

On May 18, 2018, Mr. Zuniga returned to Ingalls for another follow-up. He reported minimal pain in his right hand when not in use, but made worse by performing work-related activities and writing with a pen. He reported that pain was in the same location as before - the volar aspect of the forearm with tingling into the second, third, and fourth fingers of the right hand. He again reported pain and tingling in his right hand while sleeping which awakened him. He had completed four out of six sessions of physical therapy and was given a second order for six sessions. He had completed three out of six sessions from that order. He was scheduled for the remaining three sessions in the coming week. He reported that he felt no improvement after completing the sessions that he did. The diagnosis was the same as at the prior visits. Nurse practitioner Christy Davis still felt that Mr. Zuniga had symptoms consistent with carpal tunnel syndrome but that confirmation was needed through EMG. She recommended completion of the additional three sessions of physical therapy and continued use of the wrist splint. She recommended that Mr. Zuniga have the EMG completed for the next appointment. The same 10-pound lift and carry restriction was in place. (P.X.3).

On May 30, 2018, Petitioner saw Dr. Patrice Burch (hereinafter "Dr. Burch") at Ingalls for a follow-up. Mr. Zuniga reported no improvement in pain level with activity and that he was awaiting an EMG to be performed to get a definitive diagnosis of carpal tunnel. Dr. Burch noted that the problem in the right hand began on April 23, 2018 while at work pulling and twisting wires that were around a bale. Mr. Zuniga reported no improvement after completing the total of seven physical therapy sessions. He reported persistence of

weakness and tingling in the right hand and decreased strength in the fingers, yet minimal to no pain when his right hand was not in use. Dr. Burch wrote that there was no change in the exam. She recommended that Mr. Zuniga complete the one sessions of physical therapy that he had scheduled, continue use of the wrist splint, continue naproxen over-the-counter, and the home exercise program. Dr. Burch kept the same 10-pound lift, carry restriction. (P.X.3).

On June 6, 2018, Petitioner had a follow-up with nurse practitioner Carmelita Lewis-Buchanan at Ingalls. Petitioner reported that he completed 15 sessions of physical therapy and felt as if there was no effect on his right hand injury. He reported being scheduled for an EMG on June 13, 2018. Phalen's and Tinel's tests were still positive and there was no change in the exam. Mr. Zuniga was instructed to complete physical therapy, continue with the wrist splint, continue naproxen as needed for pain, and continue the home exercise program. The same 10-pound lift, carry restrictions was in place. (P.X.3).

On June 13, 2018, Petitioner had the EMG/NCV with Dr. Michael Spence. (P.X.5). As Mr. Zuniga had testified and as the record reflects, the EMG/NCV focused only on the right upper extremity. (P.X.5). The result was consistent with a severe proximal right median neuropathy at the forearm suggestive of pronator syndrome, severe proximal right ulnar neuropathy likely at the elbow, and carpal tunnel syndrome at the right wrist. (P.X.5).

On June 18, 2018, Petitioner saw Dr. Amy Allegretti (hereinafter "Dr. Allegretti) at Ingalls for a follow-up. The same work history is repeated, along with Mr. Zuniga's complaints of pain while performing work-related activities or writing with a pen, with accompanying numbness and tingling to the fingers. He reported that his symptoms were improved with rest. He reported no improvement from physical therapy, continued use of the wrist splint and non-steroidal anti-inflammatory medication. Dr. Allegretti reviewed the EMG study of the right upper extremity that was done on June 13, 2018 and noted findings of carpal tunnel syndrome, pronator syndrome, and ulnar neuropathy. Her examination revealed pain with forced supination and pronation, tenderness to forearm musculature, tenderness at the medial epicondyle, pain with flexion, extension, inversion and eversion of the right wrist, pain with forced supination/pronation of the right forearm, pain at end range of motion flexion and extension of the right wrist, and decreased sensation to light touch of the right first three fingertips. Dr. Allegretti referred Mr. Zuniga to an orthopedic hand doctor for further evaluation. She reduced the lift, carry maximum from 10 pounds to five pounds. (P.X.3).

On June 25, 2018, Petitioner saw Dr. Daniel Bakston (hereinafter "Dr. Bakston") at Ingalls. Dr. Bakston's note provides that Mr. Zuniga began having problems in the right hand/wrist and forearm on June 13, 2018. Mr. Zuniga described a burning sensation in that extremity and reported that the pain and burning was made worse by moving the extremity. Mr. Zuniga also reported numbness in the forearm. The history recorded is that Mr. Zuniga said he was using more force mopping the floor and felt forearm and upper arm pain in April. The sentence is grammatically non-sensical. Dr. Bakston noted that Mr. Zuniga was demonstrated to have severe carpal tunnel syndrome and pronator Teres syndrome. He noted that Mr. Zuniga had 16 sessions of physical therapy which did not help and was pending a hand/ortho specialist referral. Dr. Bakston diagnosed right carpal tunnel syndrome, right ulnar nerve lesion and right median nerve lesion. A fourth unusual diagnosis was "[o]verexertion from prolonged static or awkward postures . .." Dr. Bakston recommended Tylenol for pain, continued use of the wrist splint at night and with activity, ICE as needed and for Mr. Zuniga to continue with the home exercise program. Dr. Bakston held any further therapy and requested a referral to a hand ortho a second time for the right wrist and hand. He reiterated the same 10-pound restriction. (P.X.3).

On June 27, 2018, Petitioner saw Ms. Davis again at Ingalls and reported that while at work on restricted duty for his right arm injury, he was using his left arm repetitively and was experiencing pain that started in the left wrist, radiated into the left elbow and into the shoulder. It is noted that the problem started on June 13,

2018. The history noted is that Petitioner was using more force mopping the floor with his left arm "last Wednesday" and was experiencing generalized left forearm and upper arm pain. He denied numbness or tingling in the left upper extremity. There were no acute findings on x-ray of the left upper extremity. After an examination, the diagnosis was strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm. It was explained that the x-rays were done to establish a baseline for the new injury complaint and because Petitioner has an underlying history of rheumatoid arthritis. Petitioner was told to continue with Tylenol and naproxen as prescribed for his right hand/wrist. He was advised to continue with the home exercise program. An order for physical therapy for the left upper extremity from elbow to wrist was made. Ms. Davis opined that the left shoulder was consistent with an overuse injury but that physical therapy would focus on the left wrist and elbow as the pain was originating from the wrist. Mr. Zuniga now had a restriction of 10 pounds maximum lift, carry and no repetitive motions as to the left upper extremity (P.X.3).

Dr. Bakston referred Petitioner to Dr. John Kung (hereinafter "Dr. Kung") at Illinois Premier Orthopaedic and Hand Center. On July 2, 2018, during a visit with Dr. Kung, Petitioner complained of right hand pain since April 23, 2018 after twisting wires. He described also feeling pain, some numbness and tingling radiating into the right elbow, and loss of strength. After an examination, Dr. Kung's assessment was right carpal tunnel syndrome and lesions of the right ulnar and radial nerves. Dr. Kung reviewed the EMG/NCV findings of right carpal tunnel syndrome, pronator syndrome and cubital tunnel syndrome and discussed options with Mr. Zuniga. Dr. Kung's also examined the left upper extremity. Dr. Kung then provided an injection of Celestone and lidocaine into the right carpal tunnel and right radial tunnel. Dr. Kung placed a five-pound lifting restriction along with no repetitive pushing/pulling and no repetitive grasping. Mr. Zuniga was also required to wear a splint. (P.X.8).

On July 11, 2018, Petitioner saw Dr. Kung for a second time. An exam of the right upper extremity revealed tenderness at the lateral forearm, at the radial tunnel area, and over the ulnar nerve in the cubital tunnel. Tinel's sign along the median nerve was negative, but was positive along the ulnar nerve at the elbow. Phalen's sign was positive along the median nerve at the wrist. Dr. Kung's also examined the left upper extremity. Dr. Kung's assessment at this visit was right carpal tunnel syndrome and lesions of the ulnar and radial nerves. Dr. Kung mentioned that a repeat EMG/NCV of the right arm was pending. He discussed with Mr. Zuniga that he may need surgery and Mr. Zuniga advised he wished to have it done closer to where he lives in Portage, Indiana. Dr. Kung referred Petitioner to Dr. Kenneth Ham. Dr. Kung placed a five-pound lifting restriction along with no repetitive grasping and no use of vibratory tools. Mr. Zuniga was also required to wear a splint. (P.X.8).

On August 7, 2018, Petitioner had an EMG/NCV test on the left upper extremity with limited comparison on the right (per protocol) by Dr. Richard L. Cristea. Mr. Zuniga complained of left wrist pain that radiated up into his forearm. He also reported a little numbness in his left first, second and third digits. The study revealed evidence for bilateral median neuropathies at or distal to the wrists (such as that as seen in carpal tunnel syndrome), characterized as mild in degree bilaterally, with slightly more involvement on the right than left. (P.X.8).

On August 15, 2018, Petitioner returned to see Dr. Kung. It is noted that Petitioner had a new complaint of left wrist pain with numbness and tingling since June 13, 2018. The history reported is that Petitioner was pushing a broom at work and felt pain, pressure and numbness. His left arm had been splinted and x-rayed, and an EMG had been performed. Mr. Zuniga complained of a sensation of pins and needles in his left wrist and hand with mild-to-moderate pain. An exam of the right upper extremity revealed tenderness at the lateral forearm, the radial tunnel area, and over the ulnar nerve in the cubital tunnel. There was no tenderness at the pronator syndrome area. An exam of the left upper extremity revealed scattered tenderness over the volar forearm and a positive Tinel's sign along the median nerve at the wrist. There was full range of motion without

pain, however, and normal sensation. Dr. Kung's assessment was right carpal tunnel syndrome and lesions of the ulnar and radial nerves on the right, and left carpal tunnel syndrome. Dr. Kung recommended a repeat EMG/NCV of the right arm. He discussed with Mr. Zuniga that he may need surgery and Mr. Zuniga expressed wanting to have it done closer to his home in Portage, Indiana. Dr. Kung referred Mr. Zuniga to Dr. Kenneth Ham. Dr. Kung kept the same restrictions in place. (P.X.8).

On August 31, 2018, Petitioner saw Dr. Kenneth Ham (hereinafter "Dr. Ham") at Bone & Joint Specialists. Dr. Ham noted that Mr. Zuniga reported bilateral hand numbness and tingling apparently from pulling wires and tying bales with a repetitive wrist motion. Dr. Ham noted that Mr. Zuniga had completed an EMG on each extremity at two different locations. He noted that the right upper extremity EMG concluded that Mr. Zuniga had pronator syndrome, severe carpal tunnel syndrome, and cubital tunnel syndrome. He noted that the left EMG concluded that Mr. Zuniga had carpal tunnel syndrome. Dr. Ham noted the injection given by Dr. Kung, which Petitioner reported did not alleviate his pain. Dr. Ham's examination revealed some positive Tinel's over the pronator area, carpal tunnel and elbow on the right, but a negative Tinel's on the left over the elbow. Dr. Ham's assessment was bilateral carpal tunnel syndrome, pronator syndrome on the right and cubital tunnel syndrome on the right. He reviewed Petitioners medications. Dr. Ham opined that Mr. Zuniga seems to have failed conservative measure and therefore, carpal tunnel releases [both wrists], a pronator release and cubital tunnel release [right only] were recommended. He opined that the nerve testing on the right side showed a severe degree for which the recommendation was made for surgical decompression. Dr. Ham ordered pre-op testing. (P.X.5).

On October 23, 2018, Petitioner saw Dr. John Diveris (hereinafter "Dr. Diveris") for new left shoulder pain. Mr. Zuniga hand-wrote on the Patient History sheet that the onset date was one year earlier when he was playing with his son and his son pulled his left arm too hard. Dr. Diveris diagnosed adhesive capsulitis of the left shoulder. (P.X.6).

On November 16, 2018, Petitioner had a second visit with Dr. Ham. He reported numbness in all fingers. An exam revealed positive Tinel's over the right lateral epicondyle, the pronator, the carpal tunnel, and cubital tunnel, all on the right. His impression was right upper limb carpal tunnel syndrome. He noted that Mr. Zuniga [surgery] is pending workers' compensation approval. He advised Mr. Zuniga to return when medically cleared. (P.X5).

<u>Section 12 Examination by Dr. Sam Biafora</u>

Dr. Biafora examined Petitioner on February 7, 2019 at the request of the Respondent in regard to the April 23, 2018 date of injury. Dr. Biafora's examination revealed diffuse tenderness in the bilateral elbows throughout. He noted more significant tenderness throughout the extensor forearm and flexor forearm bilaterally. He noted tenderness bilaterally at the medial and lateral epicondyles. He noted pain with Tinel's at the cubital tunnel, though Mr. Zuniga denied any radiation of symptoms into the forearm or hand. Dr. Biafora diagnosed Mr. Zuniga with diffuse pain complaints with electrodiagnostic evidence consistent with right pronator syndrome on the right, right cubital tunnel syndrome and right carpal tunnel syndrome. (R.X4) He opined that ulnar nerve compression at the elbow (cubital tunnel syndrome), median nerve compression in the forearm (pronator syndrome), and carpal tunnel syndrome (median nerve compression at the wrist), can explain numbness, tingling and pain complaints into the hand. Pronator syndrome can explain some pain in the area of the median nerve/pronator in the forearm. Dr. Biafora opined that it cannot explain the diffuse tenderness throughout the forearm as identified through his exam. Dr. Biafora is of the opinion that there is no causal connection between Mr. Zuniga's right upper extremity complaints and the electrodiagnostic findings. (R.X4)

Section 12 Examination by Dr. Nikhil Verma

On February 25, 2019, Dr. Verma examined Petitioner at the request of Respondent in regard to the June 13, 2018 date of injury. Dr. Verma, by reviewing a job description of duties Mr. Zuniga is required to perform, noted that Mr. Zuniga is required to perform grasping, turning, and fine manipulation. However, his opinions were based on a causal connection between Mr. Zuniga's left shoulder condition of adhesive capsulitis and work injury of June 13, 2018. The injury Mr. Zuniga is claiming occurred on June 13, 2018 is left carpal tunnel syndrome. The records reflect that Petitioner told his doctor that his left shoulder issue started a year prior to the visit and was the result of his son pulling hard on his left arm. Dr. Verma did not address the left carpal tunnel syndrome. (R.X5)

CONCLUSIONS OF LAW

With respect to issues (C) whether an accident occurred that arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that Petitioner proved by a preponderance of the evidence that his accident on April 23, 2018, arose out of and in the course of his employment with Respondent. In addition, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that his accident on June 13, 2018, also arose out of and in the course of his employment with Respondent. "A claimant bears the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of the employment." 820 ILCS 305/2 (West 2002). Both elements must be present in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483, 137 Ill. Dec. 658, 546, N.E.2d 603 (1987).

A claimant's injury "arises out of" his or her employment if the origin of the injury "is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury." *Saunders v. Industrial Comm'n*, 189 Ill. 2d 623, 627 (2000). A risk is incidental to the employment when it belongs to or is connected with what the employee has to do in fulfilling the employee's duties. *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 45 (1987). In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n*, 167 Ill.2d 77, 81. With respect to factual matters, it is within the province of the Commission to judge the credibility of the witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences therefrom. *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill.App.3d 665, 674 (2009).

18wc15628 – April 23, 2018 accident and 18wc20666 – June 13, 2018 accident

Petitioner testified that prior to working for the Respondent he had not experienced any problems with his right upper extremity or left upper extremity. The medical records entered into evidence did not reflect that any prior injuries to either the right upper extremity or the left upper extremity. In addition, Respondent presented no evidence to the contrary of this testimony. Petitioner had been employed by and working for Respondent for 19 years prior to his alleged April 23, 2018 and June 13, 2018 accidents. Petitioner testified that he reported both accidents on the same dates they occurred. The medical evidence entered and Petitioner's testimony, corroborate that he was taken to Ingalls by employees of the Respondent on April 23, 2018 and on June 13, 2018. Respondent submitted a security video showing Petitioner mopping the warehouse floor on June 13, 2018 in order to establish that Petitioner had no problems with that work activity since he was using both upper extremities. The video is about 30 seconds long and does not sufficiently depict Petitioner as he was working on June 13, 2018. It is insufficient to conclude by way of the short security video, that Petitioner was mopping with no problems in either upper extremity. Petitioner is seen in the video wearing wrist splints on

both forearms/hands. In review of the medical records presented into evidence, Petitioner's physicians infer that it is sufficient that such work activities performed by Petitioner repetitively and over time is sufficient to cause symptoms in an upper extremity. The Arbitrator concludes that the Petitioner has proven, by a preponderance of the evidence, that accidents occurred that arose out of and in the course of his employment with Respondent on April 23, 2018 and June 13, 2018.

With respect to issue (F) whether the Petitioner's current condition of ill-being is causally related to the Injury, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds that the Petitioner proved by a preponderance of the evidence that his current condition of ill-being related to his right upper extremity and left wrist is casually connected to his April 23, 2018 and June 13, 2018 work accidents.

"In a workers' compensation case, the claimant has the burden of proving by a preponderance of the evidence, some causal relation between her employment and her injury." Mansfield v. Ill. Workers' Comp Comm'n, 2013 IL App (2d) 120909WC, p. 27, 376 Ill. Dec 657, 999 NE 2d 832.

In order to obtain compensation under the Act, a claimant must prove, by a preponderance of the evidence, that he suffered an injury which arose out of and in the course of employment. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203, (2003). For a finding that an injury "arose out of" employment, the injury must have "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." Id. at 203.

For an employee's workplace injury to be compensable under the Workers' Compensation Act, he must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. Hansel & Gretel Day Care Center v. Industrial Comm'n, 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. Board of Trustees of the University of Illinois v. Industrial Comm'n, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969).

It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. O'Dette v. Industrial Comm'n, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. Hosteny v. Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 674 (2009).

The Arbitrator finds that Petitioner's current conditions of ill-being are causally related to the accidents of April 23, 2018 and June 13, 2018. There was no testimony elicited that Petitioner had prior problems with either his right upper extremity or left upper extremity prior to the aforementioned accidents. The medical records reflect the onset dates of symptoms to each upper extremity. The medical evidence corroborates the onset dates of Petitioner's symptoms and thus, through the continuation of treatment, it is evident that Petitioner's current conditions of ill-being in each upper extremity are causally related to each respective accident date. Petitioner testified he was on light duty for a period of time as a result of his right upper extremity injury. He testified that he then worked substantially with the use of his left upper extremity.

Dr. Biafora's Section 12 examination revealed diffuse tenderness in the bilateral elbows throughout. He noted more significant tenderness throughout the extensor forearm and flexor forearm bilaterally. Dr. Biafora

diagnosed Mr. Zuniga with diffuse pain complaints with electrodiagnostic evidence consistent with right pronator syndrome on the right, right cubital tunnel syndrome and right carpal tunnel syndrome. However, he fails to consider that the pain and symptoms that Petitioner complained of his hand, wrist, elbow and forearm, are all interrelated to comprise the diagnoses of pronator syndrome, right cubital tunnel syndrome and right carpal tunnel syndrome. Further, it is counter-intuitive that there would be no causal connection between Mr. Zuniga's right upper extremity symptoms and the electrodiagnostic findings per Dr. Biafora. The question of whether there is a causal connection goes to the electrodiagnostic findings and the actual diagnoses, not symptoms. Symptoms may not be definitive, but electrodiagnostic findings are definitive and it is based on those findings that Dr. Biafora's diagnoses is the same as the treating providers in regard to the right upper extremity. Dr. Biafora's causal connection denial seems counter-intuitive.

Dr. Biafora believes that Mr. Zuniga's underlying known conditions of rheumatoid arthritis and fibromyalgia are a "contributing factor" in his diffuse findings and complaints of the wrist, forearm and elbow. However, there is nothing in the medical evidence to suggest that the rheumatoid arthritis and/or fibromyalgia are the sole or significantly greater causative factors. Dr. Biafora fails to acknowledge the 19+ years of work duties Petitioner has been performing for Respondent. Based on the Findings of Fact above, the Arbitrator finds the Petitioner's treating providers more credible than Dr. Biafora. The treating providers conducted more extensive examinations, had more knowledge of Mr. Zuniga's consistent right upper extremity complaints and symptoms, and noted specific history.

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the Petitioner and finds Petitioner's treating providers to be credible. The Arbitrator finds a causal connection between Petitioner's current condition of ill-being in the right upper extremity and the work accident of April 23, 2018. The Arbitrator finds a causal connection between Petitioner's current condition of ill-being in the left upper extremity and the work accident of June 13, 2018.

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

The Arbitrator concludes that Respondent has not paid all appropriate charges for reasonable and necessary medical treatment. Petitioner offered into evidence medical expenses totaling $3,453.00 for both dates of accident. These expenses were incurred for services rendered by Ingalls Care Center, Bone & Joint Specialists, Diveris Orthopedics & Sports Medicine, Community Healthcare System, and Premier Orhtopaedic & Hand Center. The Arbitrator finds that the uncontradicted testimony of Petitioner as well as the certified medical records, establish that these expenses were incurred when Mr. Zuniga sought treatment after his injuries on April 23, 2018 and June 13, 2018.

The Arbitrator finds that the treatment rendered by the providers was necessary and reasonable as defined by Section 8(a). Therefore, the Arbitrator finds Petitioner is entitled to an award of $3,453.00 for said medical expenses.

With respect to issue (K), whether the Petitioner is entitled to Prospective Medical Care, the Arbitrator finds as follows:

The Arbitrator adopts the above findings of fact in support of the conclusions of law and set forth below. The Arbitrator finds Petitioner's current condition of ill-being are relative and causally related to his work accidents on April 23, 2018 and June 13, 2018. It has been recommended by Dr. Kung and Dr. Ham that Petitioner undergo carpal tunnel releases as a result of his work injuries. Petitioner testified that he wishes to

have the surgeries performed in order to alleviate his pain so that he can return to work. The Arbitrator finds that the recommendations of Dr. Kung and Dr. Ham are reasonable, necessary and causally related to the work accidents of April 23, 2018 and June 13, 2018. Respondent shall pay for such treatment to the right wrist and left wrist.

With respect to issue (L), whether Petitioner is entitled to TTD Benefits for the June 13, 2018 accident for the period of time between 2/1/19 and 5/4/19, representing 14&5/7ths weeks, the Arbitrator finds as follows:

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to TTD benefits from February 1, 2019 through May 14, 2019 for the June 13, 2018 date of injury. That time period represents 14 & 5/7ths weeks. Using the stipulated rate of $518.93, the Petitioner is owed $7,635.67 in TTD benefits by Respondent.

With respect to issue (M), whether Penalties should be imposed upon Respondent, the Arbitrator finds as follows:

Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous for the delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

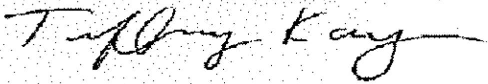
Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a0 or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

Evidence was introduced that Petitioner worked light duty and received a full salary between April 24, 2018 through the end of 2018. Effective February 1, 2019, Respondent could no longer accommodate Petitioner's new restrictions. Temporary Total Disability Benefits were not paid from February 1, 2019 through May 14, 2019. After reviewing the testimony and evidence submitted by the parties, the Arbitrator finds the Petitioner is entitled penalties under Section 19 (l). In reaching said decision, the Arbitrator finds that there was an unreasonable delay by Respondent to pay the Petitioner TTD benefits.

With respect to issue (N), whether Respondent is due any credit, the Arbitrator finds as follows:

The parties have stipulated that Respondent paid to Petitioner $21,455.68 in TTD for which Respondent shall be given a credit.



Signature of Arbitrator

02/20/2020

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EVERARDO ZUNIGA,

Petitioner,

20 I W CC0650

vs. NO: 18 WC 20666

CALUMET CARTON COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment on June 13, 2018.

I. Findings of Fact

Petitioner was employed as a baler/operator for Respondent. However, on June 13, 2018, he was working in an accommodated position after being placed on light duty restrictions for his right upper extremity related to an April 23, 2018 accident, which is covered under the consolidated claim of 18 WC 15628 and addressed by the Commission in a separate Decision.

On direct examination, Petitioner testified that his accommodated duties included cleaning the floors with his left arm, sorting, and completing inventory of boxes at the warehouse. He testified that on June 13, 2018, he had been cleaning the floor with a dust mop the whole day just using his left arm when he felt pain in his left arm that moved all the way up to his shoulder. Petitioner testified that the floor was really wet that day, so he had to use more strength. He testified that after reporting the pain to Dave Miller, his supervisor, Mr. Miller drove him to and dropped him off at Ingalls Clinic. Petitioner testified that he thereafter returned to work the following day with a five-pound restriction for his left hand.

On cross examination, Petitioner further testified that he had been pushing the dust mop all day when he injured his left arm. He then identified his signature on RX 3, which was an employee

report of injury he filled out on June 14, 2018 that indicated his shift had begun at 6:00 a.m. and his injury had occurred at 6:30 a.m. Petitioner testified that he had been working for eight hours pushing the mop on June 13, 2018, but he nevertheless agreed that the accident report said the accident happened 30 minutes after his shift started. When asked to clarify if he had pushed the mop for eight hours or 30 minutes, Petitioner testified that when the accident happened at 6:30 a.m., he could not find Mr. Miller, so he continued pushing the mop and doing his work. He testified that he worked approximately a full day, but he also agreed that at 12:24 p.m. on the accident date, he saw Dr. Michael Spence in Munster, Indiana for a previously scheduled right arm EMG. Petitioner testified that he did not make any left arm complaints, nor mention any left arm injury, to Dr. Spence at that appointment.

On redirect examination, Petitioner testified that he verbally reported his left arm injury to Mr. Miller on June 13, 2018, but he did not fill out his report until the next day, because he could not initially find Mr. Miller on the accident date and only found him when he was on his way out. Petitioner then testified that it was possible he may not have gone to Ingalls Clinic on June 13, 2018.

Robert Byrne, Respondent's plant manager, testified that after RX 3 was completed, Petitioner continued to work in his light duty accommodated position for six more days until his last day on June 20, 2018. He testified that Petitioner's light duty work ended, because Petitioner was seen at Ingalls Clinic and given a five-pound restriction on his left hand that Respondent could no longer accommodate.

Mr. Byrne further testified that Respondent's investigation into Petitioner's accident included reviewing security camera footage in the area of the reported injury. Mr. Byrne testified that when he looked at the footage, he saw Petitioner pushing the dust mop with both hands. He testified that he did not observe the floor to be damp or wet on the video. Instead, he testified that the floor, which was made of polished concrete, looked dry. Nevertheless, Mr. Byrne conceded that the video was only 30 seconds long, and it was possible that the floor could have been wet other than those 30 seconds. Mr. Byrne identified RX 6 as a true and accurate copy of the video retrieved from the security camera on June 13, 2018 at around 6:25 a.m. He testified that the video showed no water in the truck bay and no indication of puddles or a wet floor anywhere. He further estimated that the dust mop Petitioner was seen pushing weighed approximately two pounds.

After Mr. Byrne testified, Petitioner was recalled as a witness by his attorney. In his rebuttal testimony, Petitioner testified that the floor he was mopping was damp, because it was a very humid morning. He explained that the floor was exposed to the outside, as there were approximately six docks in the area that were regularly open and had just a mesh screen protecting them. Petitioner also testified that the mops he used weighed two to three pounds. He testified that even though he used both hands to mop at times, it was still within his restrictions.

The treatment records show that on June 13, 2018, Petitioner was under light duty restrictions with a 10-pound weight limitation for his right hand from Ingalls Clinic. After the accident, on June 13, 2018, Petitioner presented for a right upper extremity EMG at 12:24 p.m. followed by a physical therapy session for his right hand at Ingalls Clinic. Petitioner made no left hand complaints at either of these visits, nor did he complain of any left hand symptoms when he

followed up at Ingalls Clinic for his right hand on June 18, 2018.

On June 25, 2018, Petitioner told Dr. Daniel Bakston at Ingalls Clinic that he had right hand and forearm pain accompanied with numbness that began on June 13, 2018. Petitioner reported that he was using force to mop the floor when he felt the forearm and upper arm pain. Although Petitioner discussed the June 13, 2018 accident, this treatment note references Petitioner's right hand as opposed to his left hand. Dr. Bakston's diagnoses were right carpal tunnel syndrome, right ulnar and median nerve lesions, and overexertion from prolonged static and awkward positions.

The first treatment note focused on the left upper extremity was Petitioner's June 27, 2018 visit at Ingalls Clinic. At that time, Petitioner reported that he was on restricted duty for his right arm and using his left arm repetitively. He complained of pain in his left arm from the shoulder to the wrist that began on June 13, 2018 after he had used more force to mop the floor with his left arm. On exam, a Phalen's test was negative and a Tinel's test was positive for the left wrist. X-rays of left wrist, elbow, and shoulder further revealed no acute findings. Christy Davis, a nurse practitioner, diagnosed Petitioner with left wrist pain and a strain of the muscle, fascia, and tendon at the left shoulder and upper arm level. She indicated that Petitioner's left shoulder problem was consistent with an overuse injury. Nevertheless, Nurse Practitioner Davis stated that she would focus on the left wrist and elbow, because Petitioner's pain originated in the left wrist. She recommended Tylenol and naproxen, ordered occupational therapy, and provided light duty restrictions for the left arm.

On July 2, 2018 and July 11, 2018, Petitioner treated for his right upper extremity with Dr. John Kung of Illinois Premier Orthopaedic and Hand Center. Petitioner's left upper extremity complaints were not the main focus of these appointments; however, at the July 2, 2018 visit, Dr. Kung noted that an exam of Petitioner's left upper extremity was normal with negative Phalen's and Tinel's tests on the left side.

On August 7, 2018, a left upper extremity EMG with limited comparison on the right revealed bilateral median neuropathies at or distal to the wrists, such as seen in carpal tunnel syndrome, with slightly more involvement on the right than left. There was no other evidence of left cervical radiculopathy, left brachial plexopathy, or any disorder of the lower motor neuron.

When Petitioner returned to Dr. Kung on August 15, 2019, he noted a new complaint of left wrist pain with numbness and tingling since June 13, 2018. Petitioner reported that he was using a broom at work when he felt pain, pressure, and numbness. Dr. Kung's left wrist exam revealed tenderness in the volar forearm and a positive Tinel's sign along the median nerve. Dr. Kung added a diagnosis of left carpal tunnel syndrome to the diagnoses he already made regarding the right upper extremity. He stated that Petitioner understood he might need surgery, but it was not specified whether Dr. Kung was referring to Petitioner's right or left side. He then referred Petitioner to Dr. Kenneth Ham.

On August 31, 2018, Petitioner presented to Dr. Ham of the Bone and Joint Specialists. On the patient intake form, it was noted that Petitioner had a history of rheumatoid arthritis and fibromyalgia. Dr. Ham reported that Petitioner presented with bilateral hand numbness and

tingling from pulling wires and tying bales with a repetitive wrist motion. After considering Petitioner's EMGs, he diagnosed Petitioner with bilateral carpal tunnel syndrome, as well as right pronator syndrome, right cubital tunnel syndrome, and a right ulnar nerve lesion. Dr. Ham recommended carpal tunnel releases, a pronator release, and a cubital tunnel release.

Several months later, on October 23, 2018, Petitioner saw Dr. John Diveris of Diveris Orthopedics & Sports Medicine with complaints of left shoulder pain that onset one year prior. The mechanism of injury was listed as trauma axial distraction, playing with his son, and a hard pull. Left shoulder X-rays were obtained and revealed mild joint space narrowing, but no acute pathology. Dr. Diveris diagnosed Petitioner with left shoulder adhesive capsulitis and administered an injection to the left glenohumeral joint.

Thereafter, at Respondent's request, Dr. Sam Biafora of the Hand to Shoulder Associates performed a §12 examination of Petitioner's right and left upper extremities on February 7, 2019 and authored a corresponding report on February 11, 2019. Regarding the left upper extremity, Dr. Biafora found that Petitioner had diffuse pain and tenderness complaints without a specific anatomic pattern of distribution. He indicated that an electrodiagnostic study had confirmed the carpal tunnel syndrome diagnosis, but it could not explain the diffuse findings in the left upper extremity, elbow, forearm, and wrist. Dr. Biafora found no causal connection between Petitioner's left upper extremity condition and his work activities. He stated that Petitioner had presented with symptoms while pushing a broom, and there was no indication that he was performing his typical bale-tying activities during the onset of the symptoms.

Also at Respondent's request, Petitioner presented for another §12 examination with Dr. Nikhil Verma for his left shoulder on February 25, 2019. In his report of the same date, Dr. Verma diagnosed Petitioner with left shoulder adhesive capsulitis and opined that there was no causal connection between this diagnosis and the alleged June 13, 2018 work injury. Dr. Verma explained that adhesive capsulitis was an idiopathic condition that occurred within the general population and was not associated with repetitive use or traumatic etiology. Additionally, Dr. Verma noted that in Petitioner's records, there was no immediate complaint of left shoulder pain after the June 13, 2018 incident that would indicate any acute or traumatic injury to the shoulder.

II. Conclusions of Law

Following a careful review of the entire record, the Commission finds that Petitioner failed to prove he sustained an accident arising out of and in the course of his employment on June 13, 2018.

Petitioner's testimony is inconsistent with the timeline of the accident provided in the accident reports and medical records. Petitioner testified that he had been mopping the floor all day on June 13, 2018; however, RX 3 shows that the accident occurred at 6:30 a.m. after his shift started at 6:00 a.m. Petitioner agreed that the accident report said the incident happened 30 minutes into his shift, but he still testified that he had been working for eight hours pushing the mop. When asked to clarify, Petitioner testified that when the accident happened at 6:30 a.m., he could not find Mr. Miller until later, so he continued pushing it and working. However, Petitioner's explanation falls short, because there is further conflicting testimony as to when Petitioner stopped working

and sought treatment for his left arm after the accident.

On direct examination, Petitioner testified that after he reported the accident, Mr. Miller drove him to Ingalls Clinic. Petitioner testified that he then returned to work the day after the accident with a five-pound restriction for his left hand. However, the treatment records do not support this testimony. Instead, the treatment notes show that on the day of the accident, Petitioner presented for a right upper extremity EMG and a physical therapy session for his right hand. He made no left hand complaints at these visits, nor did he seek treatment for his left upper extremity on the accident date. Thereafter, on June 18, 2018, Petitioner followed up at Ingalls Clinic for his right hand and again did not convey any left hand complaints.

Petitioner did not mention the June 13, 2018 accident to his doctor at Ingalls Clinic until June 25, 2018, and even then, the treatment note suggested that Petitioner's injury occurred to his right hand as opposed to his left hand. The first clear mention of Petitioner's June 13, 2018 accident involving his left hand was made at his June 27, 2018 visit to Ingalls Clinic. On redirect examination, Petitioner then conceded that it was possible he might not have gone to Ingalls Clinic on June 13, 2018 after all.

It is further problematic that Petitioner testified that he worked approximately a full day on June 13, 2018, but his treatment records show that he presented for an EMG that day in Munster, Indiana at 12:24 p.m. This EMG conflicts with Petitioner's implication that he worked eight hours or a full day on the accident date.

The Commission finds that Petitioner's credibility is diminished, because his testimony as to how long he worked on the accident date and when he sought treatment for his left arm conflicts with the timeline provided in his treatment records. The treatment records show that Petitioner did not make any left hand complaints to his doctors until June 25 or June 27, 2018, although he continued to seek treatment for his right arm in the period between the alleged June 13, 2018 accident and those treatment dates.

Additionally, in further conflict with Petitioner's testimony, Mr. Byrne testified that the floor appeared to be dry in the surveillance video taken shortly before the accident. Mr. Byrne testified that the video showed no water in the truck bay and no indication of puddles or a wet floor anywhere. Petitioner also testified that he had been mopping the floor all day using his left arm; however, in the surveillance video, he can be seen mopping the floor with both arms at times.

Due to the numerous inconsistencies, the Commission finds that Petitioner failed to prove he sustained an accident to his left upper extremity that arose out of and in the course of his employment on June 13, 2018. All compensation benefits, as well as Petitioner's request for §19(l) penalties and fees, are therefore denied. The Decision of the Arbitrator is reversed accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated February 24, 2020, is hereby reversed as stated herein.

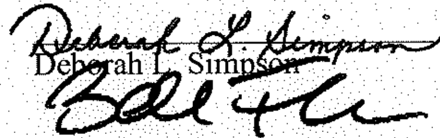
IT IS FURTHER FOUND that Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment on June 13, 2018.

IT IS FURTHER ORDERED that Petitioner is denied all benefits under the Illinois Workers' Compensation Act, including but not limited to, prospective care, temporary total disability benefits, and payment of medical expenses related to the June 13, 2018 alleged accident.

IT IS FURTHER ORDERED that penalties and fees pursuant to §19(l) are denied.

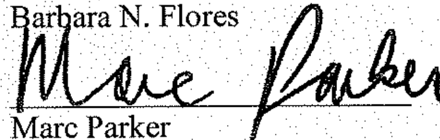
The party commencing proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 6 - 2020



Deborah L. Simpson

Barbara N. Flores



Marc Parker

DLS/met
O: 9/17/20
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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: Up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD MUNIZ,

Petitioner,

20 I W C C 0 6 5 1

vs.

NO: 10 WC 39469

ROUTINE MAINTENANCE & STATE TREASURER AS
EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Respondent, Injured Workers' Benefit Fund ("IWBF"), and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, employment relationship, average weekly wage/benefit rate, temporary total disability/maintenance, penalties & fees, and medical expenses both current and prospective, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact – Testimony

Mr. Andrew Majernik was called by Petitioner. He testified that on November 30, 2007 he was owner of Respondent, Routine Maintenance. He described the company as "a marketing company" which "secured jobs for contractors, and then they would do the work and give us a commission." It did not "have any laborers to speak of." He knew who Petitioner was but never met him.

The contractors would have the responsibility of completing the work, receiving payment from the customer, and remitting the commission to Routine. The commission could either be a percentage of the contracted amount or a flat fee, depending on the job. He was never on the jobsite where Petitioner was and he did not have foremen there. He never saw any work being performed.

Carlos was an employee of Routine as office manager and was responsible for directing Petitioner for a certain job. He "oversaw the day-to-day office interactions," and could be at a jobsite. He would not perform work but "might make like a sales call so to speak." The contractor himself would oversee the particular jobsite. He had no idea how the contractors got themselves to the jobsites. The contractors used their own ladders on the jobs. He was shown a purported independent contractor contract between Routine and Petitioner. Carlos is the named contractor and Petitioner is the named "contractee." Mr. Majernik never saw Petitioner work.

On cross examination, Mr. Majernik testified he found jobs and contractors "mainly" from "telemarketing." He also did some newspaper ads, fliers, and referral business. They would give contractor jobs in exchange for a commission. The contractors were never on Routine's payroll, and did not wear uniforms. Routine found customers who wanted work performed and contractors to perform the work. He reiterated his testimony that Routine did not provide transportation or equipment to the contractors. Routine never issues W-2s.

In 2007, Routine had less than 10 employees. Routine used the same independent contractor contracts for all contractors. Routine never provided Workers' Compensation insurance to contractors. Mr. Majernik testified that he did not know whether Routine provided such insurance for its employees, but "apparently not."

On redirect examination, Mr. Majernik testified he had no recollection of meeting or hiring Petitioner or of the job he was working on. He had no knowledge on how his work was supervised. He had no idea how any of the workers were supervised on that jobsite, how they came to the worksite, or what tools were used. He could not testify whether Carlos was at the jobsite.

On re-cross examination, Mr. Majernik testified that Routine never provided transportation for contractors, and was not at the jobsite Petitioner worked at in 2007. Upon questioning by the Arbitrator, Mr. Majernik testified that he "inherited" contractors for jobs when he took over the company. Otherwise he would find contractors the same way he found customers.

Petitioner testified that on November 30, 2007 he was employed by Routine. He has specific recollections of that day and his employments status at that time. Routine hired him to clean gutters. He was hired pursuant to an ad in the paper. He answered the ad and spoke to Carlos, who hired him in Routine's office. He understood that he was being hired to clean gutters at a residential complex.

Petitioner used his own vehicle and ladder for "small homes" but Routine provided ladders if his did not go high enough. He worked for Routine for three days before the accident. He signed an application with Routine on November 27, 2007. He did not recall anything else he signed. But if he were presented with a document to sign he would have. He understood that if he refused to sign anything, he would not be allowed to work. Petitioner had not worked previously cleaning gutters. He was a union bricklayer, was laid off, and needed extra money for the holidays. Routine would set the rate of pay for a job and pay him after the job was complete. He received checks from Routine. He earned a total of $600 for the three days he worked.

On the day of the accident, he met the crew at Respondent's office. They loaded up the company truck, rented ladders from a hardware store, and went to the jobsite. Carlos drove the company truck, was the supervisor of the crew, and was going to tell them what to do when they got to the jobsite. Carlos instructed them to open the ladder and go up and clean the gutters. The weather was "cold and windy." Carlos directed them to proceed with the work and the order of the buildings to work on. Respondent collected the money and paid the crew. Respondent chose the worksites and Petitioner never previously cleaned gutters.

Petitioner was coming down the ladder. A gust of wind caught him in the back. The person who was supposed to steady the ladder was not there. Petitioner felt the ladder slip on the gutter. Petitioner jumped off the ladder and caught the balcony with his armpits. He could not keep hold of the balcony and fell to the ground from about 30 feet. Carlos witnessed the accident. He felt agonizing pain in his legs (he fractured his pelvis in three places), in his shoulders bilaterally, and in his tailbone. He was on the ground screaming. The ground around the area was rocky and grassy. It was November and cold so the ground was frozen. Petitioner suffered a fractured pelvis, fractured vertebrae, fractured right hip, fractured collarbone, and bilateral shoulder injuries. He had ORIF repair of his pelvis, open right-shoulder rotator cuff repair with acromioplasty, left SLAP repair surgery with subacromial decompression debridement, and revision left-shoulder SLAP repair surgery.

Following surgeries, Petitioner was diagnosed with a staph infection, "central cord syndrome," and cervical stenosis. In 2009, a doctor recommended that he pursue a sedentary job. Nevertheless, he was able to resume working as a supervisor but not for Routine. He "used to be a union instructor, so they found [him] an easier job to do." He was still earning union scale, which was currently $46.88. No doctor ever released him to full work. Petitioner took that upon himself; he had to earn money.

Petitioner currently took Norco, maybe twice a week. That was the only medical treatment he was receiving currently. It was prescribed by his primary care physician. He also takes about 12 Aleve tablets a day. Currently, at work he has difficulty sitting for extended periods; his tailbone starts hurting. When he walks extended distances his hips/pelvis hurts. If he carries anything heavy, he feels pain in his shoulders and back. He can't lay bricks. He can no longer compete in martial arts. He rated his pain as "a controlled 6/10."

On cross examination by IWBF, Petitioner testified he believed he filled out the job application on the 26th and began working on the 27th. He did not remember the application being a contract. While it says he was an independent contractor, that was not what happened. It also provides that Petitioner was responsible for maintaining Workers' Compensation insurance. He really did not read or understand the agreement. He never received any training from Routine. He replied to an ad for gutter cleaners among other jobs. He never met the owner of Routine.

He was to be paid weekly, and received a check in the mail for the days he worked. He was never given a W-2. There was not a set number of jobs to which he was assigned. He was assigned as much as he could handle. Petitioner agreed that he could have chosen not to work some jobs. His employment was terminable at will by Routine. He believed he got paid by the job between $15 and $30. He had no other jobs while he worked for Routine. Other than the supervisor, who was present and witnessed the accident, Petitioner did not notify anyone else from Routine. He did not notify anyone about his doctor appointments. He worked other jobs for Routine prior to the instant job. In the other jobs he used his own ladder.

Petitioner testified he performed martial arts since he was five years old. He had broken his nose and fingers in martial arts, but nothing else.

On cross examination by Mr. Majernik, Petitioner reiterated that they never met previously. The company truck was white, but he could not remember the brand. It did not have Routine Maintenance on it, but Carlos called it the company truck. He came to the office in his vehicle and went to the jobsite in the truck. They rented ladders because they were working on three-story buildings. If he deemed a job dangerous, he would have refused to work. The prior two jobs he worked for Respondent were small house gutters. He thought he did not receive a W-2 because he had not made enough money. He had no receipts for the money he earned.

On redirect examination, Petitioner was again shown the "contract." It listed himself as contractee (*sic*) and Carlos, Respondent's employee, as contractor. He understood that if he did not obey orders from Carlos, he "wouldn't be employed." Carlos presented him the document, but did not explain it. He really does not understand the difference between a contractor and contractee. Carlos instructed him to meet the crew at Routine's facility. He was in a hospital for about 2 months and at a nursing home for several months more. Nobody from Routine ever contacted him. On the day of the accident, Routine provided him tools and transportation and he was paid with a Routine check.

Mr. Majernik was recalled by IWBF. He testified he did not know how long Routine was in operation, its annual income, or the annual income in 2007. Carlos' job was not to provide assistance to contractors. To the best of his knowledge, Routine did not have a company truck, and did not rent ladders for contractors.

On cross examination, Mr. Majernik agreed that he testified that Carlos was the office manager. He also agreed that he did not recall anything about November 30, 2007, that he was not at the jobsite on that date, and he knew nothing of what Carlos did at the jobsite.

Findings of Fact – Medical Records

On November 30, 2007, Petitioner presented to the Advocate Lutheran General Hospital Emergency Department by ambulance after a 30-foot fall from a ladder. He had multiple fractures but denied any loss of consciousness. A CT of the pelvis showed bilateral pelvic fractures. A cervical CT showed congenital fusion at C2-3 and no acute abnormality. A CT of the brain was normal. A thoracolumbar CT showed L5 and sacral fractures. A pelvis CT showed multiple pelvic fractures. Chest x-rays were normal. X-rays of the right shoulder showed bony fragment in the distal end of the clavicle, widening of the AC joint, and fragmentation of the superior lateral portion of the acromion. It was not clear whether these findings were acute or from an old injury. There was also a later right shoulder x-ray which showed separation of the AC joint and lucency of the coracoid process of the scapula, suggesting fracture. Lumbar x-rays showed degenerative retrolisthesis of L5 on S1 but no evidence of dislocation or fracture. Petitioner was admitted to the hospital.

The day after being admitted, a social worker noted that Petitioner came in with a positive toxicology screen for cocaine and opiates. Petitioner reported he only took cocaine thrice in his life, the most recent, a couple of days previously, and it was supplied by a friend. He denied use of prescriptions medications. He had been recently laid off due to reduced work and weather conditions.

On December 5, 2007, Dr. Jimenez performed surgery inserting two screws in the SI joint, anterior external fixation of the anterior pelvis using two half pins for unstable pelvic ring disruption, anterior pelvic ring disruption, and unstable posterior pelvic ring disruption distribution through sacrum.

Petitioner was discharged on December 11, 2007 to an extended care facility. Dr. Martin noted that Petitioner was admitted on November 11th, upon transfer from Northwest Community Hospital due to the level of trauma care needed. He had ORIF surgery on his pelvis with Dr. Jimenez. He was to follow up with Dr. Jimenez concerning his pelvis and with Dr. Mardjetko about his L5 fracture.

On December 15, 2007, Petitioner returned to the emergency department because of increased redness over the fixture sites and some bilateral arm weakness/paresthesia. He was deemed to have a staph infection and was re-admitted. Dr. Jimenez removed the pins around the infection on December 19th. An MRI taken of the right shoulder on December 22nd showed an anterior nondisplaced labral tear, probably full-thickness rotator cuff tear, and edema within the humeral head related to a prior subluxation.

On December 25, 2007, Dr. Jimenez noted cervical imaging showed no cord or nerve root compression, but an EMG showed evidence of right carpal tunnel syndrome and an MRI showed a rotator cuff tear of the right shoulder. Petitioner was doing well in physical therapy. Petitioner was discharged back to the extended care facility.

On January 5, 2008, a brain CT was normal. A chest x-ray was normal. Pelvis x-rays showed bilateral superior and inferior pubic rami fractures and 2 screws across the right SI joint. A lumbar MRI showed artifacts at L5-S1 and S1, and degenerative disc disease at L3-4, but no spinal stenosis.

On January 22, 2008, Petitioner returned to Dr. Jimenez who noted Petitioner had an unstable pelvic ring disruption. He was treated with an anterior ring fixator, which had since been removed. An MRI also showed a complete tear of the rotator cuff supraspinatus muscle. Dr. Jimenez opined that Petitioner's pelvis had sufficiently healed and they should proceed with surgical repair of the right shoulder rotator cuff and noted he would be non-weightbearing for 12 weeks from pelvis surgery. On January 30, 2008, Dr. Jimenez performed right shoulder open acromioplasty and open rotator cuff repair for complete right rotator cuff tear and impingement.

On April 22, 2008, Petitioner presented to Dr. Guelich after falling 3&1/2 floors fracturing his pelvis and injuring both shoulders. He had surgery on his pelvis and right shoulder by Dr. Jimenez at Lutheran General. However he was terminated by Workers' Compensation, was now on public aid, and Dr. Jimenez discontinued care. Dr. Guelich noted Petitioner was in physical therapy, but Dr. Guelich believed it may be difficult to restore full range of motion in the shoulders. He indicated that Petitioner was not a surgical candidate until they restored full range of motion. He administered an injection, continued physical therapy, and ordered an MRA. The MRA of the left shoulder taken on July 3, 2008 showed rotator cuff tendonitis and partial tear of the anterior glenoid labrum. On August 7, 2008, Dr. Guelich performed left-shoulder SLAP type 2 repair, subacromial decompression, and limited debridement of the undersurface cuff tear, for SLAP tear with impingement and partial thickness rotator cuff tear. The rotator cuff tear was found intra-operatively.

On May 6, 2008, Petitioner presented to Dr. Metz, D.P.M. for left foot/ankle pain after falling from a ladder in November of 2007. He had x-rays and an MRI of the ankle and told there was nothing wrong, but his pain persisted. Dr. Metz noted that the left leg was longer than the right due to the pelvis/femur fracture. He opined that the condition placed greater strain on the left leg causing his chronic pain. He provided a heel lift, advised Petitioner he would use on full time, and referred his to get custom orthotics.

On June 20, 2008, Dr. Guelich noted that overall Petitioner's shoulders appeared to be improving in physical therapy. He switched from Norco to Tramadol for pain. Dr. Guelich was concerned about Petitioner's left shoulder which exhibited persistent pain and possible instability. He ordered an MRA of the left shoulder.

On August 7, 2008, Dr. Guelich performed left shoulder SLAP type 2 repair, subacromial decompression, and limited debridement of the undersurface cuff tear for SLAP tear with impingement and partial-thickness rotator cuff tear.

Dr. Guelich noted Petitioner was doing well five weeks after left-shoulder SLAP repair. He wanted Petitioner to continue physical therapy. He also note that Petitioner was concerned about his pelvis. Dr. Guelich would take x-rays on the next visit.

On October 22, 2008, Petitioner returned to Dr. Guelich, who had last seen him on September 15th. At that time he was doing very well. However, he sustained a reinjury when a child, weighing more than 150 pounds, fell down some stairs. Petitioner caught him, straining his left shoulder. Dr. Guelich diagnosed recurrent strain post SLAP repair. He continued physical therapy and noted that if he had persistent pain, he would order an MRA.

The new MRA was taken on November 13, 2008. It was compared to a study on July 3rd MRA and showed stable AC joint arthritis and a partial-thickness tear of the supraspinatus muscle. On November 19th Petitioner reported he stopped physical therapy due to pain and was taking narcotic pain medication occasionally. He denied any instability. The MRA showed "continued partial thickness rotator cuff tear," but the SLAP repair appeared intact. Because of the complicated nature of Petitioner's symptoms, Dr. Guelich wanted a second opinion from Dr. Nam.

Petitioner presented to Dr. Nam on December 3, 2008. Dr. Nam noted that Petitioner had SLAP repair surgery, but then felt a pop in his left shoulder trying to stop a child from falling two months previously. He had persistent and worsening pain since. He had physical therapy and an injection since the reinjury. Dr. Nam thought it was difficult to determine whether there was a re-tear of the labrum from the MRA. He diagnosed partial-thickness rotator cuff tear and possible recurrent tear of the anterior and superior labrum. After discussing alternative treatment options, Petitioner wanted only surgical intervention.

On February 3, 2009, Dr. Guelich performed revision left SLAP repair with removal of suture revision of labral repair, and debridement of partial-thickness rotator cuff tear for reinjury and superior labral tear. A week later, Dr. Guelich noted Petitioner was doing well post SLAP repair surgery. Because of the nature of the injury, Petitioner was susceptible to re-injury. Therefore, Dr. Guelich wanted to go slow in returning to activities and should remain in a sling.

On February 5, 2013 Petitioner presented to Dr. Newman with his son, who had suffered a wrestling injury. Petitioner asked that his right elbow be evaluated while he was there; it had been a problem for some time. On exam, he had reduced elbow range of motion and was very tender. X-rays showed evidence of prior trauma, with spur formation at the and suspected loose body in the lateral joint. Dr. Newman indicated that Petitioner had failed conservative treatment, and recommended surgery.

On February 8, 2013, Dr. Newman performed right elbow arthrotomy with the coracoid process and olecranon, epicondylectomy, and lengthening of the common extensor for synovitis, tendonitis, and epicondylitis.

On March 12, 2013, Petitioner reported no problems while he was on vacation. However, on return his surgical wound was red. Dr. Newman did not see evidence of deep infection but noted some fibrous tissue, which he debrided to remove some of the fibrous material. Two weeks later, Petitioner's infection appeared to be resolved after a round of Keflex. Dr. Newman re-debrided fibrous material. On March 2nd, Dr. Newman noted that Petitioner was improving but he still debrided some fibrous material. A week later, Dr. Newman noted that Petitioner was healing nicely. He had an exacerbation of medical epicondylitis and Dr. Newman administered an injection.

On January 8, 2014, Dr. Newman noted that Petitioner's lateral epicondylitis resolved after the injection, but he now had medial epicondylitis. He did not recall any trauma on the right side. He also had pain in the PIP joint of the left index finger. X-rays showed collapse of cartilage on the ulnar aspect of the PIP joint. He thought this condition was the result of an old sprain which had degenerated. He administered an injection in the trigger point.

Dr. Chudik examined Petitioner on November 18, 2018 at the request of his lawyer and issued a report. In it he noted that his current diagnoses were post-traumatic bilateral hip arthritis after bilateral acetabular fractures, inferior pubic rami fracture, right sacral fracture and right transverse process fracture at L5, which was caused by the work accident. Right shoulder post-traumatic arthritis after coracoid fracture and rotator cuff tear post open repair and acromioplasty, caused by the work accident. Left shoulder SLAP tear and partial thickness rotator cuff tear after surgical repair and subsequent surgical repair revision, which was caused by the work accident. Chronic right SI joint pain after unstable anterior pelvic ring disruption post SI joint screw fixation and pelvic external fixation.

Currently, Petitioner complained of constant LBP that radiated to the groin mostly on the right worsened by sitting, or long car rides. He uses a pillow donut while driving. He noticed his back pain worsened over the past two years, especially after he was very active. He also reported bilateral shoulder pain with work/activity. He was working, but should refrain from heavy lifting/carrying.

Petitioner reported he no longer participated in martial arts. He received periodic trigger-point injections for back pain and was prescribed Norco and Flexeril as needed. Dr. Chudik noted that Petitioner reported the accident in which he fell 28-30' and landed mostly on his back and right hip. Dr. Chudik then summarized treatment through September 11, 2013. His clinical exam appears to have been normal.

20IWCC0651

Dr. Chudik concluded that the diagnoses cited above were all caused by the work accident on November 30, 2007. He continued to suffer from pain associated with his work-related conditions of ill-being. He was unable to work up to April 13, 2009. He will need permanent restrictions of no heavy lifting/carrying. All medical treatment incurred was necessary and reasonable.

In addition, he would need prospective treatment, including but not limited to, physical therapy and injections for his SI joint/hip pain and left shoulder arthritis. He would also need prospective surgeries, including but not limited to bilateral hip arthroplasty and left-shoulder arthroplasty for his post-traumatic arthritis. Dr. Chudik also itemized his recommended prospective treatment which would cost an estimated $322,585.05.

Findings of Fact – The Contract

The "contract" executed by the parties, identified by Mr. Majernik, was submitted into evidence. It provides that Petitioner (contractor) was an independent contractor hired by Carlos Hernandez (contractee). The document specifies that no employment relationship was established. Petitioner represented that he had his own business. While Carlos had the right to "control the results to be accomplished" Petitioner had the right to control the "manner or means by which the task" was to be performed. Petitioner was free to take work from other entities. However, Petitioner was not allowed to solicit Routine's customers while working on a job for Routine. Petitioner could refuse any job offered by Carlos that he not already accepted in writing and was responsible for all taxes and to have WC insurance. Either side could terminate the contract upon completion of a contemplated job or after a 30-day notice. Carlos would send Petitioner an invoice for fees and Petitioner had the obligation to pay the fees.

Conclusions of Law – Employment Relationship

The Arbitrator found that Petitioner established an employment relationship with Routine with regard to his work on the day of the accident. She found Petitioner's testimony credible about his initial encounter with Carlos when he was hired. She also found him credible about Carlos' activities on the jobsite, that he oversaw Petitioner's work, he drove Petitioner to the jobsite, and he supplied the 40-foot ladder. She also found that Petitioner established "the nature of the work," as performing unskilled labor and not anything to do with his expertise of bricklaying. As such, Petitioner "advanced Routine Maintenance's goal of providing such labor to customers." Finally, the Arbitrator explained that the Supreme Court has held that the parties' description of the relationship between them is only one factor in determining whether an employment relationship existed.

 20IWCC0651

Respondents argue that the Arbitrator erred in finding an employment relationship. They stress the credibility of Mr. Majernik and base their arguments on the veracity of his testimony. IWBF stresses that Petitioner's testimony was "illogical and confusing." It notes he testified that he was paid between $15 and $30 depending on the job, but also that he received a check for $600 for the 3 days worked. IWBF described that testimony as illogical. Both Routine and IWBF argue that Petitioner did not establish that Routine controlled Petitioner's work citing the provisions of the contract and Mr. Majernik's testimony. Routine also argues the Arbitrator erred in her finding about the nature of Routine's work. It stresses that Routine did not provide maintenance services itself but rather acted as a conduit between independent contractors and customers.

The Commission agrees with the analysis of the Arbitrator in finding an employment relationship between Petitioner and Routine Maintenance and affirms the Arbitrator on the issue of employment relationship. Here, the relative credibility of the competing witnesses is a fundamental issue. Generally the Arbitrator is in a better position to assess the relative credibility of witnesses than the Commission. The Arbitrator clearly found Petitioner more credible than Mr. Majernik and there does not appear any compelling reason to disturb that assessment.

In addition, the Commission finds Petitioner's version of the relationship makes more intuitive sense than Mr. Majernik's. It make little sense for Petitioner to set up an independent company to perform professional activities he had never done before. His testimony that he had no expertise in gutter cleaning was not rebutted and it would appear likely that Carlos would have in some way directed his work.

Conclusions of Law – Average Weekly Wage/Benefit rate

The Arbitrator found an AWW of $450 a week based on Petitioner's testimony that on average he worked four jobs per day for Respondent and was paid $15 to $30 per job. She took the average of the two at $22.50 per job. Petitioner argues that the Arbitrator should have found an average weekly wage ("AWW") of $1,000 based on his testimony that he earned $600 for three days of work.

There is precious little information upon which to assess the correct AWW. Petitioner's testimony about AWW was inconsistent. However, in the Request for Hearing form ("stip sheet"), Petitioner alleged an AWW of $600. Respondent disputed that amount, but did not provide an alternate AWW. The Commission concludes that we should not make awards based on an AWW larger than the one Petitioner alleged in the stip sheet. While the Respondent disputed Petitioner's alleged AWW in the stip sheet it failed to provide an alternative AWW or provide any means to calculate an alternative AWW. The Commission finds that Petitioner's alleged AWW of $600 in the stip sheet was not adequately rebutted. Therefore, the Commission modifies the Decision of the Arbitrator to increase the AWW to $600 and to increase the associated benefit rates.

Conclusions of Law – Causation/Medical

The Arbitrator found that Petitioner proved causation to the conditions of ill-being of the pelvis fractures, right-shoulder rotator cuff tear, left-shoulder labral tear, L5 traverse fracture, and a left ankle injury. However, she also found that Petitioner did not sustain his burden of proving that he sustained an injury to his right elbow/hand in the accident and that the required revision left-shoulder labral repair was not caused by the accident, but rather by the intervening accident of Petitioner trying to catch the 150-pound falling child. Therefore, the Arbitrator denied medical for treatment of Petitioner's right elbow, right hand, and revision left-shoulder labral repair surgery. The Arbitrator also denied prospective medical. The Arbitrator found Dr. Chudick's report unpersuasive. She noted that he did not review all medical records, was not aware that Petitioner had been released to work, and he opined that Petitioner would need bilateral hip replacements, even though clinically he found no abnormalities. Petitioner argues that the Arbitrator erred in not awarding all medical. He also seeks an award of prospective medical in the amount of $332,585.05, per the report of Dr. Chudik.

The Commission agrees with the Arbitrator that there is no evidence that Petitioner's elbow/hand conditions were caused by his fall. However, the Commission disagrees with the Arbitrator on the issue of whether the need for Petitioner's left-shoulder revision surgery was causally connected to the original work accident. There is no question that the work-related accident resulted in a left-shoulder injury and an associated condition of ill-being. In addition, he had left-shoulder surgery only two and a half months prior to the "falling child incident" and was still being treated for his left shoulder at the time of that incident. In addition, the post-incident MRA showed "continued partial thickness rotator cuff tear," but the SLAP repair appeared intact. The Commission concludes that the later incident did not cause any structural change in Petitioner's left-shoulder and that the incident did not result in an intervening accident terminating causation. Therefore, the Commission finds that the need for left-shoulder revision surgery was still causally connected to the original work accident and awards medical accordingly.

However, the Commission agrees with the Arbitrator and concludes that awarding the prospective medical is inappropriate here. As with all aspects of his case, Petitioner has the burden of proving all elements of his claim, including a claim for prospective medical. First, the Commission agrees with the Arbitrator that Dr. Chudik's report is unpersuasive. Second, here Petitioner sought PPD at arbitration and is currently seeking review on the issue of PPD before the Commission. Such requests connote Petitioner considers himself at MMI. The assumption that Petitioner is at MMI and that permanency can be adjudicated, is in conflict with his request for prospective medical. Petitioner apparently did not file any 19(b)/8(a) petition and at this stage in litigation, perhaps a 19(h)/8(a) petition may be a better avenue to pursue prospective medical, if Petitioner's condition changes.

Conclusions of Law – TTD

The Arbitrator awarded 40 weeks of TTD, through September 15, 2008, prior to the left-shoulder revision surgery in 2009. Petitioner argues the TTD award should be extended to include the period of disability caused by the "re-stain" and revision surgery. He requests TTD of 78 weeks through July 1, 2009. IWBF preserved the issue of TTD, but neither it nor Routine argues the issue in their briefs. Because the Commission finds that the need for left-shoulder revision surgery was still causally related to the work accident, the Commission modifies the Arbitrator's TTD award accordingly.

Conclusions of Law – PPD

The Arbitrator awarded Petitioner 175 weeks of PPD representing loss of 35% of the MAW. Principally, the Arbitrator based her award on the excellent recovery Petitioner had from his significant injuries. Petitioner seeks an award of 375 weeks of PPD representing loss of 70% of the MAW.

The Commission concludes that the Arbitrator was correct in noting a good recovery and that such recovery should be considered in arriving at an appropriate PPD award. In addition, Petitioner testified that he still earned the same union scale wage that he would of absent the injuries. Nevertheless, the Commission has modified the Decision of the Arbitrator and found that the need for left-shoulder revision surgery was still causally connected to the original work accident. Therefore, the Commission concludes that Petitioner is entitled to additional PPD benefits for his second left-surgery surgery and an associated increase in permanent partial disability. Therefore, the Commission modifies the Arbitrator's PPD award from loss of 35% of the person-as-a-whole to loss of 45% of the person-as-a-whole.

Conclusions of Law – Penalties & Fees

The Arbitrator denied Petitioner's request for penalties and fees noting that there was no written demand for payment made. Petitioner argues the Arbitrator erred in not awarding penalties & fees and seeks 19(k) penalties of $162,263.55, 19(l) penalties of $10,000, and 16 fees of $34,452.71. The Commission agrees with the Arbitrator and finds that there were legitimate issues for adjudication. Therefore, the Commission finds Respondents actions were not arbitrary or capricious in denying benefits. Therefore, the Commission affirms the Arbitrator's denial of penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $400 per week for a period of 78 weeks, that being the period of temporary total incapacity for work under §8(b)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to for medical expenses under §8(a) of the Act for all medical treatment incurred to date other than that incurred to treat his right elbow or laceration of his thumb.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner request for prospective medical treatment and for the imposition of penalties and fees is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner the sum of $240 per week for a period of 225 weeks because the injuries sustained resulted in the 45% loss of use of the person-as-a-whole.

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

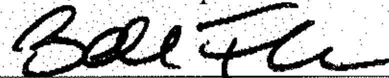
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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.

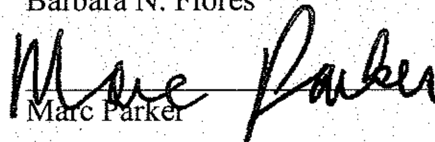
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 6 - 2020

Deborah L. Simpson



Barbara N. Flores



Marc Parker

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O-9/17/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0651

MUNIZ, RICHARD J
Employee/Petitioner

Case# **10WC039469**

ROUTINE MAINTENANCE AND ILLINOIS STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 8/9/2019, 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 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:

4642 O'CONNOR & NAKOS
STEPHEN CUMMINGS
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0000 ROUTINE MAINTENANCE
158 N BRANDON DR
GLENDALE HTS, IL 60139

0000 ASSISTANT ATTORNEY GENERAL
N OBAH
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

20IWCC0651

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

- [x] 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 MUNIZ
Employee/Petitioner

Case # **10** WC **39469**

v.

Consolidated cases: **D/N/A**

ROUTINE MAINTENANCE and ILLINOIS TREASURER as EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 18, 2019**. 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **Prospective medical, coverage and credibility of Petitioner and Andrew Majernik**

FINDINGS

On **11/30/2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to pelvic fractures requiring surgery, a sacral fracture, an L5 transverse process fracture, a right shoulder rotator cuff tear requiring surgery on January 31, 2008, a left shoulder SLAP lesion requiring surgery on August 7, 2008 and a left ankle condition requiring radiographic studies and conservative podiatric care. See the attached decision for further details.

For the reasons set forth in the attached decision, the Arbitrator finds an average weekly wage of $450.00.

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 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

Medical benefits
Of the claimed expenses (PX 7), the Arbitrator awards only the $151,564.24 from Advocate Lutheran General Hospital. These expenses relate to Emergency Room and inpatient care Petitioner underwent between November 30, 2007 and February 1, 2008. The Arbitrator finds that the treatment underlying the remaining claimed expenses is not related to the accident of November 30, 2007.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $300.00/week for 40 weeks, commencing 12/1/07 through 9/15/08, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Person as a whole (For injuries before 9/1/11)
Respondent shall pay Petitioner permanent partial disability benefits of $290/week [the applicable minimum rate] for 175 weeks, because the injuries sustained caused the 35% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Penalties
For the reasons set forth in the attached decision, the Arbitrator declines to find Routine Maintenance liable for penalties or fees.

Prospective Care
For the reasons set forth in the attached decision, the Arbitrator declines to award the prospective care contemplated by Petitioner's examining physician, Dr. Chudik.

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 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 Petitioner pursuant to Sections 5(b) and 4(d) of this Act.

All issues are in dispute. Arb Exh 1.

Arbitrator's Findings With Respect to Insurance Coverage

Petitioner produced certified records showing that NCCI's research and database revealed no policy of workers' compensation coverage for Routine Maintenance as of November 30, 2007. PX 5. Routine Maintenance's owner, Andrew Majernik, did not object to PX 5. T. 12-13. In fact, he confirmed his business lacked workers' compensation coverage, even for those individuals he considered to be employees, as of the November 30, 2007 accident. T. 38-39.

The Arbitrator finds that Routine Maintenance lacked workers' compensation insurance coverage as of November 30, 2007.

Arbitrator's Findings of Fact

Andrew Majernik, Petitioner's first witness, testified he owned Routine Maintenance as of November 30, 2007. T. 16. Routine Maintenance was located on North Brandon Drive in Glendale Heights. Majernik was unable to recall exactly how long he owned Routine Maintenance before November 30, 2007. He estimated he owned the company a couple of years. T. 17.

Majernik testified he does not recall whether Routine Maintenance was hired in November 2007 to perform work at the Arrow Apartment Complex. T. 17-18. He does not recall Routine Maintenance securing a job at that complex in the past. T. 18.

Majernik described Routine Maintenance as a "marketing company [that] secured jobs for contractors." T. 18. The contractors would perform work for customers, secure payment from customers and then pay Routine Maintenance a commission. T. 18, 20. testified that Routine Maintenance primarily found customers via telemarketing. The company also received some direct referrals. Routine Maintenance primarily offered maintenance services, including window cleaning, air duct cleaning, carpet cleaning and pressure washing. Once it secured a customer, the customer would indicate when he or she wanted the work done. Routine Maintenance would then assign the work to an independent contractor. Routine Maintenance did have employees, including Carlos, as of November 30, 2007, but the employees worked in Routine Maintenance's office, not in the field. T. 19, 22. Carlos was the office manager. T. 24. Majernik acknowledged that Carlos could have visited a jobsite but testified he would have done so to make a sales call and not to do work or oversee work. T. 23. It was the independent contractor who would provide the equipment and oversee and/or perform the actual job. T. 24. The customer would pay the independent contractor, who would then pay Routine Maintenance a commission. The commission could be a percentage of the price or a flat amount, depending on the job.

Majernik testified that Routine Maintenance did not employ laborers or foremen as of November 30, 2007. He had no information as to how workers got to the jobsites. T. 25.

Majernik had no recollection of meeting Petitioner prior to the hearing. T. 19. It was Carlos who "acquired" Petitioner. T. 22.

Majernik identified PX 13 as a multi-page document entitled Routine Maintenance Independent Contractor Agreement. On page 1 of this document, Petitioner is identified as a contractor. On page 3,

however, Petitioner is identified as a contractee and Carlos Hernandez is identified as a contractor. T. 28. Majernik testified he did not witness Petitioner signing this document. He denied presenting any documents to Petitioner for his signature. T. 29.

Under cross-examination by the Injured Workers' Benefit Fund [hereafter "the Fund"], Majernik testified that the independent contractors used by Routine Maintenance in November 2007 were not on Routine Maintenance's payroll and did not wear uniforms. T. 32-33. Routine Maintenance did not provide transportation to jobsites. Nor did it provide equipment used at jobsites. Routine Maintenance never issued W2 forms to independent contractors. Once a job was completed, an independent contractor could be paid by a customer. T. 36. The independent contractor then had to pay Routine Maintenance a commission. As of November 2007, Routine Maintenance had a two-room office and employed fewer than ten individuals. T. 37. The independent contractors always signed independent contractor agreements. T. 38. Routine Maintenance never provided workers' compensation coverage to the independent contractors. Routine Maintenance also "apparently" never provided workers' compensation coverage to the employees who worked in the office. Majernik testified he does not know whether he ever procured such coverage. T. 38-39.

Under cross-examination by Petitioner's counsel, Majernik testified he has no independent recollection of Petitioner or the job where the accident occurred. He had no independent recollection of how Petitioner would have been paid. T. 40-41. He also does not recall Routine Maintenance providing transportation to that jobsite or equipment used at the jobsite. He had no recollection of Carlos playing any role at that site. He could not say whether Carlos was at that site. T. 40-42.

Under additional cross-examination by the Fund, Majernik testified that, to his knowledge, Routine Maintenance did not provide transportation to jobsites as of November 2007. Nor did Routine Maintenance provide equipment to be used at jobsites. T. 44-45. He is not aware of Routine Maintenance providing equipment to be used at the Arrow Apartment Complex. T. 46.

In response to a question posed by the Arbitrator, Majernik testified that Routine Maintenance found independent contractors via newspaper advertisements or referrals. He acquired the business from someone else so some contractors were already established when he took over. T. 49-50.

In response to a follow-up question posed by Petitioner's counsel, Majernik testified he has no recollection of when he acquired Routine Maintenance. T. 50.

Petitioner testified he was born on July 8, 1967. He lives in Chicago. As of November 2007, he had been married for about 12 years and had two minor children: Jasmine, born on June 4, 1990, and Joshua, born on September 17, 1994. T. 53, 62-63. PX 1-3.

Petitioner testified that, as of November 2007, he was a member of the bricklayers' union but was not working as a bricklayer due to a seasonal layoff. As of November 30, 2007, he was employed by Routine Maintenance. T. 53. Before beginning to work for Routine Maintenance, he had never worked as a laborer or gutter cleaner and had never operated a business offering labor or gutter cleaning. T. 59.

Petitioner testified that, prior to November 30, 2007, he responded to an ad placed by Routine Maintenance. He responded to the ad because he was on layoff and wanted to earn some extra money before the holidays. T. 59. He then met with Carlos, the "shop manager," at Routine Maintenance's office in Glendale Heights. T. 55-56. He signed an application at that time. If he had not signed, he

would not have been allowed to work. Routine Maintenance hired him to clean gutters at single-family residences and building complexes. T. 57. At the time of the hiring, it was his understanding he would provide his own vehicle and ladder in connection with work done at residences unless the work was "beyond the reach" of the ladder he owned. In that event, Routine Maintenance would provide the ladder. He also understood that Routine Maintenance would set the rate of pay depending on the nature of the job. He worked for Routine Maintenance for three days before November 30, 2007 and earned a total of $600 for that work. He received the $600 via a check that bore the name Routine Maintenance. T. 60-61. He never received any additional checks from Routine Maintenance.

Petitioner testified he could not remember exactly when he was scheduled to begin working on November 30, 2007. He believes he started at 7:00 or 8:00. T. 63. On that date, he met Carlos at Routine Maintenance's shop in Glendale Heights. T. 63-64. At that location, they loaded up a pick-up truck that belonged to Routine Maintenance. The truck had ladder racks. T. 65. He and other workers, including a man named "Jim," got in the truck. Carlos drove them to a hardware store. At that store, Carlos rented two 40-foot ladders. T. 66. Using the same truck, Carlos then drove them to a complex consisting of three or four three-story apartment buildings. This complex was called the Arrow Apartment Complex. T. 66-67. After they arrived, Carlos directed him and the other workers to climb the ladders and clean the gutters and downspouts. It was Carlos who decided where they should start and who should do what. They started working at about 8:00 or 8:30 AM. It was cold and windy that day but Carlos directed them to proceed. T. 69-70.

Petitioner testified the accident occurred as he was descending one of the 40-foot ladders. The wind hit his back as he started climbing down. The worker who had been designated to hold and stabilize the bottom of the ladder left. T. 70-71. Petitioner testified he has "no idea" why this individual left. T. 71. He was about 36 feet above the ground when the wind hit his back and the ladder started to slip on the gutter. T. 71. Petitioner testified he could tell that the ladder "was going down." T. 71. There was "no way" he was going to go down with the ladder so he threw himself off. He managed to catch the top of a balcony with his armpits as he fell. The balcony was about 6 feet below the roof. T. 71-72. He struck the top rail of the balcony so hard that he "ripped [his] shoulders out." He could not hang on. He then fell straight down, a distance of about 30 or 32 feet. T. 72. He initially landed on his feet on the ground, which was frozen. T. 75. Carlos witnessed his fall. Petitioner testified he was in agonizing pain and screaming after he landed. T. 73. The fall resulted in injuries to his pelvis, tailbone and both shoulders. T. 74. He fractured his pelvis in three places. He was initially taken to Northwest Community Hospital but this facility did not have a trauma center so he was transferred to Advocate Lutheran General Hospital, where he remained for the next two months. He underwent pelvic surgery, a right shoulder surgery on January 31, 2008 and a left shoulder surgery on August 7, 2008. T. 76-77. He was bedridden for a period following the accident. T. 81. He stayed in a nursing home for several months. T. 83. In 2009, he underwent a second left shoulder surgery. T. 85.

No Fire Department paramedic records are in evidence.

Only two pages of Northwest Community Hospital Emergency Room records are in evidence. These pages appear in PX 9. They bear the date November 30, 2007 and the time 11:29. They reflect Petitioner fell 30 feet from a ladder and that paramedics found him lying on his back. Petitioner underwent CT scans of his pelvis, chest, abdomen, right shoulder and brain. He was given Dilaudid and several doses of Morphine for pain. He was diagnosed with a bilateral acetabular fracture, a pubic rami fracture, a right sacral fracture and a right AC separation and possible shoulder fracture. The Emergency

Room physician arranged for him to be transferred to Advocate Lutheran General Hospital. PX 9, pp. 243-244.

An Advantage Ambulance report dated November 30, 2007 reflects that paramedics transferred Petitioner from Northwest Community Hospital's Emergency Room to Advocate Lutheran General Hospital's Emergency Room at approximately 6 PM. The comment section of this report reflects that Petitioner "had been working on a ladder 3 stories up when he fell, striking his pelvis on the ladder and then the ground." The paramedics noted that fire department personnel had initially transferred Petitioner from the accident scene to Northwest Community Hospital. They also noted that a pelvic scan had demonstrated three fractures to the pelvic ring and that Petitioner "also suffered dislocation to the L shoulder." PX 10, p. 54.

After Petitioner arrived at Advocate Lutheran General Hospital, he saw Dr. Jimenez for an orthopedic consultation. The doctor noted that Petitioner reported falling from a ladder that was at approximately a third story level. He also noted that Petitioner had originally undergone care at Northwest Community, "where his C spine was cleared and he was diagnosed with a R shoulder dislocation and pelvic fracture." The doctor described Petitioner's past history as significant for a prior right shoulder surgery and a prior right ankle surgery. He noted complaints of low back pain and right shoulder pain.

A radiologist at Advocate Lutheran General Hospital interpreted CT scans of the chest and pelvis that had been obtained earlier in the day at Northwest Community Hospital. He interpreted the chest CT scan as showing bilateral atelectasis. He interpreted the pelvic CT scan as showing a fracture involving the medial wall and anterior aspect of the left acetabulum, a fracture through the left inferior public ramus, a vertical fracture through the right ischial tuberosity and base of the right superior pubic ramus, and a vertical fracture through the right sacral wing extending through multiple neural foramina. PX 10, p. 9.

A thoracic spine CT scan performed on November 30, 2007 showed a fracture of the right transverse process of L5 and a fracture of the right sacral ala. PX 10, p. 12.

Toxicology studies performed on the evening of November 30, 2007 were positive for cocaine and opiates. PX 10, p. 25.

Pelvic X-rays taken on the morning of December 1, 2007 showed bilateral pubic fractures and acetabular fractures. PX 10, p. 146.

An inpatient cover sheet dated December 1, 2007 identifies Routine Maintenance in Glendale Heights as Petitioner's employer. This document also reflects that Petitioner sustained an accident at work on November 30, 2007. PX 10, p. 40.

A patient progress note dated December 1, 2007, completed by a licensed clinical social worker, reflects that Petitioner "came with positive tox screen for cocaine and opiates." The social worker indicated that Petitioner denied using any substances on a regular basis, reported having used cocaine three times in his life, with the last time occurring a "couple of days ago." This note also reflects that Petitioner "was recently laid off from work due to decrease in workload, weather conditions" but was "still covered under BC insurance from his local union." PX 10, p. 75.

On December 5, 2007, Dr. Jimenez operated on Petitioner, placing two screws across the right sacroiliac joint in an effort to manage Petitioner's "unstable pelvic fracture." PX 10, pp. 148, 171-172. Petitioner was given morphine and other pain medication postoperatively.

On December 11, 2007, Petitioner was discharged from Advocate Lutheran General Hospital and transferred to Lee Manor, a rehabilitation facility. At discharge, Petitioner was instructed to remain non weightbearing and follow up with Drs. Jimenez and Mardjetko as needed. PX 10, p. 44. A discharge-related cover sheet identifies Routine Maintenance as Petitioner's employer and Blue Cross as Petitioner's insurance carrier. PX 10, p. 41.

On December 15, 2007, Petitioner presented to the Emergency Room at Advocate Lutheran General Hospital complaining of increasing redness around the external fixture sites, fever, neck pain, tingling and weakness in both arms, right worse than left, and tingling in his fingers. Petitioner described his arm symptoms as having started after his fall and worsening during the preceding two days. Emergency Room personnel noted redness at the pelvic fixator site.

A cervical spine MRI, performed on December 15, 2007, was classified as "limited," with the radiologist noting Petitioner "refused one part of the study." The MRI showed no definite acute abnormalities and mild degenerative disc disease at C3-C4 and C4-C5. PX 10, p. 304.

On December 16, 2007, Dr. Kushner evaluated Petitioner, noting worsening upper extremity complaints, weakness of the middle three fingers of the right hand and erythema of the pin sites from the external fixator. He noted that Petitioner had had a fever the previous day and that Petitioner's wife had noted erythema of the right groin. On upper extremity examination, Dr. Kushner noted "reasonable" strength but indicated the right arm seemed weaker than the left. He diagnosed cellulitis of the pin sites, worse on the right, and recommended Vancomycin. He recommended an orthopedic consultation for the upper extremity complaints. PX 10, pp. 250-252.

On December 17, 2007, Dr. Bauer, a neurosurgeon, evaluated Petitioner's arm complaints at Advocate Lutheran General Hospital. He noted that Petitioner "had a three story fall" and had been experiencing numbness down his arms and into his fingers since the fall. On examination, Dr. Bauer noted slightly diminished sensation in the fourth and fifth fingers of the right hand, a positive Tinel's sign at the ulnar nerve on the right and grip weakness. He suspected a central spinal cord syndrome. He recommended a repeat MRI and MR angiogram. PX 10, p. 253. The repeat cervical spine MRI, performed on December 18, 2007, showed no acute abnormalities. PX 10, p. 308. An EMG performed on December 18, 2007, showed findings "compatible with a right carpal tunnel compression of the median nerve without denervation." PX 10, p. 299. Petitioner reported improvement of his arm symptoms on December 19, 2007, secondary to a Medrol Dose Pak. Dr. Jimenez removed the external fixator on December 19, 2007, in a bedside procedure. PX 10, p. 229.

A right shoulder MRI, performed on December 22, 2007, showed an anterior nondisplaced labral tear, a small effusion and a probable distal anterior full-thickness rotator cuff tear. PX 10, pp. 29, 310. Petitioner continued complaining of bilateral shoulder pain following this study.

Petitioner was discharged from Advocate Lutheran General Hospital on December 25, 2007 and transferred back to Lee Manor. PX 10, pp. 185-186.

Petitioner was readmitted to Advocate Lutheran General Hospital on January 5, 2008 due to "right neck, arm and hand numbness." He underwent a lumbar spine MRI and other studies. A head CT scan performed on January 5, 2008 was normal. A right upper and lower extremity EMG performed on January 8, 2008 was normal. PX 10, pp. 456-457. Petitioner was discharged on January 9, 2008 and transferred back to Lee Manor. Dr. Kushner's discharge summary reflects that a right rotator cuff tear was suspected and that "the etiology of the numbness of the right upper extremity and right lower extremity was not completely clear." Petitioner was treated via Elavil, Motrin and Duragesic patches.

On January 22, 2008, Dr. Jimenez saw Petitioner for his pelvis and right shoulder. He obtained pelvic X-rays. He noted that the films showed the fracture to be "well aligned." He recommended that Petitioner remain nonweightbearing. He also recommended a right rotator cuff repair. PX 10, pp. 214-216.

On January 30, 2008, Dr. Jimenez performed a right open rotator cuff repair at Advocate Lutheran General Hospital. PX 10, pp. 374-375. Petitioner was transferred back to Lee Manor on February 1, 2008.

NovaCare therapy records dated March 25, 2008 reflect that Petitioner was discharged from Lee Manor two days earlier. These records set forth a history of the November 30, 2007 fall. They document complaints related to the lower back, groin, right shoulder, left ankle and coccyx.

Petitioner underwent left shoulder and left ankle MRIs on April 1, 2008. The following day, he saw an unidentified physician at Resurrection Health Care. He provided a history of the fall and reported having been released by Dr. Jimenez secondary to insurance issues. He complained of 8/10 pain in his left shoulder, pelvis, groin and coccyx. He also complained of numbness in the left lateral three fingers. He reported having previously worked as a bricklayer and believing he would be unable to resume that trade due to his injuries. He indicated he planned to return to school so he could function in a more supervisory position. The doctor's note is incomplete but he indicated he felt Petitioner's main limitations were related to his shoulders and left ankle. PX 9, pp. 224-226.

On April 22, 2008, Petitioner saw Dr. Guelich. The doctor noted a history of the November 2007 fall and subsequent pelvis and right shoulder surgeries. He indicated that Petitioner had been "dropped from his workers' comp insurance." He noted that Petitioner was "now on Public Aid" and no longer seeing his previous orthopedic surgeon. He indicated that Petitioner was rehabbing his right shoulder but also having left shoulder issues. He also noted that Petitioner had undergone a left shoulder MRI but that this study was "useless due to a significant motion artifact." He administered an injection and prescribed therapy. He also ordered a left shoulder MR arthrogram. PX 9, p. 221.

On May 6, 2008, Petitioner saw a podiatrist, Dr. Metz. Petitioner provided a history of his November 2007 fall. He complained of pain in his left ankle and foot. He reported having undergone an MRI and X-rays and being told "nothing was wrong." Dr. Metz described his gait as antalgic. He attributed the pain to the left limb being longer secondary to the pelvic fracture. He placed a heel lift in Petitioner's right shoe and prescribed orthoses.

On May 23, 2008, Dr. Guelich noted that Petitioner was still recovering from the right rotator cuff repair. He rechecked Petitioner's left shoulder. He indicated he suspected a left rotator cuff tear. He recommended that Petitioner continue therapy and return in two months. He postponed a left shoulder MRI to allow complete rehabbing of the right shoulder. PX 9, p. 220.

On June 20, 2008, Petitioner returned to Dr. Guelich. The doctor noted right shoulder improvement secondary to therapy. He indicated Petitioner was using a cane due to his pelvic fracture and complaining of left shoulder pain. The doctor noted he had previously undergone a left shoulder MRI. He described this study as "very poor in quality." He recommended an MR arthrogram. PX 9, p. 101.

Dr. Guelich operated on Petitioner's left shoulder on August 7, 2008, performing a SLAP repair.

On September 15, 2008, Dr. Guelich noted that Petitioner was doing well following the left shoulder SLAP repair and had "almost regained all motion." He recommended that Petitioner continue therapy. He also noted that Petitioner was concerned about his pelvis. He indicated he planned to order new X-rays but that "otherwise [Petitioner] should continue pushing forward without restriction associated with the shoulder." PX 9, p. 240.

On September 19, 2008, Dr. Lee issued a note indicating that Petitioner was still recovering from his fall-related injuries. He also noted that Petitioner was suffering from severe depression requiring three days of hospitalization in September 2008. [No records concerning this hospitalization are in evidence.] He found Petitioner unable to work. He also found Petitioner unable to sit, stand, walk, lift, carry, handle objects or even travel for any period of time. PX 9, p. 239.

On April 13, 2009, Dr. Lee released Petitioner to full duty. PX 9, p. 303.

Petitioner testified that, in June 2009, he resumed working through the bricklayers' union. He testified the union placed him in lighter, supervisory positions but he continued to earn union scale. T. 87. Petitioner claimed he was never formally released to work. No doctor ever released him to full duty. T. 89. He "took it upon [himself] to go back to work" because he had to earn money. T. 89. He denied receiving any workers' compensation benefits between the November 30, 2007 accident and June 2009. T. 90.

On September 22, 2009, Dr. Lee issued a note indicating that, due to his fall-related injuries, Petitioner has been "unable to continue his same profession in construction." Dr. Lee recommended that Petitioner pursue a "more sedentary career." PX 9, p. 301.

Petitioner identified PX 7 as a group of medical bills relating to treatment he underwent in connection with the November 30, 2007 accident. T. 90. None of these bills were paid by workers' compensation. T. 91.

Petitioner denied injuring his collarbone, shoulders, right hip, low back, neck or pelvis before the November 30, 2007 accident. He also denied reinjuring any of those body parts after the accident. T. 91. He currently suffers from pain "every now and then." He takes Norco twice weekly. He also takes Aleve. Dr. Lee, his family physician, prescribes the Norco. T. 92-93. He "can't lay brick" and experiences pelvic and low back pain when he walks for long periods. He used to be a martial artist but can no longer compete. T. 95. On an average day, his controlled pain level is 6/10. After a physically active day, his pain rating is 8/10. T. 95.

On November 15, 2011, Petitioner saw Dr. Lee and complained of right hip pain of three weeks' duration. The doctor administered an injection.

On December 12, 2012, Petitioner saw Dr. Lee and complained of right elbow pain. The doctor noted that Petitioner was a bricklayer and had a "hx of tennis elbow." He administered an injection. PX 9, p. 202.

Records in PX 8 and PX 9 reflect that Petitioner underwent a right elbow arthrotomy and epicondylectomy on February 8, 2013 "for chronic elbow pain." Dr. Newman performed this surgery at Presence St. Joseph Hospital. The hospital records identify Dougal Building Maintenance as Petitioner's full-time employer. PX 8, p. 2. Postoperatively, Petitioner went on a cruise to Belize and Mexico, where he was exposed to ocean water and developed an infection. Petitioner initially saw Dr. Lee, his primary care physician, and was started on Keflex. He saw Dr. Weinstein, an infectious disease specialist, on March 18, 2013, with the doctor continuing him on the Keflex.

Records in PX 9 reflect that, on September 9, 2013, Petitioner fell from a 6-foot ladder while working for Triumph Restoration, injuring his lower back and neck. He initially underwent Emergency Room care at Alexian Brothers Medical Center. PX 9, pp. 41-49. He subsequently underwent X-rays and therapy after this accident and was released to full duty on October 7, 2013. PX 9, pp. 35-37.

On November 8, 2018, Petitioner underwent an examination by Dr. Chudik, a physician associated with Hinsdale Orthopaedics. Petitioner underwent this examination at the request of his attorney. In his report, Dr. Chudik indicated he reviewed an ambulance report of November 30, 2007, a transfer note from Northwest Community Hospital, records from Advocate Lutheran General Hospital, office records from Dr. Guelich and Dr. Nam's note of December 3, 2008. He described Petitioner as "working but experiencing back and bilateral shoulder pain." He indicated Petitioner reported being unable to participate in martial arts. He recommended permanent restrictions "to avoid heavy carrying and lifting" and indicated Petitioner would require future care, including but not limited to therapy, injections, bilateral hip replacements and a left shoulder replacement. He estimated the costs of this future care to be $322,585.05. PX 6.

Under cross-examination by the Fund, Petitioner testified he believes he completed the job application on November 26, 2007 and started performing actual work on November 27, 2007. T. 99. He acknowledged signing PX 13, the contractor agreement. T. 101. He signed this document when he first went to Routine Maintenance's office. T. 101. He acknowledged the document states the relationship being created is one of contractor and "contractee", not employer and employee. T. 102. He also acknowledged the second page of the document states it is the "contractee's" sole responsibility to obtain and pay for workers' compensation and other insurance coverage. T. 102. He signed this document but "really didn't read it." T. 103. He did not undergo any training before beginning to work for Routine Maintenance. He denied being injured during the time he worked as a union bricklayer. T. 104. He acknowledged breaking his right ankle and undergoing right ankle surgery "about 30 years ago." T. 105. The advertisement he saw before he met with Carlos indicated Routine Maintenance was looking for gutter cleaners, duct cleaners, pressure washers, carpet cleaners and window washers. He never met the owner of Routine Maintenance. T. 106. On the morning of the accident, he and others met Carlos at the shop at 6:30 AM, at the direction of Carlos. T. 106. He started working at the Arrow apartment complex between 8:00 AM and 8:30 AM, using the ladders Carlos rented at the hardware store. T. 106. He was not required to clock in, follow any rules or wear a uniform. He knows that the truck Carlos drove was owned by Routine Maintenance because Carlos referred to it as a "company truck." He was paid via check, once a week. He did not receive a check from Routine Maintenance until weeks after the accident. He does not have a copy of this check. T. 107-108. He never received a W2.

He does not know how many hours he was supposed to work per week. Routine Maintenance "gave you three or four jobs to do in a day and if you had time to do more, they would give you more." He could perform as many jobs as he could handle. T. 108. He could elect not to perform certain jobs. Routine Maintenance could terminate him at any time. T. 109. He had no other jobs during the period he worked for Routine Maintenance. He was paid by the job. He received between $15 and $30 per job, depending on the nature of the job. T. 109-110.

Petitioner testified his gutter cleaning tasks involved just that, cleaning gutters. When asked whether he notified Routine Maintenance of his fall, he testified he "fell in front of everybody" and "was screaming." To him, "it was pretty obvious." T. 110. His supervisor saw him fall so he did not notify anyone else at Routine Maintenance. T. 111. He did not inform Routine Maintenance of his medical care. He never spoke with anyone at Routine Maintenance after the accident. T. 111.

Petitioner testified that, during his first three days of work, he worked at sites other than Arrow Apartment Complex. At those sites, he used his own ladder to access gutters. T. 112.

Petitioner testified he began participating in martial arts when he was five years old. Before the accident, he broke his nose and injured his fingers while practicing martial arts. T. 112.

Under cross-examination by Andrew Majernik, Petitioner testified he agreed he and Majernik never previously met. The vehicle Carlos used on the morning of the accident was a white pick-up truck. Carlos's "exact words were: we're going to use the truck, the company truck, to pick up the ladders and go to the job." The truck did not bear the name "Routine Maintenance." T. 114. One of the other workers who accompanied them that day was named "Jim." He does not recall the other worker's name. He does not know whether Jim and the other worker were contractors. Carlos "was supervising." T. 115. Carlos rented the ladders because the complex consisted of three-story buildings "and nobody had 40-foot ladders to do the job." If he (Petitioner) had deemed a job unsafe, he would have refused to perform it. During the days he worked for Routine Maintenance before November 30, 2007, he worked on small residential gutters. T. 117. He does not have a copy of the check he received. He believes Routine Maintenance did not give him a W2 because he did not earn a set amount. R. 117.

On redirect, Petitioner again looked at PX 13. Petitioner testified no one explained the contents of this document to him. On page 1, he is identified as the contractor but on page 3 he is identified as the "contractee." T. 119. On page 3, Carlos Hernandez is identified as the contractor. Carlos Hernandez is the "Carlos" he has been referring to who supervised the job. T. 120. It was his understanding he would not be able to work for Routine Maintenance unless he signed PX 13. Carlos presented PX 13 to him but did not explain the document to him. T. 120. He was given only a few minutes to look at the document. He knows what a contractor is. He is not a contractor. T. 121. He did not drive directly to the apartment complex on November 30, 2007 because Carlos instructed him to meet him at the shop. T. 121-122. He did not know what he was going to earn the week after he was hired. T. 122. No one from Routine Maintenance came to see him in the hospital. He was in the hospital and then in a nursing home for several months. No one from Routine Maintenance ever reached out to him. T. 122. At the Arrow job on November 30, 2007, Routine Maintenance provided him with transportation, ladders and tools. T. 123.

The Fund then recalled **Andrew Majernik.** Majernik testified he does not know how long Routine Maintenance was in business. He does not know the business's net income in 2007. T. 125-126. Carlos was the office manager. His job was to oversee the day to day activities in the office. T. 126.

It was not part of Carlos's job to provide transportation or equipment. Nor did Carlos have the duty of telling contractors how to perform their work. Carlos would have been acting outside the scope of his employment if he provided transportation and/or equipment to contractors or if he directed contractors how to perform their work. T. 127. To the best of his knowledge, Routine Maintenance did not own a company truck or rent ladders for contractors. T. 128. Nor did it provide transportation to contractors. T. 128.

Under cross-examination, Majernik reiterated that Carlos was his employee. He (Majernik) does not recall anything specifically from November 30, 2007. He was not on the jobsite on November 30, 2007 and has absolutely no idea what, if anything, Carlos did at that site. T. 129.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning his initial hiring and his pre-accident interaction with Carlos was detailed and believable. Routine Maintenance's owner, Andrew Majernik, admitted Carlos was his employee as of November 2007. He also admitted Carlos "could" have gone to a jobsite, although he claimed his purpose in doing so would have been strictly sales-related. Majernik assigned Routine Maintenance a "hands-off", go-between role but admitted he had no specific knowledge of the work performed at the site where the accident occurred or the role Carlos might have played there on November 30, 2007. He did not refute Petitioner's very specific testimony concerning the distinction that was drawn between residential and commercial jobs. Ultimately, Majernik could not refute any aspect of Petitioner's account of the events of November 30, 2007.

Majernik's testimony concerning his ownership of Routine Maintenance was vague. He acknowledged acquiring the business from someone else but claimed he could not recall when he acquired it or exactly how long he operated it before November 2007. While the hearing did not take place until almost twelve years after the accident, the Arbitrator is troubled by Majernik's claimed inability to recall significant details.

Although Petitioner's account of his hiring and the accident was credible, the Arbitrator had significant problems with other aspects of Petitioner's testimony.

Petitioner failed to offer into evidence the first set of paramedic records or a complete set of records concerning his initial Emergency Room care at Northwest Community Hospital.

A toxicology report dated November 30, 2007 and a social workers' note of December 1, 2007 offer a possible explanation for this omission. The social worker indicated that Petitioner arrived [at Advocate Lutheran General Hospital] "with positive tox screen for cocaine and opiates." PX 10, p. 75. No one addressed this at the hearing but the limited available records from Northwest Community Hospital do not describe Petitioner as unresponsive or impaired. Those records show Petitioner was given Dilaudid and Morphine for pain after he arrived on the morning of November 30, 2007, hours before being transferred.

There is no question that the accident resulted in significant orthopedic injuries but Petitioner's testimony as to the extent of the disability resulting from those injuries was not credible. He claimed that no doctor ever released him to work after the accident. This testimony is contradicted by several return to work notes in PX 9. Petitioner also claimed that, while he began obtaining jobs through his union in June 2009, and resumed earning union scale, he only performed light, supervisory tasks. This

claim is contradicted by Dr. Lee's full duty release of April 13, 2009. PX 9, p. 303. [Later in 2009, Dr. Lee recommended Petitioner "pursue a more sedentary career" but the basis for this recommendation is not clear, given the prior full duty release.] Petitioner's testimony is also contradicted by records in PX 9, which reflect that he fell from a 6-foot ladder in September 2013, while working for Triumph Restoration.

Petitioner's overall credibility was also undermined by his claim of numerous medical expenses having nothing to do with the November 30, 2007 accident. It was left to the Arbitrator to cull out the related records and bills.

Arbitrator's Conclusions of Law

Was Routine Maintenance operating under the Act on November 30, 2007?

The Arbitrator finds that Routine Maintenance was operating under the Act at the time of the accident. In so finding, the Arbitrator relies on Section 3, subsection (1) of the Act. This subsection provides that the Act shall apply automatically and without election to any employer engaged in "the erection, maintaining, removing, remodeling, altering or demolishing of any structure." Petitioner credibly testified that he, under Carlos's supervision, was performing gutter cleaning at an apartment complex as of the accident. The Arbitrator views gutter cleaning as a maintenance-related task.

Did Petitioner establish he was Routine Maintenance's employee at the time of the accident?

The Arbitrator finds that Petitioner was Routine Maintenance's employee at the time of the November 30, 2007 accident. In so finding, the Arbitrator relies primarily on Petitioner's credible testimony concerning his initial interaction with Carlos, at the time of his hiring, and the distinction he drew between the role he was to play at small, residential jobs (such as those he performed for several days before November 30, 2007) versus the role he played at a commercial apartment complex on the day of the accident. Petitioner testified he came away from his meeting with Carlos with the understanding he was to function on his own and provide his own equipment on small jobs but that Routine Maintenance would take over on larger, commercial jobs involving taller structures. This distinction makes perfect sense to the Arbitrator. Routine Maintenance would have had a significantly greater interest in the mechanics and outcome of a commercial job since such a job would produce more income and potentially repeat business. To ensure the completion and success of a commercial job, Routine Maintenance would have wanted to make sure the necessary workers arrived at the site with the equipment they needed. By providing transportation to the Arrow apartment complex, along with two 40-foot ladders, and overseeing the work, Carlos, who was admittedly an employee, furthered Routine Maintenance's business interests. The Arbitrator is not persuaded by Andrew Majernik's claim that Carlos would have been acting outside his employment if he provided transportation or supervised work at a jobsite.

While Petitioner acknowledged signing a document labeled "Independent Contractor Agreement" when he met with Carlos, that agreement (PX 13) is internally inconsistent in terms of its identification of the respective roles of the parties. Portions of the agreement also vest control in Routine Maintenance. The contractor (identified as Routine Maintenance at the top of page 1) retained "the right to control the results to be accomplished." The "contractee" (identified as Petitioner on page 3) agreed not to solicit or work for any of Routine Maintenance's customers during or after the term of the agreement. Both parties had the right to cancel the agreement upon 30 days' written notice. The

"contractee" could only submit correspondence to a customer "on contractor's letterhead," provided he had the "previous written approval" of the contractor. The "contractee" could decline a project but not after committing in writing to complete that project.

Moreover, the Illinois Supreme Court has held that the parties' labeling of their relationship is only one factor to consider in determining whether an injured worker was an independent contractor or an employee. See Roberson v. Industrial Commission, 225 Ill.2d 159 (2007). With respect to the relationship that existed at the time of the accident, Petitioner established the most important factor, i.e., right to control. He credibly testified that Carlos drove him to the jobsite, provided him with 40-foot ladders to be used at that jobsite, directed the workers to proceed despite the windy conditions and remained at the jobsite, overseeing the work. He also established another factor, i.e., nature of the work. He did not bring any outside skill, such as his bricklaying expertise, to the job. It is not as if Routine Maintenance retained him to repair a brick chimney at its offices. Rather, he was injured while performing unskilled labor, i.e., gutter cleaning, as part of a crew. He advanced Routine Maintenance's goal of providing such labor to customers.

Did Petitioner sustain an accident arising out of and in the course of his employment by Routine Maintenance? What was the date of the accident?

The Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment by Routine Maintenance. The Arbitrator further finds that the accident occurred on November 30, 2007. In making these findings, the Arbitrator relies primarily on Petitioner's credible description of the weather conditions, the work he was assigned to perform at the apartment complex and the events immediately preceding the accident. The Arbitrator also relies on the treatment records in evidence. The histories in those records reflect that, on November 30, 2007, Petitioner fell from a significant height off a ladder while working.

The Arbitrator recognizes that only very limited Northwest Community Hospital Emergency Room records are in evidence and that, on the evening of November 30, 2007, after being transferred to Advocate Lutheran General Hospital, Petitioner underwent toxicology studies which were positive for cocaine and opioids. [With respect to the opioids, the Arbitrator notes that Petitioner was given Dilaudid and several doses of Morphine at Northwest Community Hospital, hours before being transferred.] The Arbitrator also acknowledges that a social worker's note of December 1, 2007 reflects Petitioner acknowledged taking cocaine several days before the accident. There is, however, no evidence suggesting Petitioner was intoxicated or impaired when he fell. The Act provides that no compensation shall be payable if the employee's intoxication was the proximate cause of the accident or the employee was so intoxicated at the time of the accident that the intoxication constituted a departure from his employment. Petitioner testified he fell while descending a 40-foot ladder that Carlos had rented that morning. He indicated the wind hit his back and the person who was supposed to be stabilizing the base of the ladder had left, for reasons unknown. The ladder started slipping on the gutter and he decided to launch himself away rather than go down with the ladder. T. 71-72. His goal was to "catch" a balcony as he went down. He managed to catch the balcony with his armpits but the impact was so severe that he "ripped [his] shoulders out" and could not continue to hang. He then fell straight down, initially landing on his feet. His credible testimony establishes he fell because of the wind and the ladder slippage, not his own conduct.

Did Petitioner provide Respondent Routine Maintenance with timely notice of the accident?

The Arbitrator finds that Petitioner provided Routine Maintenance with near-immediate notice of his accident. Petitioner testified that Carlos was present at the scene of the accident and saw him fall. T. 73. Andrew Majernik, who owned Routine Maintenance as of November 2007, acknowledged Carlos was his employee. Majernik maintained that Carlos worked in the office, not in the field, but he acknowledged that Carlos "could have" gone out to a jobsite. Majernik did not deny that Routine Maintenance had a presence at the Arrow Apartment Complex on November 30, 2007, although he testified he did not recall such a job. Ultimately, he admitted he had no idea what activities Carlos engaged in on November 30, 2007.

Did Petitioner establish a causal connection between the accident and his various claimed conditions of ill-being?

The Arbitrator, having carefully reviewed the available treatment records, finds that Petitioner established causation as to pelvic fractures requiring surgery and post-operative infection-related care, a sacral fracture, an L5 transverse process fracture, a right shoulder rotator cuff tear requiring surgical repair by Dr. Jimenez in January 2008, a left shoulder SLAP tear requiring surgical repair by Dr. Guelich in August 2008 and a left ankle condition requiring radiographic studies, a heel lift and orthotics.

The Arbitrator finds that Petitioner did not establish causation as to the left shoulder SLAP revision surgery performed in 2009. Dr. Guelich indicated the need for the revision stemmed from an intervening event, i.e., an injury Petitioner sustained while trying to prevent his 150-pound child from falling down stairs. PX 12, p. 35.

The Arbitrator finds that Petitioner did not establish causation as to the right elbow surgery Dr. Newman performed on February 8, 2013. Although Dr. Newman indicated in his operative report that Petitioner injured his right elbow in a fall occurring years earlier, presumably referring to the November 30, 2007 fall, Petitioner did not testify to injuring his right elbow and the records from his orthopedic surgeons, Drs. Jimenez and Guelich, do not mention such an injury. Other records in evidence reflect that the need for the right elbow surgery arose from chronic pain related to bricklaying.

The Arbitrator finds that Petitioner did not establish causation as to a left thumb/hand injury of July 19, 2016 or the need for the tendon repair performed by Dr. Mercier on July 21, 2016. There is no evidence indicating Petitioner injured his left thumb or hand in the fall of November 30, 2007.

What was Petitioner's age and marital status as of the accident? Did Petitioner have dependent children as of the accident?

The Arbitrator relies on Petitioner's credible testimony, along with the hospital records (PX 10) and marriage and birth certificates (PX 1-3) in finding that Petitioner was 40 years old and married, with two dependent children, as of the November 30, 2007 accident.

What were Petitioner's earnings during the year preceding the accident? What was Petitioner's average weekly wage?

On the Request for Hearing form, Petitioner claimed earnings of $31,200 during the year preceding the accident and an average weekly wage of $600.00. Arb Exh 1.

Petitioner's wage-related testimony was inconsistent. He initially testified that Routine Maintenance based his rate of pay on the nature of the job and paid him once a job had been completed. T. 60. He went on to state that, weeks after the accident, he received a $600 check from Routine Maintenance. He indicated this check represented his earnings for the three days of work he performed prior to the accident. T. 61. Under cross-examination by the Fund, he testified he was paid at the rate of $15 or $30 per job, depending on the size of the job. T. 109-110. He further testified he could perform as many jobs as he could handle per day, typically three to four, but potentially more. T. 108-109. Under cross-examination by Majernik, he testified he believes he did not receive a W2 because he did not receive a set amount per day or week. T. 117. He did not produce a copy of the $600 check or any other documents bearing on the issue of earnings.

Petitioner subsequently argued his average weekly wage was in fact $1,000, based on the $600 payment for three days of work and his professed expectation of a five-day work week. He testified, however, that, when he was hired, he had no idea what to expect in terms of his work schedule.

Andrew Majernik, who owned Routine Maintenance as of November 2007, denied hiring Petitioner or having any knowledge about the jobsite where Petitioner claimed to have fallen. Majernik acknowledged that Routine Maintenance secured customers and paired them with contractors who would perform tasks such as cleaning gutters. Majernik testified the contractors "could" receive payment from the customers and would typically pay Routine Maintenance a commission upon completing a job and receiving payment from a customer. T. 36. In response to questions posed by the Fund, he indicated that Routine Maintenance never had contractors on its payroll and never issued W2 forms to contractors. T. 33, 36. He did not specifically refute Petitioner's testimony concerning the $600.00 check.

The Arbitrator finds Petitioner's average weekly wage to be $450.00. The Arbitrator arrives at this figure by assuming an average per job rate of $22.50 (a midpoint between $15.00 and $30.00), an average of four jobs per day (giving rise to a daily rate of $90.00) and a five day work week. Although Petitioner testified he did not know what to expect, in terms of his schedule, he worked every day after being hired. He denied working for any other employer during this period.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses from five providers. PX 7.

The Arbitrator notes that many of the claimed expenses clearly have nothing to do with the accident of November 30, 2007. The Arbitrator finds this very troubling, particularly given the underlying purpose of the Injured Workers' Benefit Fund. For example, Petitioner claims a number of expenses relating to a left hand tendon repair surgery he underwent on July 21, 2016. As noted earlier, Dr. Mercier performed this surgery following a left thumb injury of July 19, 2016. PX 12, pp. 7-25. Petitioner also claims a number of expenses relating to a left shoulder SLAP revision procedure he underwent in February 2009. Dr. Guelich's records clearly reflect the revision was necessitated by a re-injury occurring in the summer/autumn of 2008, when Petitioner tried to prevent his 150-pound child from falling. PX 12, p. 35.

With respect to the first provider, Advocate Lutheran General Hospital, Petitioner claims expenses stemming from treatment provided from November 30, 2007 through December 11, 2007 ($66,872.00), December 15, 2007 through December 25, 2007 ($46,584.24), January 5, 2008 through

January 9, 2008 ($21,727.00) and January 30, 2008 through February 1, 2008 ($16,381.00). The itemized bills in evidence identify Illinois Medicaid as Petitioner's primary insurance carrier and Blue Cross PPO as his secondary insurance carrier but they do not reflect any adjustments or payments. The bills are supported by the records in PX 10. The charges clearly relate to treatment Petitioner underwent in connection with the accident. The Arbitrator awards Petitioner the claimed charges of $151,564.24.

The Arbitrator declines to award the claimed $12,841.00 charges from Chicago Orthopaedics & Sports. These charges relate to left shoulder-related office visits of November 19 and December 3, 2008, the left shoulder revision SLAP repair performed on February 3, 2009 and the left thumb/hand injury of July 19, 2016. Based on the prior causation-related analysis, the Arbitrator finds that none of these charges stem from treatment necessitated by the November 30, 2007 fall.

The Arbitrator declines to award the claimed $54,212.06 charges from Illinois Bone & Joint Institute. The first few pages of the bill in evidence (PX 7) make some references to pelvic-related care rendered in 2007 and 2008 but the dates of service and correlating charges are impossible to determine. The bill mentions insurance payments and "bankruptcy" and includes charges for treatment extending into 2014. The last page shows three $0 balances. Petitioner provided no assistance in deciphering this bill.

The Arbitrator declines to award the claimed charges of $9,284.00 from Park West Family Physicians (the group with which Dr. Lee is associated). These charges relate to office visits from May 29, 2007 (<u>before</u> the work accident) through 2017. The bill does not reflect the involved body parts and shows a $0 balance. As with the Illinois Bone & Joint bill, Petitioner provided no assistance in deciphering the charges.

The Arbitrator declines to award the claimed charges of $44,625.53 from Presence St. Joseph Hospital. These charges stem from the right elbow surgery of February 8, 2013, an abdominal CT scan performed on April 11, 2014 (due to diffuse epigastric pain of five months' duration, PX 8, p. 108) and the left hand tendon repair of July 19, 2016. PX 8. Petitioner failed to establish a causal relationship between the November 30, 2007 accident and this care.

<u>Is Petitioner entitled to temporary total disability benefits?</u>

Petitioner claims he was temporarily totally disabled from November 30, 2007 (the date of the accident) through June 1, 2009.

Based on the foregoing causation-related findings, the Arbitrator concludes Petitioner was at or near maximum medical improvement as of September 15, 2008, the date on which Dr. Guelich suggested he "continue forward without restriction" with respect to his left shoulder. PX 12, p. 34. Petitioner underwent a left shoulder revision surgery in 2009 but the Arbitrator has previously found he failed to establish causation with respect to this surgery. In late September 2008, Dr. Lee issued a note indicating Petitioner had recently been hospitalized due to depression and should be off work but Petitioner did not testify to this and failed to offer the correlating records into evidence.

The Arbitrator finds that Petitioner was temporarily totally disabled from December 1, 2007 through September 15, 2008, a period of 40 weeks. The Arbitrator, having previously found an average weekly wage of $450.00, finds Petitioner's temporary total disability rate to be $300.00.

What is the nature and extent of the injury?

As indicated earlier, there is no question that Petitioner's 30-foot fall resulted in significant orthopedic injuries but the Arbitrator concludes that Petitioner overstated the disability resulting from those injuries. Petitioner's claim that no doctor released him to work and that he never resumed the physical tasks associated with his trade is inconsistent with the records he offered into evidence. Those records show that Dr. Jimenez, the orthopedic surgeon who operated on Petitioner's pelvis and right shoulder, viewed Petitioner as making a good recovery. The Arbitrator found no evidence indicating Dr. Jimenez imposed work restrictions. The records also show that Dr. Guelich, who operated on Petitioner's left shoulder in August 2008, described Petitioner as doing well and being "able to push forward without restriction" [relative to the shoulder] as of September 15, 2008. PX 12, p. 36. The subsequent left shoulder revision surgery was necessitated by an intervening injury, not the November 30, 2007 accident. PX 12, p. 35. Dr. Lee released Petitioner to full duty in April 2009, contrary to Petitioner's assertion. Records in PX 9 contradict Petitioner's claim that he never returned to physical work. Those records show that Petitioner sustained an injury while working off of a 6-foot ladder for Triumph Restoration in September 2013. This injury occurred almost six years before the hearing.

The Arbitrator finds that Petitioner established permanency equivalent to 35% loss of use of the person as a whole, representing 175 weeks of benefits under Section 8(d)2 of the Act. The Arbitrator, having previously found an average weekly wage of $450.00, and noting the date of accident and three dependents, finds the applicable minimum permanency rate to be $290.00.

Is Routine Maintenance liable for penalties and fees?

Petitioner seeks an award of penalties and fees on his claimed temporary total disability benefits and medical expenses. The Arbitrator declines to award Section 19(l) penalties because Petitioner offered no evidence of a "written demand for payment," as required by the Act. See Theis v. IWCC, 2017 IL App (1st) 161237WC. The Arbitrator also declines to award Section 19(k) penalties and fees. The Arbitrator has elected to rely on Petitioner's testimony concerning his hiring and the events preceding the accident but, on this record, and considering the numerous credibility-related issues, cannot conclude that Routine Maintenance acted in an objectively unreasonable manner, under all of the existing circumstances, in failing to pay benefits.

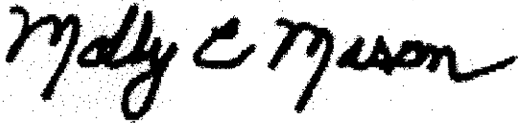
Is Petitioner entitled to $322,585.05 for prospective care per his examining physician, Dr. Chudik?

The Arbitrator declines to award the prospective care outlined by Dr. Chudik. This is a Fund case in which Petitioner placed permanency at issue. Additionally, Dr. Chudik did not review all of Petitioner's treatment records. He expressed no awareness that Dr. Lee released Petitioner to full duty in April 2009. He was also unaware of the back and neck injuries Petitioner sustained in the September 2013 fall. He appeared to link the need for the left shoulder revision surgery to the November 30, 2007 fall while simultaneously acknowledging the intervening injury in 2008. He noted no abnormalities (other than surgical scarring) on bilateral hip and bilateral shoulder examination yet opined Petitioner will require bilateral hip replacements and a left shoulder replacement. He noted that X-rays taken on September 26, 2018 showed some arthritic changes but otherwise he provided no real explanation for his conclusion that Petitioner will require three major replacement surgeries. None of the orthopedic surgeons who treated Petitioner projected the need for these surgeries.

Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to Petitioner from the Injured Workers' Benefit Fund.

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

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



Signature of Arbitrator

8/9/19
Date

AUG 9 - 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DANIELLE HENDERSON-RYAN,

Petitioner,

vs. NO: 14 WC 005817

EDWARD HOSPITAL,

Respondent.

20 I W CC 0652

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, average weekly wage, medical expenses, temporary total disability, permanent partial disability, and credit 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.

Permanent Disability

The Arbitrator awarded 40% loss of use of the left leg citing that Petitioner underwent a surgical repair to the peroneal nerve resulting in scarring, discoloration, and atrophy. *Arbitration Decision*, p. 15. However, the records and testimony evidence a large portion of Petitioner's current condition as it relates to this work accident is attributable to her left foot. Treatment records from Dr. Voronov evidence Petitioner's left foot demonstrated persistent drop foot, weakness, and reduced dorsiflexion. PX9b. Petitioner testified she is only able to move her big toe and the neighboring toe. T. 43. Additionally, Petitioner testified she possess limited movement in her ankle, which causes difficulty with walking. T. 44.

The Commission agrees as to the Arbitrator's application of factors pursuant to Section 8.1b(b) of the Act but is of the opinion the award should be rebalanced to reflect the evidence of

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disability to the left foot, which is corroborated by the medical treatment records. The Commission finds that Petitioner proved a loss of 50% loss of use of the left foot pursuant to Section 8(e)11 and 20% of the left leg pursuant to Section 8(e)12 of the Act.

The Commission notes Petitioner received a prior settlement in the amount of 26.4% loss of use of the left foot. RX9. Thusly, pursuant to Section 8(e)17 of the Act, Petitioner's permanency award with respect to the foot will be reduced by the amount of the prior settlement.

Average Weekly Wage

The Arbitrator correctly found overtime/on-call hours are a condition of Petitioner's employment and included in the calculation of the average weekly wage. Deducting the overtime premium results in total earnings of $14,906.41. The Arbitrator determined Petitioner worked a period of 22.2 weeks, which yields an average weekly wage of $671.46. In calculating the number of days worked, the Arbitrator stated,

> The wage information provided shows the total hours per pay period but does not include the number of days worked. Petitioner testified that she would sometimes be sent home early or would not be scheduled. The Arbitrator cannot infer that weeks with less than 80 hours represent less than full work weeks resulting a reduction in the number of weeks worked except for the 8/23/13 pay period which only notes 1.25 hours of orientation and the remainder as unpaid unscheduled absence. This pay period can only represent 1 day and 1/5 of a week. Based on this analysis the Arbitrator finds that Petitioner worked 22.2 weeks. *Arbitration Decision*, p. 12.

The Arbitrator properly deducted the unscheduled absence time noted on the pay statement for the period ending August 17, 2013 but did not similarly deduct the 16 hours (two workdays, or 2/5 of one week) of unscheduled absence from the pay period ending October 12, 2013. PX17. The Commission modifies the average weekly wage to reflect those two additional days of unscheduled absence. Calculating work weeks in fifths, where two days equal 0.4 weeks, 22.2 weeks reduced by 0.4 weeks for unscheduled absence equals 21.8 weeks of total work. Total earnings of $14,906.41 divided by 21.8 weeks of work yields an average weekly wage of $683.78.

Temporary Disability

The Commission affirms the Arbitrator's award of temporary partial disability benefits. The Arbitrator properly found Petitioner is entitled to benefits from March 14, 2016 through September 25, 2016. As Petitioner refused to cooperate with the vocational plan intended to increase her earning capacity, the Arbitrator correctly terminated benefits corresponding with the anticipated completion date for the proposed vocational program.

Petitioner commenced working for Bloomingdale Township on March 14, 2016 earning $15 dollars an hour. However, there is nothing in the record to determine her working hours in order to derive an average weekly wage. Respondent's Exhibit 2 documents temporary partial disability payments to Petitioner beginning March 28, 2016 through September 25, 2016, on a two-week schedule. The Commission agrees with the Arbitrator's finding that RX2 is the best evidence of the correct amount of temporary partial disability owed for this period.

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All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2018, as modified above, is hereby affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services of $1,688.00 to Dr. Voronov, $5,801.80 to Athletico, and $1,668.25 to Barnes Jewish Hospital, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $455.85 per week for a period of 113.6/7 weeks, representing January 7, 2014 through March 13, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of $48,088.56 for temporary total disability benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner temporary partial disability benefits of $5,975.40 for the period March 14, 2016 through September 25, 2016, as provided in §8(a) of the Act. Respondent shall have a credit of $5,579.65 for temporary partial disability benefits already paid.

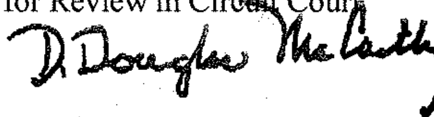
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $410.27 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 20% loss of use of the left leg pursuant to §8(e)12 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $410.27 per week for a period of 39.41 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 50% loss of use of the left foot pursuant to §8(e)11 of the Act- less a deduction of 26.4% of the left foot pursuant to §8(e)17 of the Act for the prior settlement in 13 WC 002511.

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 $46,900. 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: NOV 6 - 2020

D. Douglas McCarthy

LEC/cak

O: 9.11.2020

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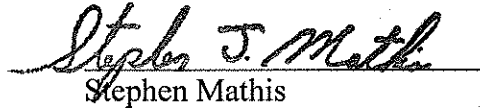


Stephen Mathis

SPECIAL CONCURRENCE/DISSENT

I concur with all aspects of the Majority's Decision save its calculation of the average weekly wage. I find pursuant to Section 10 of the Act, Petitioner's average weekly wage equals $603.24. Therefore, I respectfully dissent.

Pursuant to Section 10 of the Act, the third method of calculation for the average weekly wage is utilized as Petitioner worked less than a full 52 weeks prior to her injury. The wage records evidence Petitioner worked from July 20, 2013 through December 21, 2013 equaling 24 weeks although the records for the pay period ending October 26, 2013 are not included. PX17. As such, the evidence verifies 22 weeks of wages.

I concur with the Majority's Decision that Petitioner's employment required her to be on-call, therefore such hours are included. Where I differ is the hourly rate to be utilized. If Petitioner was required to work while on call, the wage records evidence she earned time and a half or $24.39 per hour. If Petitioner was merely on-call without working, then she earned $4 per hour. As such, over the 22-weeks worked, Petitioner earned $13,271.33 which includes all hours worked at straight time of $16.26 per hour as well as on-call hours at $4.00 per hour. This figure divided by 22-weeks renders an average weekly wage of $603.24.

Unlike the Majority, I utilize a denominator of 22-weeks as there is no evidence in the record which supports an inference that the days missed by Petitioner were due to no fault of her own. On the contrary, the wage records evidence Petitioner missed work during the pay periods of August 17, 2013 and October 12, 2013 due to unscheduled absences with no further explanation. As the court noted in *Farris v. Industrial Commission* quoting *Illinois-Iowa Blacktop, Inc.*, 180 Ill. App. 3d 885, 891 (1989), "the new simplified version of section 10 plainly states that in all cases where the employee lost five or more days of work during the 52 weeks prior to the injury, the lost time (*to the extent not due to the fault of the employee*) should be deducted from the wage calculation denominator. (emphasis added)." 357 Ill. App. 525, 528, 829 N.E.2d 372 (2005). Work was clearly available to Petitioner which she chose not to accept.

For the above-stated reasons, I respectfully dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENDERSON-RYAN, DANIELLE
Employee/Petitioner

Case# **14WC005817**

EDWARD HOSPITAL
Employer/Respondent

20IWCC0652

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:

0000 R MARK MARITOTE PC
1060 E LAKE ST
HANOVER PARK, IL 60133

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

Danielle Henderson-Ryan
Employee/Petitioner

v.

Edward Hospital
Employer/Respondent

Case # **14** WC **5817**

Consolidated cases: **N/A**

20 IWCC0652

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Wheaton**, on **December 28, 2017 and June 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 ______

FINDINGS

On **January 6, 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 $**14,906.41**; the average weekly wage was $**671.46**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **4** dependent children.

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

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

Respondent shall be given a credit of $**48,088.56** for TTD, $**5,579.65** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**53,668.21**.

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

ORDER

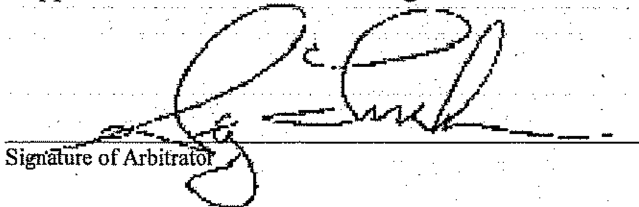
Respondent shall pay Petitioner temporary total disability benefits of $447.64/week for 113 6/7 weeks, commencing January 7, 2014 through March 13, 2016, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner temporary partial disability benefits totaling $5,975.40 for the period commencing March 14, 2016 through September 25, 2016, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $48,088.56 for TTD, and $5,579.65 for TPD, for a total credit of $53,668.21.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,688.00 to Dr. Voronov, $5,801.80 to Athletico, and $1,668.25 to Barnes Jewish Hospital, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $402.88/week for 86 weeks, because the injuries sustained caused the 40% loss of the Left Leg, as provided in Section 8(e)12 of the Act.

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

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



Signature of Arbitrator

August 24, 2018
Date

AUG 29 2018

Statement of Facts

Petitioner Danielle Henderson-Ryan testified that she is a licensed LPN. She received her nursing license in 2005. In July 2013, she began work for Respondent Edward Hospital as an IT Interventionalist. She assisted doctors during procedures. She testified the job required her to be on her feet 10 to 12 hours per day. She worked full time. She was paid $16.26 per hour. She received PTO time. She was on call. She was paid for being on call in addition to her regular pay. She testified that there were various clock-in codes for the work done. These would be entered into the computer. She would call a phantom line every night to find out if she was going to work. There were times she was told not to come in if she was not scheduled. There were times she would be told to leave early because there was not enough work. Petitioner's pay statements were admitted as PX 17. Respondent's wage statement for Petitioner was admitted as RX 4.

Petitioner testified that in January 2014, she had no physical issues. She had no issue with her ankles, knees or legs. RX 9 documents Petitioner's prior Workers' Compensation settlements in 03 WC 2511 for a January 16, 2003 left hand injury working for Forever 21 settled March 29, 2005 for 2.5% of the left hand; 03 WC 2512 for a December 30, 2002 left foot injury working for Forever 21 settled March 29, 2005 for 26.4% of the left foot; and 05 WC 18575 for a February 6, 2005 spine injury working for County of DuPage settled April 25, 2006 for 9.5% man as a whole. Petitioner testified that she did not recall any prior Workers' Compensation settlements. She agreed she had worked for Forever 21. She stated she retained attorneys because she was terminated but does not recall getting a settlement. She testified her foot was completely fine. She denied receiving almost 70 weeks of temporary total disability. She remembers burning her hand but does not remember settling anything. She recalls lifting a patient working for the County of DuPage but does not remember settling any cases.

Petitioner testified that on January 6, 2014, she was setting up a room for an emergency procedure when an x-ray table struck her left leg. Her leg turned in. Her ankle was sideways. Petitioner went to Employee Health. The history of injury indicates an x-ray table rolled over her left foot. She complained of tingling in the outer aspect of the left foot and 3rd, 4th and 5th toes. X-rays of the left foot were negative for fracture or dislocation. The foot was casted. The diagnosis was left foot pain, left lateral ankle pain, and a contusion of the left foot. Petitioner was instructed to follow up with Dr. Lapinski (PX 1).

On January 8, 2014, Petitioner saw Dr. Lapinski of M&M Orthopedics. She provided a consistent history of accident and complained of pain in the anterolateral ankle without numbness, tingling or radiation. Dr. Lapinski reviewed x-rays noting they were negative for fracture, dislocation, or degenerative changes. Physical examination noted the ankle was held inverted and plantar flexed. There was mild swelling and tenderness over the anterolateral ankle. Dr. Lapinski's impression was left ankle crush injury. A CT scan was ordered to rule out an occult fracture (PX 2). A January 9, 2014 CT scan of the left ankle showed corticated irregularity in the posterior lateral aspect of the talus, likely representing a developmental os trigonum or sequelae of a remote injury. Acute osseous abnormalities were not clearly delineated, and close clinical correlation was recommended (PX 2). On January 13, 2014, Petitioner reported numbness and that her foot has a purplish hue. Dr. Lapinski reviewed the CT and indicated it was essentially normal. He noted Petitioner's pain was out of proportion. He was concerned that she could be setting up to develop chronic regional pain syndrome. He started physical therapy and referred Petitioner to Dr. Ellen Voronov for a pain evaluation (PX 2). Physical therapy was initiated at Athletico on January 16, 2014. The January notes include findings of sensitivity to light touch, mild discoloration, decreased sensation and loss of hair (PX 3A).

On January 29, 2014, Petitioner presented to Dr. Voronov. She complained of burning left ankle pain, discoloration, and a cold sensation about the foot. She denied numbness, tingling or radiation of pain. She stated the pain had been getting progressively worse. Physical examination noted the foot was inverted. There was tenderness and some swelling. There was a purplish color and allodynia present. Sweat pattern was normal. The doctor assessed CRPS Type 1. Physical therapy and medications were prescribed (PX 9a).

On February 17, 2014, Petitioner returned to Dr. Lapinski. She was improving. She was still on crutches and partial weight bearing. He counseled her to continue to work in therapy and treat with Dr. Voronov. There was not much else he could offer her. Petitioner could follow up with him as needed (PX 2). Petitioner followed with Dr. Voronov. On March 18, 2014, Dr. Voronov adjusted Petitioner's medications and ordered and EMG (PX 9a). On April 18, 2014, an EMG/NCV of the left lower extremity was performed. It was limited due to Petitioner's poor tolerance, but there were findings of sensory motor demyelinating and axonal neuropathy (PX 4). On April 22, 2014, Dr. Voronov noted the EMG indicated an absent response of the peroneal nerve at the extensor digitorum brevis. She diagnosed CRPS Type II and recommended Petitioner off work (PX 9a). On May 5, 2014, Petitioner returned to Dr. Lapinski. Petitioner still had pain, but it was improving. She had been unable to get out of the cam boot because her left foot was floppy. His impression was left foot drop. Dr. Lapinski noted the EMG revealed compression above the level of the ankle. He stated it was unclear why she would be developing entrapment neuropathy proximal and he referred Petitioner to Dr. Sandeep Jejurikar for possible decompression (PX 2).

On May 20, 2014, Petitioner presented to Dr. Jejurikar. He noted marked left foot drop with no active dorsiflexion, extreme numbness over the lateral aspect of the lower extremity and foot, and evidence of compression involving both the common peroneal nerve and the left sural nerve. He recommended nerve decompression surgery (PX 5). On June 19, 2014, Petitioner underwent decompression of the left common peroneal nerve at the proximal fibula as well as decompression of the sural nerve in the upper third performed by Dr. Jejurikar. The pre-operative and post-operative diagnoses were left common peroneal nerve compression and left sural nerve compression. The operative report notes the primary point of compression was the posterior sural intramuscular septum (PX 4).

Petitioner saw Dr. Jejurikar for post-operative care. On June 27, 2014, Petitioner reported increased pain since surgery and an "electrical-type" pain shooting down her leg. Tapping of the common peroneal nerve elicited a tingling sensation down the entire anterolateral aspect of the leg, which the doctor noted was indicative of nerve regeneration. On July 8, 2014, Petitioner reported diminished pain but complained of persistent numbness along the lateral aspect of the leg. On examination, there was no edema. Her Tinel's sign over the common peroneal nerve was positive, but the doctor was optimistic this was indicative of nerve recovery. The doctor recommended Petitioner resume physical therapy. She was prescribed a left lower extremity compression stocking. On August 5, 2014, Petitioner exhibited a Tinel's sign that was approximately two centimeters lower than the previous examination over the anterolateral aspect. Petitioner was instructed to continue with occupational therapy. On September 23, 2014, Petitioner reported that she had absolutely no improvements in motor or sensory function since her last visit. The doctor recommended a repeat left lower extremity nerve conduction velocity examination (PX 5).

On October 17, 2014, Petitioner presented to Advocate Good Samaritan Hospital for a follow-up left leg EMG. It was consistent with predominantly sensory axonal neuropathy, absent sural nerve response, no change from previous study, but peroneal motor responses were normal (PX 4). On October 21, 2014, Dr. Jejurikar noted as far as the nerve conduction was concerned, the surgery was successful. He was "perplexed" as to

why this did not translate into more definitive clinical improvement. Dr. Jejurikar recommended Petitioner be seen by Dr. Susan MacKinnon, a peripheral nerve specialist at Washington University in St. Louis (PX 5). Petitioner testified the Dr. Jejurikar surgery did not help. Petitioner also continued treatment with Dr. Voronov, who adjusted her medications. On September 17, 2014, therapy was placed on hold due to minimal progress. Dr. Voronov suggested pain psychology and referral consideration of sympathetic nerve blocks (PX 9a). Petitioner attended physical therapy at Athletico ending on October 29, 2014. Her discharge note indicates she was placed on hold by her doctor (PX 3A). On November 5, 2014, Dr. Voronov noted the follow up EMG, referral to St. Louis and the scheduling of an IME. She continued Petitioner off work (PX 9a). On June 5, 2015, Dr. Voronov noted Petitioner was scheduled for an evaluation with Dr. MacKinnon on June 8. Her diagnoses, treatment recommendations, and work restrictions remained unchanged (PX 9a).

Petitioner attended a Section 12 examination with Dr. Kenneth Candido at Respondent's request on November 11, 2014. Dr. Candido testified by evidence deposition taken February 7, 2017 with respect to this examination and subsequent evaluations on August 18, 2015 and January 19, 2016 and an addendum report dated May 16, 2016 (RX 1). Objections were raised to the testimony and reports pursuant to Section 12 of the Act at the time of the deposition and briefs of the parties with respect to the objections were submitted (PX 23, RX 12). The Arbitrator has reviewed the testimony and the exhibits, particularly Deposition Exhibit 3 which is the report dated January 19, 2016 which was admitted without objection (RX 1, p 37). The Arbitrator notes that this report, which was properly provided to Petitioner pursuant to Section 12, includes the findings and opinions of the doctor rendered at the earlier examinations. There was therefore no surprise to Petitioner as the essential information and opinions from the earlier examinations as the content of the earlier report was provided. The Arbitrator also finds that the May 16, 2016 addendum report contains no new opinions but addresses how the previously presented opinions would be applicable to Petitioner's current treatment recommendations and work status. The Arbitrator therefore denies Petitioner's objections and motion to bar any of Dr. Candido's testimony. His testimony and opinions will be addressed further in the Statement of Facts and Conclusions of Law.

On June 8, 2015, Petitioner had an EMG at the Washington University School of Medicine, which showed a single abnormality of incomplete activation. There was no evidence for a left peroneal neuropathy. Incomplete activation with normal CMAPs and pain may be seen in reflex sympathetic dystrophy or functional neurological disorder. Clinical correlation was recommended (PX 8). Petitioner also saw Dr. Susan Mackinnon on that date. Dr. Mackinnon's June 11, 2015 letter to Dr. Jejurikar states Petitioner complained of pain into the distribution of the superficial peroneal nerve and a bit into the distribution of the sural nerve. Recent electrical studies were normal. Petitioner was still wearing the boot. Physical examination noted a positive Tinel's sign over the superficial peroneal nerve at its entrapment point in the distal leg. The scratch collapse test is positive here as well. Sensation in the superficial peroneal nerve was decreased. Dr. Mackinnon recommended decompression. On June 9, 2015, Petitioner underwent decompression of the left superficial peroneal nerve; anterior and lateral muscle fasciotomy. The pre and post-operative diagnoses were compression left superficial peroneal nerve. The operative report notes significant compression (PX 7). Petitioner testified that after the surgery her leg became more painful. It became purple. it was ice cold. It felt like she had no circulation. She was in a boot and confined to a wheelchair.

On July 9, 2015, Petitioner followed up with Dr. Mackinnon and reported her pain had not improved after the surgery. Petitioner still will not move her ankle, as she was preoperatively. There was no further surgery to offer and Dr. Mackinnon suggested she see pain physician, Dr. Michael Bottros, for nerve blocks (PX 6).

On July 9, 2015, Petitioner presented to Dr. Joseph Larese, pain management, who works with Dr. Bottros. He assessed chronic pain, neuralgia, muscle spasm, and complex regional pain syndrome of the lower extremity. Petitioner received lumbar sympathetic blocs on July 9, 2015, July 15, 2015, and July 20, 2015 (PX 6). On August 31, 2015, Petitioner was examined by Dr. Choi and Dr. Bottros. Petitioner complained of pain of 7/10 in the lateral leg distal to the knee and left lateral aspect of dorsum of foot. Petitioner completed her last session of GMI/PT. The record states that she had made tremendous progress. She was ambulating on her own and out of the wheelchair, in addition to pain control. The doctor recommended non-GMI physical therapy and prescribed a boot. She was to follow up in 3-6 months (PX 6). Petitioner testified she was paid travel expense for her first trip to St. Louis. She testified that she was not paid for the following three stays totaling 5 nights. She agreed she must have received the payments noted in RX 14.

On August 18, 2015, Dr. Candido performed a second Section 12 examination. Petitioner reported she was currently in Graded Motor Imagery therapy, which included mirror visual feedback therapy. On examination, Petitioner exhibited a foot drop on the left, plantar flexion was 0-1/5, and inversion and eversion at the ankle were 0-1/5. A temperature reading of the left ankle was 85.1 degrees, compared to 91.1 degrees on the right at his initial examination, and the left foot was 85.4 degrees on the left compared to 90.7 on the right currently. The doctor also noted there was hypesthesia within the lateral plantar nerve distribution on the left (RX 1).

Dr. Candido diagnosed status post left foot and ankle crush injury, common peroneal nerve neuropathy of the left leg, neuropathic pain of the left leg, and sural nerve neuropathy of the left leg. He opined that there was insufficient evidence for a diagnosis of CRPS Type I or Type II as there is no tactile allodynia and no hyperalgesia to deep digital pressure. Petitioner did not have the hallmark feature of CRPS, allodynia or hyperalgesia. He opined Petitioner may benefit from graded motor imagery (GMI) therapy. He stated that up to three lumbar sympathetic type nerve blocks could be implemented to provide temporary relief. He also recommended Petitioner engage in aquatic therapy. Dr. Candido admitted he is not a nerve surgeon, but based upon the lack of improvement, he opined that Dr. Mackinnon's surgery was not indicated. He agreed with her medication regimen. The doctor opined Petitioner could perform sedentary type work with no lifting or carrying anything greater than 10 pounds. She was a reasonable candidate for training in medical coding. She was not yet at MMI (RX 1, Dep. Ex. 2 and 3).

On October 7, 2015, Petitioner followed up with Dr. Voronov. Petitioner reported the pain was more tolerable and controlled with medication. The records note Dr. Mackinnon's surgery and Dr. Bottros' injections for CRPS. A home exercise program was recommended, and more lumbar blocks could be considered. Petitioner was in a CAM boot and was to follow up in four weeks and remain off work (PX 9a). On October 13, 2015, Petitioner started a new course of physical therapy at Athletico referred by Dr. Voronov for a diagnosis of CRPS (PX 3A). Petitioner testified that this was different from the therapy she received in St. Louis.

Petitioner continued to see Dr. Voronov on a monthly basis for nerve medication. On October 28, 2015, Dr. Voronov noted Petitioner had PT and started stimulation. On December 23, 2015, Petitioner followed up with Dr. Voronov who recommended a consultation with Dr. Slavin for a possible spinal cord stimulator. Petitioner's off work restrictions were continued. On January 14, 2016, Petitioner was fitted for an AFO brace. Physical examination noted trace dorsiflexion and EHL extension. There was purplish discoloration, hypoesthesia, some mild hyperalgesia, and normal sweat pattern. There was atrophy of the calf muscle (PX 9a).

On January 19, 2016, Petitioner was re-examined by Dr. Candido at Respondent's request. She reported increased range of motion which made her pain slightly more tolerable. She rated her pain as 5/10 with rest

and 8/10 with activity. She reported she continued with GMI therapy and coding classes at home despite difficulties concentrating. She continues to use the CAM boot. On exam, she had no swelling of the left ankle or color abnormalities. There was no tactile allodynia and no hyperalgesia to deep digital pressure. There was visual atrophy of the left calf and partial foot drop. There was diminished sensitivity over the nerves in her left ankle/foot (RX 1, Dep. Ex. 3). Dr. Candido again opined there was insufficient evidence for a diagnosis of CRPS Type I or Type II. The doctor noted Petitioner has some features of the condition, but he was unable to support the diagnoses as tactile allodynia and hyperalgesia, the hallmarks of CRPS, were absent. Dr. Candido opined Petitioner reached MMI and could work in a sedentary capacity. He opined that Petitioner would need ongoing pain management. He agreed with the use of Lyrica for 12 months and of Cymbalta, and Naltrexone for six months. He testified that a spinal cord simulator was not indicated as Petitioner was not taking opioids and was responsive to alternative remedies. He testified that Petitioner should wean out of the boot (RX 1).

On February 11, 2016, Petitioner followed up with Dr. Voronov. She was wearing the AFO brace. She reported that she only wore her boot as needed. She reported improved but persistent pain. Dr. Voronov noted Petitioner should proceed with a consult with Dr. Slavin if her pain persisted. She noted Petitioner's work status as off work. On March 10, 2016, Petitioner reported pain of 3-6/10. She can ambulate in the AFO, only one block before the pain starts. Petitioner's work status remained off work (PX 9a). Dr. Voronov's April 20, 2016 office note includes Patient Education which states Petitioner was advised to continue normal activities as tolerated (PX 9a).

Petitioner testified that she was offered an educational program consisting of community college courses in medical coding. Ed Minnick worked with her to coordinate this program. Edward Minnick of Select Case Management Services emailed Petitioner on March 9, 2016 concerning a missed vocational appointment (RX 11). He notes Petitioner was scheduled to enroll in the Medical Office Certificate program at COD beginning March 16, 2016. She also was to complete a CareerStep program. Her start date was September 9, 2015 with an end date in June 2016, which he noted might be extended to a year. This corresponds to the timeframe outlined in the Rehabilitation Plan prepared (RX 5, Ex. 1). Petitioner was to meet him to discuss volunteer work (RX 11). Petitioner testified that she did not want to further her education. She chose to take a position as a part time case worker with the Bloomingdale Township starting March 14, 2016. She was able to sit and elevate her foot. Petitioner worked for Bloomingdale Township through February 28, 2017. She earned $15.00 per hour. Her payroll records were admitted as PX 19. Petitioner testified she was working about 20 hours per week until June 6, 2016 when she began working fewer hours. Petitioner stopped working for Bloomingdale Township because she got ill.

On May 16, 2016, Dr. Candido authored an addendum report (RX 1, Dep. Ex 4). He testified that Petitioner clinically had a foot drop. He stated that if the peroneal nerve is intact, you cannot have a foot drop. The possibilities are a subclinical pathology or that the foot drop was contrived. He thought there was a combination of pathology and symptom magnification. He testified that a repeat EMG/NCV could resolve this. Dr. Candido testified that he noted a foot drop in his examinations of August 2015 and January 2016. He had the EMG testing at each of those examinations. He did not mention at those times that the foot drop could be contrived (RX1). He also opined that, with respect to the WalkAid System, that a trial of up to 3 months has little downside. It would not be expected to be required for more that 6 to 9 months (RX 1, Dep. Ex. 4).

Petitioner continued with monthly office visit to Dr. Voronov from April 5, 2016 through November 12, 2016. Petitioner transitioned from the boot to the AFO brace and to regular shoes with the AFO brace as needed (PX 9b, PX 9c). Petitioner continued with physical therapy at Athletico thought July 1, 2016 (PX 3B). Petitioner

testified that she went until they stopped paying for it. On September 12, 2016, Petitioner was using the AFO brace 2-3 hours per day, alternating with regular shoes. She reported pain using regular shoe. She had mild return of dorsiflexion. Dr. Voronov recommended a neurosurgery consult. Dr. Voronov noted that Petitioner is not at MMI as potential for nerve stimulation, transposition or additional exploration to improve patient's function/ability to walk should be determined. She also discussed additional lumbar sympathetic block as an option. She noted that FES, additional lumbar sympathetic blocks, consult with Dr. Slavin and Lyrica have been denied by insurance (PX 9b). On November 12, 2016, Dr. Voronov notes Petitioner is tolerating the regular shoe better. Dr. Voronov reiterated her recommendations (PX 9c).

Respondent had Utilization Reviews performed which non-certified the purchase of the WalkAid System on April 19, 2016 (RX 6); non-certified lumbar sympathetic blocks as ordered on June 27, 2016 on July 11, 2016 (RX 7); and retrospectively non-certified Flex Gar-sock and batteries ordered November 5, 2015 on February 15, 2017 (RX 8). By letter dated September 13, 2016, Respondent disputed all bills for medical services on or after September 12, 2016 (RX 10).

On February 1, 2017, Petitioner presented to primary care physician Dr. Kevin Kovitz. A history of hemoptysis was noted. Petitioner was recently hospitalized due to gastric ulcers and for a seizure. On February 10, 2017, Petitioner presented to the Elmhurst Hospital Emergency Department complaining of abdominal pain and spitting up blood. A pelvic CT indicated colonic diverticulosis. The differential diagnosis was biliary colic, pancreatitis, gastritis, PUD (PX 9c). Petitioner testified she had to stop working at Bloomingdale Township due to this illness. As of July, or August 2017, she felt well enough to work again and started working for Falcon Care on November 1, 2017. She travels to multiple clinics to chart on chronic care patients. She also works from home. She testified that she gets paid for 40 hours per week but works about 25. She testified that her salary is $39,000.00.

Petitioner saw Dr. Voronov on March 1, 2017. She reported she was using regular shoes, she was tolerating the shoe better. She admitted improvement with dorsiflexion. Physical examination noted no tenderness or swelling. The foot was cold to the touch. Strength was 3+/5. Petitioner walked with an antalgic gait due to pain. There was atrophy of the calf muscles. There was no discoloration. Dr. Voronov's impression was left peroneal nerve injury, chronic pain, neuropathic in nature due to the work-related injury and the result of previous CRPS Type II. Dr. Voronov continued recommended a neurosurgery consult and opined that Petitioner was not at MMI due to possible additional treatment options (PX 9c).

Dr. Voronov testified by evidence deposition taken on September 9, 2016 (PX 10) and May 22, 2017 (PX 11). She testified to her treatment of Petitioner and her initial diagnosis of Complex Regional Pain Syndrome, Type I. She modified her diagnosis to Complex Regional Pain Syndrome, Type II when there was clear evidence of the peroneal nerve injury. She stated the first surgery had limited success. She continued to have neuropathic pain and continued signs of CRPS. Dr. Voronov testified that the Petitioner had nerve conduction testing but could not complete the EMG due to pain. She has continued to treat Petitioner since the second surgery. Petitioner only had little improvement from the second surgery to the date of the first deposition session. She recommended another EMG, additional lumbar blocks, and referral to a neurosurgeon (PX 10).

Dr. Voronov testified that her findings fluctuated regarding the presence of allodynia. This is because the signs of CRPS fluctuate. Her impression often did not indicate CRPS (PX 10). She did not restrict Petitioner form driving. Dr. Voronov opined that Petitioner could do sedentary work since she began treating her. She then testified that Petitioner had to be off work until late 2015 or early 2016, and later testified that Petitioner was

able to do normal activities as tolerated in April 2016 and could work in November 2016. As of March 1, 2017, Dr. Voronov testified to Petitioner's improvement with motor recovery and denial of left foot numbness (PX 11)

Petitioner testified her leg is still uncomfortable. She has a lot of pain. She rated her pain as 5/10 on a good day and 8/10 on a bad day. She is limited in her walking. She has complete numbness from the outside of her leg to the middle of her foot. She has a stabbing, burning sensation on the outer part of her leg. She testified she could only move the big and next toes. Petitioner demonstrated the condition of her left leg and foot including the surgical scars. She takes over the counter ibuprofen or Motrin.

Steven Borgstrom testified by evidence deposition taken April 13, 2018 (RX 14). He testified that he is the adjuster handling the matter for Respondent. He qualified RX 3 as the medical payment log documenting payments made in this matter. RX 3 includes not only payments for medical treatment but also the IME charges, transportation to Petitioner and case management (RX 14).

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 injury to her left leg and ankle when an x-ray table struck her left leg. She sought immediate medical care. The record documents a prior 2003 injury to Petitioner's left foot but no details of the nature of that injury were offered and no evidence of any ongoing medical care or disability was presented. No medical opinion that Petitioner's current condition was caused by a prior injury was presented. All medical records and opinions attribute Petitioner's condition of ill-being in the left lower extremity to the accident as consistently described in the medical histories. The Arbitrator finds that Petitioner's condition of ill-being in the left lower extremity was causally connected to the accidental injury sustained on January 6, 2014.

Respondent also disputes ongoing causation beyond Dr. Candido's examination on January 19, 2016 based upon Dr. Candido's opinions that there is insufficient evidence to support a diagnosis of CRPS and that Petitioner had reached MMI as of that date. He released her to return to sedentary duty. Petitioner continued treatment thereafter under the care of Dr. Voronov including physical therapy at Athletico through July 2016 and pain management through March 1, 2017. Dr. Voronov testified as to her findings, her diagnosis and her treatment recommendations.

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. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Having listened to the testimony, reviewed the treating records and the reports and testimony of the experts. The Arbitrator finds Dr. Candido's opinions that there is insufficient evidence to support a diagnosis of CRPS unpersuasive and not dispositive of the issue of causation.

Dr. Candido testified that Petitioner has some features of the condition, but he was unable to support the diagnoses as tactile allodynia and hyperalgesia, the hallmarks of CRPS, were absent. The Arbitrator notes that Dr. Voronov's records do document allodynia and hyperalgesia, but not consistently. Dr. Voronov testified that the symptoms of CRPS fluctuate. Petitioner's treating records note that these symptoms did appear in many visits as well as the additional signs including discoloration and temperature change. Dr. Voronov's opinion is supported by the June 8, 2015 EMG which showed a single abnormality of incomplete activation. with normal CMAPs and pain seen in reflex sympathetic dystrophy or functional neurological disorder. Following surgery by Dr. Mackinnon, Dr. Bottros assessed chronic pain, neuralgia, muscle spasm, and complex regional pain syndrome of the lower extremity. The Arbitrator finds these diagnoses consistent with the diagnostic testing and physical examinations.

The Arbitrator also finds that the dispute over the criteria to diagnose CRPS does not determine the issue of causal connection. In addition to the diagnosis of CRPS, the treating doctors and Dr. Candido agree that Petitioner has a neuropathic pain in the left leg. Dr. Jejurikar noted marked left foot drop with no active dorsiflexion, extreme numbness over the lateral aspect of the lower extremity and foot, and evidence of compression involving both the common peroneal nerve and the left sural nerve. He performed nerve decompression surgery. Dr. Mackinnon found positive Tinel's sign at the superficial peroneal nerve at its entrapment point in the distal leg. The scratch collapse test is positive here as well. Sensation in the superficial peroneal nerve was decreased. Dr. Mackinnon performed a decompression of the left superficial peroneal nerve; anterior and lateral muscle fasciotomy. In addition to CRPS, Dr. Bottros assessed chronic pain, neuralgia, muscle spasm. Dr. Voronov's impression was left peroneal nerve injury, chronic pain, neuropathic in nature due to the work-related injury and the result of previous CRPS Type II. Dr. Candido diagnosed common peroneal nerve neuropathy, neuropathic pain and sural nerve neuropathy. Whether the condition is labeled as CRPS or neuropathic pain, Petitioner's symptoms, complaints and need for treatment are related to the condition of ill-being in the left lower extremity which is causally related to the accidental injury on January 6, 2014.

The Arbitrator also finds Dr. Candido's opinion that Petitioner had reached MMI as of January 19, 2016 unpersuasive. While the Arbitrator finds Dr. Candido's opinion that Petitioner was capable of sedentary work persuasive, his finding of MMI is contradicted by the medical records and course of events.

Dr. Candido testified that Petitioner could do sedentary work based upon his examination. Dr. Voronov's testimony as to Petitioner's work ability is inconsistent. She initially testified Petitioner could perform sedentary work then contradicted herself, testifying Petitioner was disabled until late 2015 or 2016 and then until November 2016. This is despite the statement in April 2016 that Petitioner was advised to continue normal activities as tolerated and, more importantly that Petitioner had begun a vocational plan to return to work as a medical coder and actually returned to work in March 2016. The Arbitrator finds that Dr. Candido's opinion that Petitioner was capable of sedentary work as of January 2016 is persuasive and supported by the Petitioner's course of conduct and not inconsistent with the opinions of Dr. Voronov.

Dr. Candido testified the basis of his opinion that Petitioner was at MMI was that there was no anticipation that Petitioner would improve further. He agreed that Petitioner would need ongoing pain management. The facts demonstrate that Petitioner did improve. She weaned from the boot to the AFO brace and now is in regular shoes. She has returned to work. The office notes document improved strength and improvement in dorsiflexion. Dr. Voronov's records and testimony confirm improvement, even though Petitioner remains limited to sedentary work. Petitioner has had no treatment for her condition of ill-being since March 1, 2017. Despite Dr. Voronov's opinion that she is not at MMI due to the options for additional modalities, the Arbitrator notes the Utilization Reviews non-certifying the recommended care. The Arbitrator also notes that even Dr. Voronov lists these additional modalities as only potential options. Given Petitioner's improved function, lack of additional medical care and ultimate return to work, the Arbitrator finds Petitioner reached MMI as of her last visit to Dr. Voronov on March 1, 2017.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence, that her current condition of ill-being in the left lower extremity is causally connected to the accidental injury sustained on January 6, 2014. Petitioner's condition of ill-being reached maximum medical improvement as of March 1, 2017.

In support of the Arbitrator's decision with respect to (G) Average Weekly Wage, the Arbitrator finds as follows:

Section 10 of the Act states that "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed.

The parties agree that Petitioner was employed by Respondent for a period of 24 weeks and earned gross earnings of $14,953.52 of which $141.34 was paid for overtime hours and of that amount $47.11 was the overtime premium. Overtime is excluded from the calculation of a claimant's average weekly wage unless the claimant is required to work overtime as a condition of her employment, or the overtime hours are part of the claimant's consistent weekly schedule. *Airborne Express, Inc. v. Illinois Workers' Compensation*, 372 Ill. App. 3d 549; 865 N.E. 2d 979; 2007 Ill. App. LEXIS 244; 310 Ill. Dec 259. Based upon Petitioner's testimony that she would be instructed nightly how many hours per day she would be working and that she was paid

additionally for on-call hours that she did not work, the Arbitrator finds that the overtime hours are a condition of her employment and are included in the calculation of the average weekly wage at straight time. Deducting the overtime premium leaves Petitioner's earnings at $14,906.41.

To calculate the average weekly wage, the Arbitrator must also determine the weeks or parts thereof. The Arbitrator notes that the wage information provided shows the total hours per pay period but does not include the number of days worked. Petitioner testified that she would sometimes be sent home early or would not be scheduled. The Arbitrator cannot infer that weeks with less than 80 hours represent less than full work weeks resulting in a reduction in the number of weeks worked except for the 8/23/13 pay period which notes only 1.25 hours of orientation and the remainder as unpaid unscheduled absence. This pay period can only represent 1 day or 1/5 of a week. Based upon this analysis the Arbitrator finds that Petitioner worked 22.2 weeks.

Based upon the record as a whole, the Arbitrator finds that Petitioner's average weekly wage is $14,906.41/22.2 weeks or $671.46.

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). Based upon the Arbitrator's finding with respect to Causal Connection, reasonable and necessary medical for the condition of ill-being in the left lower extremity would be causally connected.

Petitioner testified that she did not receive travel expenses for her trips to St. Louis. The Arbitrator notes that Petitioner acknowledged receipt of additional payments on cross examination. The Arbitrator also notes Petitioner's memory of payments for prior Workers' Compensation claims was similarly inaccurate. PX 15 notes expenses for visits on July 19-21, 2015, August 9, 2015, and August 31, 2015. Mr. Borgstrom and RX 3 document a payment of $547.63 for travel beginning July 9, 2015 thru an undisclosed date. Petitioner did not offer any other claimed travel expenses for this period other than PX 15. The Arbitrator also notes Dr. Candido testified that GMI therapy is available in Chicago, although Dr. Bottros indicated his program is different. Based upon the evidence submitted, the Arbitrator finds that Petitioner failed to prove that any reimbursable travel expenses owed were not reimbursed.

Petitioner admitted medical bills as PX 14A, B, C, F, G, H, I, J. The Arbitrator notes that the unpaid bills and balances remaining have not been reduced per the fee schedule or negotiated rate. Respondent presented the testimony of the adjuster Steven Borgstrom who also qualified RX 3 as the medical payment log. Respondent also submitted Utilization Reviews performed which non-certified the purchase of the WalkAid System on April 19, 2016 (RX 6); non-certified lumbar sympathetic blocks as ordered on June 27, 2016 on July 11, 2016 (RX 7); and retrospectively non-certified Flex Gar-sock and batteries ordered November 5, 2015 on February 15, 2017 (RX 8). The Arbitrator has reviewed the medical records, the bills submitted, the payment log and testimony of Mr. Borgstrom and the Utilization Reviews. The Arbitrator finds that the WalkAid System was not obtained, and additional lumbar sympathetic blocks were not performed.

Based upon RX 3, PX 14C, and the testimony of Mr. Borgstrom, PX 14C, 14F and 14G have been paid. With respect to the remaining bills, the Arbitrator finds as follows:

Dr. Voronov (PX 14A): The bill reflects an outstanding balance of $1,688.00 for the office visits on March 10, 2016, April 20, 2016, and 6 visits from September 12, 2016 through March 1, 2017. The Arbitrator finds this treatment documented in the medical records, reasonable, necessary and causally related.
Athletico (PX 14B): The bill reflects an outstanding balance of $5,801.80 for physical therapy from February 17, 2016 through April 22, 2016. The Arbitrator finds this treatment documented in the medical records, reasonable, necessary and causally related.
Barnes Jewish Hospital (PX 14H and PX 14 I): These bills reflect charges of $1,446.25 for the lumbar injections performed by Dr. Bottros on July 9, 2015, July 15, 2015 and July 20, 2015, and $222.00 for his August 31, 2015 office visit. The Arbitrator finds this treatment documented in the medical records, reasonable, necessary and causally related.
ElectroStim Med Services (PX 14 J): This bill is for equipment including batteries, electrodes, lead wires, skin wipes and lotions. The bill reflects dates of service from August 12, 2017 through December 17, 2017. These dates are after the Arbitrator's finding of MMI. No medical records were admitted documenting the ordering of this equipment. Although Dr. Voronov is listed as the provider on the bill, no records or testimony supported the prescription or continued use of this equipment was offered. Petitioner did not testify to any ongoing use of such equipment. The Arbitrator also notes RX 8 which non-certified Flex Gar-sock and batteries. The Arbitrator finds that Petitioner failed to prove that this medical equipment was reasonable or necessary.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,688.00 to Dr. Voronov, $5,801.80 to Athletico, and $1,668.25 to Barnes Jewish Hospital, 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 and (N) Credit, 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.

TTD benefits may be suspended or terminated if the employee refuses to submit to medical, surgical, or hospital treatment essential to his recovery, or if the employee fails to cooperate in good faith with rehabilitation efforts. See *R.D. Masonry, Inc. v. Industrial Comm'n*, 215 Ill. 2d 397, 830 N.E.2d 584, 294 Ill. Dec. 172 (2005). Benefits may also be suspended or terminated if the employee refuses work falling within the physical restrictions prescribed by his doctor. See *Hartlein v. Illinois Power Co.*, 151 Ill. 2d 142, 166, 601 N.E.2d 720, 176 Ill. Dec. 22 (1992); *Hayden v. Industrial Comm'n*, 214 Ill. App. 3d 749, 574 N.E.2d 99, 158 Ill. Dec. 305 (1991). To show entitlement to TTD benefits, claimant must prove not only that she did not work, but that she was unable to work. *City of Granite City v. Industrial Comm'n,* 279 Ill. App. 3d 1087, 666 N.E.2d 827, 217 Ill. Dec. 158 (1996).

Petitioner was disabled from the date of the accident. Although, based upon the Arbitrator's finding with respect to Causal Connection, Petitioner was able to perform sedentary work as of January 19, 2016, this

physical level would not allow her to return to her regular work duties and Petitioner was not yet at MMI. Respondent began a rehabilitation plan for Petitioner in September 2015, but she had not completed the program to be able to return to work. Petitioner would be entitled to temporary benefits during the program until she was able to return to work. RX 11 notes that the program including the community college courses in medical coding, the CareerStep program and the volunteer work was to be concluded by June 2016 but indicated that it might be extended to September 2016. The Arbitrator notes the Petitioner's current sedentary employment is in medical coding and pays more that she was earning at the time of the accident. However, Petitioner refused to cooperate with the program and did not complete the CareerStep or enroll in the coding courses. Based upon the evidence presented, the Arbitrator finds that Petitioner would have been employable at a comparable rate of pay at the latest as of September 2016 based upon the Rehabilitation Plan and her subsequent employment with Falcon Care. Her failure to cooperate with vocational rehabilitation terminates her rights to further temporary benefits.

Petitioner was not able to return to her regular employment with a sedentary work restriction. She was entitled to temporary total disability until the beginning of her part time work with Bloomingdale Township on March 14, 2016 a period of 113 6/7 weeks. RX 2 documents TTD payments by Respondent of $48,088.56.

Petitioner began part time work earning $15.00 per hour. She testified her hours varied. Petitioner did not offer a weekly breakdown of benefits paid but did testify her hours were reduced after June 2016. Petitioner would be entitled to temporary partial disability for the period from March 14, 2016 through September 2016, at which time she would have been employable in a higher capacity after completing the vocational plan with which she refused to cooperate. RX 2 documents calculated temporary partial disability payments to Petitioner beginning March 28, 2016 through September 25, 2016 on a two-week schedule. The Arbitrator finds that RX 2 is the best evidence of the correct amount of temporary partial disability for the period owed. Respondent paid temporary total disability for the two weeks from March 13, 2016 through March 27, 2016. The Arbitrator infers that Petitioner's entitlement for temporary partial disability for this period would be the same as the subsequently paid two-week period ($395.74).

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 she is entitled to temporary total disability for the period commencing January 7, 2014 through March 13, 2016, a period of 113 6/7 weeks. Respondent shall receive credit of $48,088.56 for TTD paid. Petitioner is also entitled to temporary partial disability of $5,975.39 for the period commencing March 14, 2016 through September 25, 2016. Respondent shall receive credit of $5,579.65 for TPD paid.

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 an IT Interventionist at the time of the accident and that she is not able to return to work in her prior capacity as a result of said injury. The Arbitrator notes that Petitioner is an LPN and has returned to work in the medical field, although she in unable to perform the medium level requirements of her prior job with her current sedentary restrictions. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 28 years old at the time of the accident. Petitioner would be considered a younger worker and will need to cope with her disability both in her employment and daily life for an extended period of time. Because of this, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner has returned to work and is now earning more that she was for Respondent at the time of the injury. The Arbitrator also considers that because of Petitioner's young age and sedentary work restrictions, should she lose her current job, the market for her services would be less expansive that if she was unrestricted. Because of this, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that as a result of the accident, Petitioner has suffered a severe nerve injury to her left lower extremity. She had immediate symptoms of peroneal nerve damage. She has undergone two surgeries and extensive conservative care including physical therapy and lumbar sympathetic injections for pain and loss of function. The treating medical records document a left foot drop. The Arbitrator dismisses Dr. Candido's testimony as to possible symptom magnification. His testimony was that there are two equally possible reasons for her presentation with foot drop. This does not rise to the level of medical certainty and is therefore given no weight. In addition to her foot drop, Petitioner also presents with loss of strength and dorsiflexion, atrophy of the calf muscles and discoloration and temperature changes. Petitioner has surgical scars on her left leg as viewed by the Arbitrator and depicted in the photos contained in Dr. Candido's reports. Petitioner continues to advance pain complaints with numbness and tingling in her leg. Petitioner has been restricted to sedentary work. Because of these facts, the Arbitrator therefore gives greater weight to this factor.

The Arbitrator has reviewed the medical evidence and the elements of disability in this matter. Petitioner's injury and surgeries were to the peroneal nerve in the left calf. Petitioner demonstrates atrophy of the left calf muscles. The purplish discoloration is noted on the ankle and on the lower leg. Her surgical scars were in the left calf above the ankle. Although Petitioner has elements of her condition of ill-being in the ankle and foot including the lack of dorsiflexion, the Arbitrator finds that this matter should be properly evaluated as a loss of use of the left leg. The Commission has previously assessed injuries to the peroneal nerve as a loss of use of the leg. See: *Danny Pine v. Trailmobile*, 00 IIC 236; *Ruth Drzewiecki v. Brandt Industries, Inc.*, 07 IWCC 293.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 40% loss of use of Left Leg pursuant to §8(e)12 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AGOSTINI VINCI,

Petitioner,

20 I W C C 0 6 5 3

vs.

NO: 16 WC 20438

SOUTHWEST AIRLINES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent and "When did PPD begin to accrue?; all other applicable evidentiary and procedural issues," 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 initially note that, although the Arbitrator analyzed all five permanent partial disability factors in Section 8.1b(b) of the Act, a clerical error occurred on page 13 of the Decision and the "occupation" factor was not enumerated as the second factor. This caused each of the subsequent factors to be mis-numbered. We hereby correct the Decision to reflect the accurate factor "numbers" that were addressed.

We next make the following modifications to the Section 8.1b(b) analysis:

1) Under factor (ii), we strike the sentence that begins with "In light of" and ends with "realistic."

2) Under factor (iii), we strike the language that begins with "when symptoms may increase" through the word "injuries."

20IWCC0653

3) Regarding factor (iv), we find that there is evidence regarding future earning capacity. Petitioner testified that he is earning more now than he was before his accident. *T.41.* Petitioner also testified that he thinks his future earning capacity has been diminished because he does not think he'll be able to work as long. *T.46-47.* We do not believe this is speculation but, rather, an appropriate and relevant statement by Petitioner based on his perception of his current physical condition and symptoms. However, we do not give that self-serving testimony much weight because it is not supported by any medical opinion. We next strike the Arbitrator's inference that Petitioner "may not be able to work much overtime" as speculative because Petitioner did not testify about how his condition has affected his ability to work overtime. Overall, we give this factor little weight.

4) For factor (v), evidence of disability corroborated by the treating medical records, we first note that Petitioner has not sought any medical treatment for his neck since he was released by Dr. Rinella, on July 5, 2018, at maximum medical improvement with 2/10 (2-out-of-10) pain. The hearing was held over a year and a half later on February 20, 2020. We contrast this gap in treatment with the evidence that, even prior to Petitioner's first accident on October 15, 2015 (*See* 16 WC 20437), he had been seeing a chiropractor fairly regularly for neck complaints. *Px2.* Petitioner admitted on cross-examination that he had neck pain prior to that accident and, in the months leading up to October 2015, he had rated his neck pain as high as 6/10. *T.54.* When he was seen by Respondent's Section 12 examiner, Dr. Phillips, on January 30, 2020, Petitioner rated his neck pain as 3/10. *Px9, T.54.* Petitioner testified that he currently has pain at rest of 3 to 4/10, which increases to 5 to 6/10 after work. *T.43-44.* Therefore, the evidence suggests that Petitioner's current neck pain and symptoms are no worse than they were prior to his work accidents. Petitioner has not seen any physician or chiropractor for neck symptoms for over a year and a half, although he did testify that he uses heating pads, ice, massage oils and gets massages to relieve "the tension and stress." *T.45.*

Second, Petitioner testified that he "at times" takes over-the-counter Aleve and he also takes cyclobenzaprine, meloxicam, and Imitrex, which are prescribed by his primary care doctor. *T.44-45.* Respondent's Section 12 examiner and A.M.A. impairment rater, Dr. Neal, also mentioned in his August 6, 2019 report that Petitioner told him he was taking cyclobenzaprine, meloxicam and hydrocodone as prescribed by Dr. Singla. *Rx1.* However, there are no records in evidence from Dr. Singla after Petitioner was released by Dr. Rinella's office on July 5, 2018. Therefore, there are no *treating* medical records to support Petitioner's testimony that he is still being prescribed those medications for his neck symptoms.

Petitioner underwent two fusion surgeries and now has hardware in his neck from C3 to C7. His testimony that his neck is stiff, sore, has limited range of motion, and his muscles get tight when it is cold and rainy (*T.42)* is credible based on the medical records. We give this factor significant weight.

To summarize our analysis of the five factors in Section 8.1b(b) of the Act, we are impressed by the amazingly successful outcome Petitioner has had after a 4-level cervical fusion. He has returned to work full duty and is earning more than he was prior to his accidents. His pain complaints seem to be no worse than what he experienced before the accidents, and he has not returned for any medical or chiropractic treatment despite his testimony that he has 5-6/10 pain after work. The records of Petitioner's primary care physician, Dr. Singla, were not entered into evidence to corroborate his current and continuing complaints and prescriptions. We hereby reduce the Arbitrator's award from 40% loss of use of the person as a whole and find that Petitioner has proven a loss of use of 35% of the person as a whole under Section 8(d)2 of the Act.

Finally, we address the question of when Petitioner's permanent partial disability (PPD) award began to accrue. The Arbitrator's decision ordered, "Respondent shall pay Petitioner compensation that has accrued from the **date of accident** through **2/20/2020**, and shall pay the remainder of the award, if any, in weekly payments." *(Emphasis in original.)* Since the only issue at trial was nature and extent, this has led to a dispute about whether Petitioner's PPD award began to accrue on the date of the accident versus the date he was released at maximum medical improvement (MMI). We note that the Arbitrator never specifically found that Petitioner's PPD award began to accrue on the date of accident, but he did find, "On July 5, 2018, Dr. Rinella performed cervical x-rays and released him at maximum medical improvement." *Dec. at 17.*

We begin by addressing some of the cases and decisions cited by the parties:

- *Lester v IC*, 256 Ill.App.3d 520 (1993), involved statutory finger amputations for which the court found, "the legislature intended that individuals who receive amputations should be immediately compensated when no dispute exists as to whether the injury arose out of and in the course of employment." *Id at 523.*

- *Greene Welding Hardware v. IWCC*, 396 Ill.App.3d 754 (2009), affirmed an award of penalties for not paying permanency benefits starting on the accident date. However, this case also involved statutory finger amputations.

- *Maciasz v. Kojda Remodeling, Inc.*, 11 IWCC 1028, involved an eye injury that occurred on April 29, 2009. The Order section stated, "The respondent shall pay the petitioner compensation that has accrued from April 29, 2009, through February 1, 2011, and shall pay the remainder of the award, if any, in weekly payments." We interpret that decision as finding that the benefits that began accruing on the date of accident were temporary total disability (TTD) benefits, which were awarded from April 30, 2009 through July 8, 2010. The claimant was also awarded 173 weeks PPD for the 100% loss of his left eye with an enucleation. The question remains when did those benefits begin to accrue? Interestingly, the Commission affirmed the arbitrator's finding that claimant was "entitled to penalties and fees for the 26-week delay by the respondent in beginning the weekly payment of permanency benefits for the enucleation of his left eye on February 9, 2010." This is confusing because the decision does not indicate when the respondent

started paying the PPD but, apparently, there was a 26-week delay. However, the significance of February 9, 2010 is that is the date when the claimant underwent his final left eye surgery. Therefore, the decision is not clear if the penalties were awarded because the respondent should have begun paying PPD starting 26 weeks prior to February 9, 2010 or because it did not start paying until 26 weeks after that date. In any event, neither scenario reflects a finding that the PPD benefits were to begin on the date of accident (April 29, 2009) because 26 weeks prior to February 9, 2010 is August 12, 2009, which corresponds to no date of significance as far as we can tell. We find that Petitioner's reliance on this decision is misplaced.

- *Garcia v. Sparrer Sausage Company, Inc.*, 12 IWCC 334, involved a hand injury and the only award made was for PPD. The Commission ordered, "Respondent shall pay to Petitioner compensation that accrued from May 30, 2008 through July 23, 2010, and pay the remainder of the award, if any, in weekly payments." We note that there was no specific finding when the PPD started to accrue but the Commission did affirm the arbitrator's finding that the claimant had last seen Dr. Kaymakcalan on March 11, 2009, and that she was considered to be at MMI on that date.

- In *Lynch v. Illinois Dept. of Trans.*, 15 IWCC 831, the claimant's accident occurred on May 6, 2014, and the only issue was nature and extent. The arbitrator awarded claimant 2% loss of use of the person-as-a-whole and included the following order:

  > Respondent shall pay Petitioner compensation that has accrued from **March 6, 2014** [Date of Accident] through **February 19, 2010**, and shall pay the remainder of the award, if any, in weekly payments. *Id. at 3-4 (Emphasis in original).*

  On Review, the Commission only corrected the ending date of this "lump sum" period to be consistent with the date of the trial:

  > The Commission corrects the Decision of the Arbitrator as to the time period for which the Respondent shall pay the Petitioner accrued compensation in the Order section of the Decision. The time period is incorrectly annotated as March 6, 2014 through February 19, 2010. However, the ending date should be February 19, 2015, the date of the trial in Collinsville, Illinois. Therefore, the Commission corrects the clerical error in the second paragraph of the Order section, page two of the Arbitrator's Decision to: "Respondent shall pay Petitioner compensation that has accrued from March 6, 2014 through February 19, 2015, and shall pay the remainder of the award, if any, in weekly payments. " *Id. at 1.*

  Similar to the case at bar, the beginning of the "lump sum" period for the payment of accrued benefits was listed as the date of the accident. However, neither the arbitrator nor the Commission in *Lynch* made a specific finding that the claimant's PPD had, in fact, accrued at the time of his accident.

- In *Diercouff v. Village of Richton Park*, 18 IWCC 751, the Commission affirmed the arbitrator's decision that included the order, "Respondent shall pay Petitioner the

compensation accrued from **12/1/2014** [Date of Accident] through **12/5/2017** and shall pay the remainder of the award, if any in weekly payments." *(Emphasis in original.)* Again, neither the arbitrator nor the Commission *specifically found* that all of Petitioner's benefits started accruing as of the accident date. Rather, our interpretation is that the entire TTD and medical portion of the award had accrued as of the date of the hearing but PPD had only partially accrued from October 20, 2015 through the hearing on December 5, 2017. The arbitrator had specifically found that the claimant was entitled to TTD until her condition became permanent on October 20, 2015 (*Id. at 45)* and that she had reached MMI on that date. (*Id. at 49-50).*

- In *Hudson v. State of Illinois*, 19 IWCC 0594, the Commission affirmed the arbitrator's finding that the decedent had not reached MMI prior to her death and wrote:

> As such, assuming *arguendo*, Decedent had reached maximum medical improvement prior to her death as argued by Petitioner, the estate would only be entitled to permanent partial disability benefits from April 11, 2017, the date she allegedly reached maximum medical improvement, through May 3, 2017, her date of death, *i.e.*, 3 2/7 weeks at $ 797.50 per week. In addition, because there cannot be a simultaneous finding that Decedent's condition was both temporary and permanent, the TTD [FN1] benefits claimed for that same period would necessarily be vacated.

The footnote states, "The Commission observes Petitioner alleged, and Respondent stipulated, Decedent was temporarily and totally disabled through her demise on May 3, 2017. This position is incompatible with Petitioner's simultaneous assertion that Decedent reached maximum medical improvement prior to her death."

- The accident in *Mank v. Olin Corp.*, 11 IWCC 1060, occurred on June 28, 2008, but the arbitrator ordered that "Respondent shall pay Petitioner compensation that has accrued from **9/9/09** through **4/8/11,** and shall pay the remainder of the award, if any, in weekly payments." *(Emphasis in original.)* The Commission affirmed the arbitrator who specifically found that "Permanent partial disability benefits began to accrue as of 9/9/09 based on Dr. Brown's final release of Petitioner." *Id. at 6.*

- The Commission in *Edmonds v. Continental Tire N.A., Inc.*, 2009 Ill. Wrk. Comp. LEXIS 1124, affirmed the arbitrator's finding that:

> The law supports the principle that Respondent shall pay Petitioner permanent partial disability benefits that have accrued from the date of determination of maximum medical improvement through the date of arbitration. Petitioner clearly only reached maximum medical improvement on December 3, 2008, when he was released by Dr. Ahn and did not return for any additional treatment. Although Petitioner was suspected to have reached maximum medical improvement in August 2007, this did not come to pass as he sought additional medical treatment again with Dr. Ahn starting in September 2008.

> Petitioner reached maximum medical improvement on December 2, 2008, when he was last released by Dr. Ahn, and based upon that, permanency benefits shall accrue from then to the date of Arbitration, June 2, 2009.

We are also mindful of the Appellate Court decision in *Bell v. IWCC*, 392 Ill. Dec. 396 (4th Dist., 2015), which stated:

> In this case, the Commission found that "medical testimony along with testimony from a relative established" that Ms. Nash had a permanent partial disability. The Commission also found that Ms. Nash had reached MMI before her death. Accordingly, the Commission tacitly acknowledged that at least some PPD benefits accrued prior to Ms. Nash's death. *Id. at 400.*

In other words, we find that *Bell* stands for the proposition that PPD benefits begin to accrue on the date of MMI. If the date of MMI was irrelevant and PPD began to accrue on the date of accident, as Petitioner argues, the court in *Bell* would have simply found that Ms. Nash's estate was entitled to PPD from the date of accident through the date of her death.

Although there may be some ambiguity in the Order sections of certain Commission decisions, as cited by Petitioner, those decisions did not specifically address the issue of when PPD begins to accrue. We agree with the Commission decisions that did address the issue and, other than statutory loss cases, found that PPD begins to accrue at MMI. This is most consistent with the Appellate Court's decision in *Bell*.

Therefore, we believe Petitioner is reading too much into the Arbitrator's order that the "lump sum" period begins with the date of accident. The order simply says that Respondent shall pay Petitioner compensation "that has accrued…." Just because the specified period of time begins with the date of accident should not be interpreted to mean that PPD actually started to accrue on that date. The evidence shows that Petitioner was being paid either his full salary or TTD benefits through April 29, 2018, when he was returned to light duty, which was accommodated by Respondent. Petitioner was then released to full duty on May 31, 2018 and released at MMI on July 5, 2018. Since this is not a statutory loss case, Petitioner is not entitled to simultaneous temporary-total-disability benefits and permanent-partial-disability benefits. Therefore, we find that the PPD award began to accrue when Petitioner reached MMI on July 5, 2018.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $663.79 per week for a period of 175 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 35% 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.

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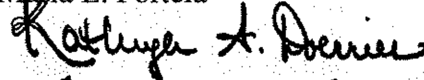
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

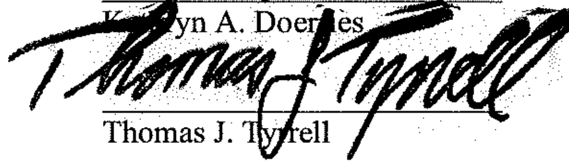
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 1 0 2020

Maria E. Portela



Kathryn A. Doerries



Thomas J. Tyrrell

SE/
O: 9/15/20
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VINCI, AGOSTINO
Employee/Petitioner

Case# **16WC020438**

16WC020437

SOUTHWEST AIRLINES
Employer/Respondent

20IWCC0653

On 4/14/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.29% 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:

1993 ROMANUCCI & BLANDIN LLC
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
RYAN J McCARTHY
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Agostino Vinci
Employee/Petitioner

v.

Southwest Airlines
Employer/Respondent

Case # **16** WC **20438**

Consolidated cases: **16 WC 20437**

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 **Joseph Amarilio**, Arbitrator of the Commission, in the city of **Chicago**, on **2/20/2020**. By stipulation, the parties agree:

On the date of accident, **6/21/2016**, 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 $**57,528.64**, and the average weekly wage was $**1,106.32**.

At the time of injury, Petitioner was **36** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $**71,068.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**71,068.00**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

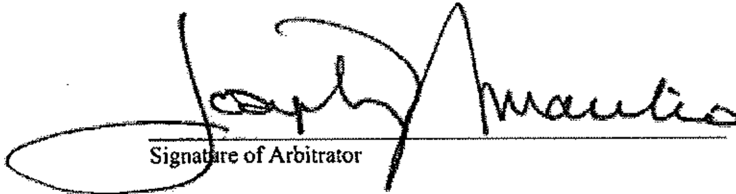
ORDER

Respondent shall pay Petitioner the sum of $663.79/week for a further period of 200 weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **40% loss of use of the person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from the **date of accident** through **2/20/2020**, 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

04/13/2020
Date

APR 14 2020

STATE OF ILLINOIS)
)
COUNTY OF COOK)

20IWCC0653

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Agostino Vinci

Case No.: 16 WC 20437
consolidated with
16 WC 20438

Employee/Petitioner

v.

Southwest Airlines

Employer/Respondent

ADDENDUM TO ARBITRATION DECISION

Procedural History: The petitioner filed two Applications For Adjustment of Claim both of which came to be heard on the petitioner's Requests for Hearing on November 19, 2019 and were continued on the record to February 20, 2020 for further proceedings in Chicago, Illinois. Both parties were represented by counsel. On November 19, 2019, Arbitrator Mason (covering for ARB TBA call) granted, over petitioner's objection, respondent's request for a continuance. Respondent requested the continuance on the day of trial in order to obtain a Section 12 examination addressing the issue of causation based on the recently tendered medical records of petitioner's chiropractor. The chiropractic records contained progress notes for treatment prior to the two dates of accident at issue in the instant cases (Transcript of Proceedings on Arbitration, November 19, 2019 ["TP."], p. 4-14).

On February 20, 2020, Agostino Vinci ("petitioner") testified on his own behalf and was the only witness to testify. Proofs were closed on February 20, 2020. The only disputed issue being the nature and extent of petitioner's injury to the accidents of October 15, 2015 and June 21, 2016.

STATEMENT OF FACTS

The petitioner, a 35-year-old (40 years old at time of trial) married man with two dependent children under the age of 18, testified that he was employed as a full-time Ramp Agent. He was hired by Southwest Airlines ("respondent") on March 16, 1998 as a full-time employee. He eventually earned $1,106.32 per week for the October 15, 2015 date of accident (16 WC 20437) (Arb. Ex. #1, 3, Transcript of Evidence on Arbitration, February 20, 2020 ["TE."], p. 5, pp. 15-17, p. 20). Petitioner was 36 years old and earned $1,106.32 per week for the June 21, 2016 date of accident (16 WC 20438) (Arb. Ex. #2, 5, TE., p. 7, pp. 17, 26).

Petitioner was and still is a union member of TWU555 and is left hand dominant (TE., pp. 17, 27). The petitioner testified that his job duties as a Ramp Agent involved heavy physical labor and consisted of the following: frequently lifting, pushing, pulling with both upper extremities, frequent overheard reaching and lifting, and occasionally operating machinery such as forklifts (TE., p. 16). Petitioner testified that the bags he would lift weighed up to 100lbs and that on average he would have to lift up to 225 bags per plane, up to 150 bags per tote, and up to 6 planes per day (TE., pp. 16-17).

Petitioner testified that he not injured his neck before to his current pending claims. (TE., p. 21). Petitioner did, however, volunteered that he had six prior work injuries; three involved his back and three involved his left knee. His prior workers' compensation injuries are as follows:

Regarding his back, 1. November 15, 2017 (08 WC 02772, which was settled); 2. May 26, 2009 (09 WC 40148, which he received a trial award); and, 3. June 10, 2010 (10 WC 30354, which he received a trial award);

Regarding his left knee. 1.October 2, 2012 (12 WC 35478, which was settled), October 15, 2003 (04 WC 38397, which was settled), and November 8, 2006 (07 WC 27859, which was settled) (TE., pp. 21-23).

The medical records were entered into evidence for treatment received before his accidents of October 15, 2015 and June 21, 2016 are summarized as follows:

On June 29, 2015, petitioner was seen by Dr. Hoekstra at Chiropractic Wellness of Tinley Park. He had frequent right sided neck, and hand pain. He rated his pain as a 6. The pain was

aching, tingling, tightness, stiffness and soreness. He also had intermittent bilateral low back/hip pain. Orthopedic tests were all negative. Palpation of the muscles revealed spasm and hypertonicity in the following areas: right cervical dorsal area and cervical region, mild subluxation with spasm, hypermobility, and end point tenderness found in the following levels: C5, C4, C3, C6, T1, T3, L5, L4, right pelvis and left pelvis. (PX. 2, p. 89).

Petitioner continued to receive chiropractic treatment through August 3, 2015 with his neck pain vacillating between 4 and 7. (PX. 2, pp. 79-88).

On August 4, 2015, petitioner complained of constant bilateral low back and hip pain. He rated his pain as a 9. He also complained of frequent right sided neck/shoulder pain. The sciatic nerve test was positive bilaterally as was the Yeoman's test. The cervical compression test was positive on the right. A cervical compression test was performed in order to localize the cervical pain. Downward pressure was applied at the top of the head. This was positive when it resulted in spinal pain. The petitioner's prognosis was guarded. There was no change after the adjustment. (PX 2, p. 77-78).

On August 26, 2015, the petitioner complained of constant of bilateral low back and hip pain rated at 5. He also complained of frequent right sided neck and shoulder pain. An MRI was discussed. He was 50% better over the last few weeks but still had pain throughout the day at work. (PX2, pp. 73-74).

On September 17, 2015, petitioner rated his pain for the bilateral low back and hip at 2. For the neck and right sided shoulder pain, the Petitioner rated his pain at 5. Headaches had been frequent. He had been working 24-hour shifts at work. An MRI was discussed with the petitioner. (PX2, pp. 71-72).

First Injury- 16 WC 20437 – October 15, 2015 Date of Accident

The petitioner testified that on October 15, 2015, while at work, he was parked while driving a forklift, when another forklift driver ran into his forklift because that driver could not see over the full pallet of freight; as a result, he felt pain in his neck (Arb. Ex. 3-4, TE., pp. 17-20, PX1, pp.4-5). Petitioner immediately reported the injury to his supervisor, Marcus Watkins (Arb. Ex. 3, TE., p. 20, PX1, pp.4-5). Respondent did not send him for medical treatment (TE., p. 20).

On October 15, 2015, petitioner was examined by his chiropractor, Dr. Jeffrey Hoekstra (TE., p. 20, PX2, pp. 69-70). Petitioner testified that he had previously seen Dr. Hoekstra for neck and back chiropractic adjustments periodically from June 29, 2015 through September 17, 2015 but had never underwent a cervical MRI (TE., pp. 21, 23, PX2, pp.71-90). On October 15, 2015, Dr. Hoekstra diagnosed him with neck and shoulder pain and began providing chiropractic adjustments to his neck (PX2, pp.69-70). He further testified that after the October 15, 2015, he continued to see the chiropractor for neck treatment until June 16, 2016, as well as for back treatment, where the back treatment was a kind of pain management from his prior lumbar surgeries, but not related to this October 15, 2015 accident (TE., pp. 23-24, PX2, pp. 17-70). Petitioner continued to work full duty with no restrictions after this October 15, 2015 injury (TE., p. 24).

Petitioner testified that Dr. Hoekstra did offer him a cervical MRI during the course of treatment but stated that he did not get it because the pain was not that bad and the adjustments seemed to work (TE., pp. 24-25, PX2, pp. 17, 19, 21, and 23). Petitioner testified that all medical bills for this chiropractic treatment was paid by United Healthcare, his Group Health Insurance Carrier through respondent (Arb. Ex.3, TE., p. 25, PX2, pp. 7-17).

Second Injury – 16 WC 20438 - June 21, 2016 Date of Accident

Petitioner testified that on June 21, 2016, while at work, he was lifting freight from on top of a cart when he felt a strain in the neck and pain radiating down both arms (Arb Ex. 5-6, TE., pp. 25-26, PX1, pp.1-2, PX3, p.8, PX4, p.165). Petitioner testified that this neck pain was different because the pain was much worse and the pain radiated down his arms, which he had never experienced before (TE., pp. 26, 55). Petitioner immediately reported the injury to his supervisor, William Velazquez (Arb. Ex. 5, TE., p. 26, PX1, pp.1-2). He was then sent by respondent to Clearing Clinic (TE., pp. 26-27). On June 21, 2016, Clearing Clinic performed x-rays of the neck, diagnosed him with right and left shoulder sprains as well as paresthesia of both arms, prescribed a Cold Pack to apply 3-4 times per day, prescribed medications of Ibuprofen and Icy Hot, gave him light duty restrictions, and advised him to follow up with his own orthopedic doctor (TE., pp. 27-28, PX3, p.8).

Respondent did not accommodate the restrictions, so he began receiving full salary as of June 22, 2016 pursuant to the union agreement (Arb. Ex.#2, 5, TE., p. 28).

Petitioner saw Dr. Anthony Rinella of Illinois Spine & Scoliosis Center on June 24, 2016 (TE., p. 28, PX4, p. 165). Petitioner had seen Dr. Rinella previously for his prior work-related back accident of June 10, 2010, where Dr. Rinella had performed lumbar surgery; however he had been released at maximum medical improvement ("MMI") and had returned him to work full duty (TE., p. 28, pp. 41-42, PX4, p. 173). On June 24, 2016, Dr. Rinella prescribed a cervical MRI, diagnosed him with cervical radiculopathy, and continued his light duty work restrictions (TE., p. 29, PX4, p. 165).

On July 1, 2016, petitioner underwent the cervical MRI, which revealed disc herniations at C3-4 and C4-5 (TE., p. 29, PX4, pp. 163-164, PX5, pp. 69-70). On July 8, 2016, Dr. Rinella reviewed the MRI films, diagnosed him with cervical radiculopathy secondary to C3/4 and C4/5 disc herniations, prescribed physical therapy three (3) times a week for six (6) weeks, and referred him to Dr. Faris Abusharif for a cervical epidural injection at C3/4 and C4/5 (TE., pp. 29-30, PX4, 164).

On August 9, 2016, petitioner was examined by Dr. Abusharif at Pain Treatment Centers of IL, who also prescribed PT and a cervical injection at C6/7 (TE., pp. 30-31, PX5, pp. 12-16). Dr. Abusharif performed the first cervical epidural steroid injection at C6/7 on August 10, 2016 (TE., p. 31, PX5, pp. 17-26). Respondent still had not authorized the physical therapy at that time so Dr. Abusharif performed the second cervical epidural steroid injection, this one at C5/6 on August 24, 2016 (TE., p. 31, PX5, pp. 27-36). On August 31, 2016, Dr. Rinella prescribed an upper extremity EMG (TE., p. 31, PX4, p. 162).

On September 12, 2016, Dr. Abusharif performed the third cervical epidural steroid injection at C3/4 and C6/7 on September 12, 2016 (TE., pp. 31-32, PX5, pp. 51-68). On September 19, 2016, petitioner underwent the EMG (TE., p. 32, PX4, pp. 260-263). On September 22, 2016, after reviewing the EMG results, Dr. Rinella recommended a C3/4 and C4/5 anterior cervical discectomy and fusion and took petitioner off work completely (TE., p. 32, PX4, pp. 158-161).

On September 28, 2016, since respondent could not accommodate the light duty restrictions and now that he was off work completely, respondent began paying temporary total disability (TTD) as of September 28, 2016, as he was paid full salary through September 27, 2016 (Arb. Ex. #2, 5, TE., p.32). On November 14, 2016, petitioner had pre-op testing at

Clinical Associates in Medicine, and, on November 23, 2016, at Silver Cross Hospital (TE., p. 33, PX4, pp. 15-16, PX8, pp. 19-34).

On November 29, 2016, petitioner was admitted to Silver Cross Hospital, where Dr. Rinella performed surgery, which consisted of anterior cervical discectomy, C3-5, anterior cervical fusion, C3-5, anterior spinal instrumentation C3/4 and C4/5, anterior interbody cage, C3-5, spinal allograft, surgical microscope, and fluoroscopy (TE., p. 33, PX4, pp. 333-334, PX8, pp. 100-101). On November 29, 2016 and November 30, 2016, Dr. Rinella performed post-op cervical x-rays and discharged him from Silver Cross Hospital on December 1, 2016 (PX8, pp. 39-69, 129-130).

On December 15, 2016, Dr. Rinella performed cervical x-rays and advised him to remain off of work, to continue Norco, to discontinue Flexeril, to commence Soma (a muscle relaxer), and to follow-up in four (4) weeks (TE., pp. 33-34, PX4, pp. 154-155). On January 11, 2017, Dr. Rinella refilled his prescriptions for Norco and Soma, advised him to remain off of work, and prescribed PT (TE., p. 34, PX4, pp. 149-151). On February 16, 2017, petitioner began PT at Silver Cross Hospital (TE., p. 34, PX8, pp. 421-424). On February 24, 2017, Dr. Rinella performed cervical x-rays, advised him to continue in physical therapy, and refilled his Norco and Soma prescriptions (TE., p. 34, PX4, pp. 97, 293-294). On March 10, 2017, Dr. Rinella performed new cervical x-rays because petitioner had extreme pain at home on March 9, 2017 and was concerned that the hardware had failed but noted that there was no new injury and the hardware was intact (TE., pp. 34-35, PX4, pp. 302-303, PX8, p. 512).

On March 17, 2017, Dr. Rinella prescribed a cervical MRI due to his increased pain and advised him to hold off physical therapy for now (TE., p. 35, PX4, pp. 144-146). On March 22, 2017, the petitioner underwent the cervical MRI, which revealed the disc herniation at C6/7 (TE., p. 35, PX4, pp. 306-307). On March 30, 2017, after reviewing the MRI films, Dr. Rinella referred him back to Dr. Abusharif for a left-sided C6/7 epidural steroid injection (TE., p. 35, PX4, pp. 141-142, 298-299). On April 26, 2017, Dr. Abusharif performed a cervical epidural steroid injection at C6/7 (TE., p. 35-36, PX5, pp. 71-74). On May 10, 2017, Dr. Rinella performed cervical x-rays and prescribed another surgery (TE., p. 36, PX4, pp. 140, 297, PX8, p. 526). On June 13, 2017 at Silver Cross Hospital, and, on June 30, 2017 at Clinical Associates in Medicine, petitioner had pre-op testing (TE., p. 36, PX4, pp. 20-25, PX8, pp. 536-553).

On July 11, 2017, the petitioner was admitted to Silver Cross Hospital, where Dr. Rinella performed surgery, which consisted of anterior cervical discectomy, C5-7, anterior cervical fusion, C4-7, anterior spinal instrumentation C3-7, anterior interbody cage, C5-7, spinal allograft, removal of instrumentation, exploration of fusion, local spinal autograft, surgical microscope, and fluoroscopy (TE., p. 36, PX4, pp. 324-325, PX8, pp. 623-624). On July 11, 2017 and July 12, 2017, Dr. Rinella performed post-op cervical x-rays and discharged him from Silver Cross Hospital on July 13, 2017 (PX8, pp. 558-586, 642-643).

On July 26, 2017, Dr. Rinella prescribed physical therapy three (3) days per week for four (4) - six (6) weeks (TE., pp. 36-37, PX4, p. 138). Petitioner began physical therapy at Team Rehabilitation physical therapy on August 7, 2017 (TE., p. 37, PX6, pp. 223-226). On August 23, 2017, Dr. Rinella referred him to Urology to discuss hematuria related to the treatment of the cervical spine because he had blood in his urine after the surgery (TE., p. 37, PX4, p. 137). Petitioner testified that he did see Urologist Dr. Andros, who had provided him with medications that resolved the issue (TE., pp. 37-38). On October 4, 2017, Dr. Rinella performed cervical x-rays, refilled Norco and Soma prescriptions, and prescribed more PT to include left shoulder (TE., p. 38, PX4, p. 99, pp.134-135, PX6, pp. 105-158, PX8, p. 939).

On November 15, 2017 and December 20, 2017, petitioner followed-up with Dr. Rinella, and he continued in PT at Team Rehab (TE., p. 38, PX4, pp. 128-129, 131-132, PX6, pp. 32-104). On January 31, 2018, Dr. Rinella performed cervical x-rays, prescribed work conditioning, and prescribed Imitrex for his Migraine headaches (TE., p. 38, PX4, pp. 122-126, PX8, 954). Petitioner completed physical on February 2, 2018 at Team Rehab and began work conditioning on February 5, 2018 (TE., pp. 38-39, PX6, pp. 24-31, 285-286). On March 29, 2018, Dr. Rinella advised him to finish work conditioning (TE., p. 39, PX4, pp. 117-120). On April 26, 2018, Dr. Rinella refilled his Norco prescription, started him on cyclobenzaprine, and released him to light duty restrictions with a 30-pound lifting restriction effective April 30, 2018 (TE., p. 39, PX4, pp. 111-115). Petitioner completed work conditioning on April 27, 2018 (TE., p. 39, PX6, pp. 227-229).

Petitioner testified that he in fact returned to work in a light duty capacity on April 30, 2018 and, thus, was paid TTD through April 29, 2018 (Arb. Ex. #2, 5, TE., pp. 39-40). On May 31, 2018, Dr. Rinella released him to full duty (TE. pp. 40, 49, PX4, pp. 107-108). Petitioner testified that when he returned to work full duty on May 31, 2018, he was working as Ramp

agent again in the same position as prior to June 21, 2016 (TE. p.41). On July 5, 2018, Dr. Rinella performed cervical x-rays and released him at MMI (TE., p. 40, PX4, pp. 101-102, PX8, p. 968). Petitioner testified that that was the last time he saw Dr. Rinella (TE., p.40).

Petitioner was examined by Dr. M. Bryan Neal for an American Medical Association ("AMA") rating on July 11, 2019 at the request of the Respondent. (TE. p. 40, RX1). The petitioner first told Dr. Neal that he was fine although he had some aches and pains which he considers to be normal. His neck is stiff all the time. He will have neck pain in rainy or humid days, but his neck pain is less than daily. Dr. Neal agreed that he is at maximum medical improvement. The Petitioner denied having any numbness or tingling or symptoms below either elbow. The Petitioner had taken Cyclobenzaprine, Meloxicam, and Hydrocodone within the last week but less than daily. (RX 1, pp. 2-3).

On physical examination, the cervical spine was normal in appearance. He had limited range of motion. He lacked at least three finger breathes of flexion chin-to-chest. He could extend about 25 degrees. Rotation to each side was limited. He rotated about 40 to 45 degrees bilaterally. The posterior cervical spine was painless as well as the right and left cervical musculature. Motor strength was normal. He had normal motor function, normal reflexes, and normal upper extremity sensation. The petitioner was diagnosed with markedly improved cervical spine symptomology with mild intermittent neck symptomology status post cervical spine surgery twice resulting in a C3-7 fusion following decompression with non-radicular static residual. (RX 1, pp. 6-7).

To assess the Petitioner's impairment, Dr. Neal used the 6th Edition of the 2nd printing of the American Medical Association's Guides to the Evaluation of Permanent Impairment. Dr. Neal used the diagnosis of cervical radiculopathy from multiple herniated cervical discs. Dr. Neal explained that the most appropriate diagnosis to use in the cervical spine regional grid is the diagnosis of intervertebral disc herniation or AOMSI. The most appropriate determination in terms of designating a class would be class I for intervertebral disc herniations or documented AOMSI at a single level or multiple levels with medically documented findings with or without surgery and for disc herniations with documented resolved radiculopathy. (Resp. Ex. 1, p. 9)

In terms of the functional history grade modifier, the doctor had the Petitioner complete the Pain Disability Questionnaire. He PDQ score was a 30 which qualifies for a mild disability classification which equates to a grade modifier of 1. This translates to "pain; symptoms with

strenuous/vigorous activity." In terms of the physical examination grade modifier, the Petitioner clearly fell under the grade modifier zero. In terms of the clinical studies grade modifier, the doctor considered the MRI and EMG results consistent with the clinical presentation which resulted in a clinical studies grade modifier of 2. Considering all these modifiers, the net adjustment was zero. There was therefore no adjustment from the default grade of C. Using table 17-2, with the diagnosis of cervical radiculopathy, class I determination, and grade C assignment, this correlated to a whole person impairment of 6% of the whole person. (Resp. Ex. 1, pp. 9-11).

Dr. Neal's August 6, 2019 report contains a 6% whole person impairment rating (WPI), pursuant to the most current edition of the AMA's Guide to the Evaluation of Permanent Impairment since he noted that petitioner underwent an anterior cervical discectomy, C3-5, anterior cervical fusion, C3-5, anterior spinal instrumentation C3-5, anterior interbody cage, C3-5, spinal allograft, surgical microscope, and fluoroscopy; and an anterior cervical discectomy, C5-7, anterior cervical fusion, C4-7, anterior spinal instrumentation C3-7, anterior interbody cage, C5-7, spinal allograft, removal of instrumentation, exploration of fusion, local spinal autograft, surgical microscope, and fluoroscopy (RX1, pp. 5-6, 11).

On January 30, 2020, Dr. Frank Phillips performed Section 12 medical examination of the petitioner at the respondent's request. It was noted that subsequent to the surgeries, the petitioner noted good improvement in his radicular pain and numbness as well as improvement in his left arm strain. He described some pain and stiffness radiating towards the trapezius and denied any upper extremity pain. He described having normal strength. Based on the information provided, Dr. Phillips believed the Petitioner had an underlying degenerative cervical condition with an acute exacerbation of symptoms including radiculopathy and weakness related to the June 21, 2016 lifting accident. Treatment subsequent to this was appropriate and related to the injury. He ultimately underwent cervical surgery with good improvement in his symptoms. He was left with some residual neck discomfort and stiffness but has assumed regular duty. Petitioner had reached maximum medical improvement and could continue working regular duty. In terms of his causation opinion, Dr. Phillips noted there was no evidence to support he had any radicular neurologic symptoms prior to the work accidents in question. Dr. Phillips believed the work accidents provoked symptoms. (PX 9).

Petitioner still works full duty with no restrictions for respondent in the same position as a Ramp Agent but is now earning more due to increases per the union pay scale (TE., pp. 41, 48). The petitioner testified that he expects to have a shorter work life following the accidents and believes he will make less money. (TE, pp. 46-47).

Petitioner did not have any subsequent injury to his neck. Petitioner testified that he still feels stiffness and soreness in his neck. It is difficult to rotate his neck up and down and to the side which impact his driving. Rain and cold causes his muscles to feel tight. He denied any complaints involving his shoulders. At work, it is harder for him to lift things, and he is more careful since the injury. (TE., pp. 42-43).

Petitioner testified he does not have numbness or tingling. He does have pain which he rated as a five or six out of ten after work. While at rest, his pain is a three or four. He no longer participates in hobbies like playing pool or darts. (TE., pp. 43-44).

On cross examination, the petitioner confirmed that he is performing the same duties at work as he was prior to his work accidents and agreed with Dr. Rinella that he could return to full duty work. He confirmed that on July 5, 2018, he did not have any upper extremity pain, weakness, or numbness, has not returned to see Dr. Rinella since that date, and has no pending appointments. (TE, pp. 49-50).

Petitioner testified he has difficulty with repetitive overhead activities, pulling and lifting at work (TE., pp. 42-43). He is more careful since the injuries (TE., p. 43). Petitioner has some stiffness, soreness, a loss of range of motion, and is affected by weather changes (TE., p. 42). After working a full day, he rates his pain as a 5-6 on a pain scale of 10 (TE., p. 43). At rest, petitioner rates his pain as a 3-4 on a pain scale of 10 (TE., pp. 43-44). He does not play pool or shoot darts anymore since the injuries, which were hobbies he enjoyed prior to these accidents (TE., p. 44). However, he continues to work through the pain, occasionally taking Aleve as well as Cyclobenzaprine, Meloxicam, and Imitrex, which were all prescribed by his primary care doctor (TE., pp. 44-45). Petitioner did use ice packs and heat pads for the neck and shoulders at times when in pain and would also use massage oils and get massages (TE., p. 45). Petitioner did do home exercises and stretches as was taught to him in physical therapy. (TE., pp. 45-46). Respondent paid all the reasonable, necessary and related medical expenses regarding these accidents (Arb Ex. #1, 2, 3, 5, TE., p. 46).

Petitioner confirmed on cross examination that as a ramp agent, he can bid on different jobs that entail different tasks. Whether a bid is successful depends on seniority. As the petitioner has 22 years of seniority, he is very senior. He bid on the overnight freight shift, and the bid was successful. He can bid on different jobs if he so desired. Petitioner admitted that his shifts vary in terms of how busy they are. When he is not busy, he can sit in the freight house and watch television provided by the Respondent. (TE., p. 50-54).

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

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, the petitioner has the burden of proving, by a preponderance of the evidence, all the elements of his or her claim O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980). Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Petitioner testified in open hearing before the arbitrator who had opportunity to view his demeanor under direct examination and under cross-examination. The arbitrator evaluated the testimony of the petitioner in consideration of all the evidence in the record. The arbitrator finds that petitioner was a credible witness. The arbitrator notes that petitioner's testimony was corroborated by and consistent with the medical records and objective findings.

The accidental injuries sustained by petitioner resulted in a cervical spine injury that required two surgeries: First, an anterior cervical discectomy and fusion at C3-4 and C4-5, and second, an anterior cervical discectomy at C5-6, C6-7, anterior fusion at C4-5, C5-6, C6-7 with instrumentation from C3 to C7.

Petitioner was released to full duty, no restriction work. He last received medical treatment with his treating surgeon on July 5, 2018, and there is no medical treatment pending but the petitioner takes medication prescribed by his primary care physician. The respondent obtained an impairment rating. Petitioner did not.

Pursuant to Section 8.1b of the Workers' Compensation Act, the following criteria and factors must be considered in assessing 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 include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

i. The reported level of impairment as assessed pursuant to the current edition of the American Medical Association (hereinafter, "AMA") "Guides to the Evaluation of Permanent Impairment";
ii. The occupation of the injured employee;
iii. The age of the employee at the time of the injury;
iv. The employee's future earning capacity; and
v. Evidence of disability corroborated by the treating medical records.

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

With respect to these factors, the arbitrator notes the following:

1. The reported level of impairment under the AMA Guides.

The level of impairment reported by Dr. Neal, pursuant to the most current edition of the AMA's Guides to the Evaluation of Permanent Impairment is 6% of the whole person (RX1). The arbitrator notes that impairment does not equate to permanent partial disability under the Workers' Compensation Act, but instead is a factor to be considered in making such a disability evaluation. but instead is a factor to be considered in making such a disability evaluation. Dr. Neal did utilize a Pain Disability Questionnaire (PDQ) in determining functional assessment, which is the functional assessment tool that is used in spinal cases (RX1). The doctor noted residual findings based on his current obvious complaints and limitations that were corroborated by postsurgical x-ray findings and other medical records. Because of petitioner's credible testimony demonstrating that he did in fact have residual pain and limitations, Dr. Neal's

impairment rating is credible, reliable, substantiated, and of a substantive impact on the arbitrator's finding as to disability.

Accordingly, the arbitrator gives greater weight to the foregoing factor in accordance to the law. The occupation of the injured employee.

Petitioner testified that he was a full-time Ramp Agent, who was a union member of TWU555 (TE., pp. 16-17). The petitioner testified that his job duties as a Ramp Agent consisted of the following: heavy level labor job, which involves frequently lifting, pushing, pulling with both upper extremities, frequent overheard reaching and lifting, and occasionally operating machinery such as forklifts. (TE., p. 16). Petitioner testified that the bags he would lift weighed up to 100lbs and that on average he would have to lift up to 225 bags per plane, up to 150 bags per tote, and up to 6 planes per day (TE., pp. 16-17). Petitioner still works for respondent in the same position (TE., p. 41). The arbitrator gives significant weight to the foregoing factor, and, noting that his job is a heavy level job, concludes that petitioner's permanent partial disability will be greater than an individual who performs lighter duty work. In light of the number of work related injuries sustained by petitioner over the years while working for the respondent, petitioner's belief that his job duties have taken a toll on his body, and his assessment that he may not be able to continue performing his job duties until 67 birthday appear to be reasonable and realistic.

2. The age of the employee at the time of the injury.

At the time of the October 15, 2015 and June 21, 2016 accidents, petitioner was 35 and 36 years old, respectively (TE., pp. 20, 26). No evidence was presented as to how petitioner's age might affect his disability. The arbitrator considers petitioner to be a somewhat younger individual and concludes that petitioner's permanent partial disability will be moderately greater than that of an older individual because petitioner will have to live with the consequences of the injuries for a longer period of time, when symptoms may increase or arthritis may set in due to age, as opposed to an older individual, who would have to work less years with the consequences of these injuries. The arbitrator places greater weight on this factor.

3. The employee's future earning capacity.

No evidence regarding petitioner's earning capacity was presented by petitioner other than the fact that because of these work-related accidents and his surgeries, he was in pain after work each day, he would take medications for the pain, do stretches, use ice and heat pads, need massages, and he did not believe he would be able to work as long as he thought he would have been able to prior to the accidents (TE., pp. 42-48). Thus, it is reasonable to infer that he may not be able to work as much overtime in the future due to the pain or be able to work for as many years into the future, thereby diminishing his future earning capacity. Because of his credible testimony, the arbitrator therefore gives greater weight to this factor.

4. Evidence of disability corroborated by the treating medical records.

First Injury – 16 WC 20437 – October 15, 2015 Date of Accident

On October 15, 2015, Dr. Hoekstra diagnosed him with neck/shoulder pain and began providing chiropractic adjustments to his neck (PX2, pp.69-70). Petitioner continued to see the chiropractor for neck treatment until June 16, 2016 (TE., pp. 23-24, PX2, pp. 17-70). The petitioner continued to work full duty with no restrictions after this October 15, 2015 injury (TE., p. 24). Dr. Hoekstra did offer him a cervical MRI during treatment, but petitioner stated that he did not get it because the pain was not that bad and the adjustments seemed to work (TE., pp. 24-25, PX2, pp. 17, 19, 21, and 23). Petitioner's testimony is corroborated by the medical records.

Second Injury – 16 WC 20438 – June 21, 2016 Date of Accident

On June 21, 2016, Clearing Clinic performed x-rays of the neck, diagnosed him with right and left shoulder sprains as well as paresthesia of both arms, prescribed a Cold Pack to apply 3-4 times per day, prescribed medications of Ibuprofen and Icy Hot, and gave him light duty restrictions (TE., pp. 27-28, PX3, p.8). On June 24, 2016, Dr. Rinella prescribed a cervical MRI, diagnosed him with cervical radiculopathy, and continued his light duty work restrictions (TE., p. 29, PX4, p. 165). On July 1, 2016, petitioner underwent the cervical MRI, which revealed disc herniations at C3-4 and C4-5 (TE., p. 29, PX4, pp. 163-164, PX5, pp. 69-70). On July 8, 2016, Dr. Rinella diagnosed him with cervical radiculopathy secondary to C3/4 and C4/5 disc herniations, prescribed physical therapy three (3) times a week for six (6) weeks, and

referred him to Dr. Abusharif for a cervical epidural injection at C3/4 and C4/5 (TE., pp. 29-30, PX4, 164).

On August 9, 2016, Dr. Abusharif also prescribed physical therapy and a cervical injection at C6/7 (TE., pp. 30-31, PX5, pp. 12-16). Dr. Abusharif performed the first cervical epidural steroid injection at C6/7 on August 10, 2016 (TE., p. 31, PX5, p. 17-26). Dr. Abusharif performed the second cervical epidural steroid injection, this one at C5/6 on August 24, 2016 (TE., p. 31, PX5, pp. 27-36). On August 31, 2016, Dr. Rinella prescribed an upper extremity EMG (TE., p. 31, PX4, p. 162).

On September 12, 2016, Dr. Abusharif performed the third cervical epidural steroid injection at C3/4 and C6/7 on September 12, 2016 (TE., pp. 31-32, PX5, pp. 51-68). On September 19, 2016, petitioner underwent the EMG (TE., p. 32, PX4, pp. 260-263). On September 22, 2016, Dr. Rinella prescribed a C3/4 and C4/5 anterior cervical discectomy and fusion and took petitioner off work completely (TE., p. 32, PX4, pp. 158-161).

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2017, petitioner underwent the cervical MRI, which revealed the disc herniation at C6/7 (TE., p. 35, PX4, pp. 306-307). On March 30, 2017, Dr. Rinella referred him back to Dr. Abusharif for a left-sided C6/7 epidural steroid injection (TE., p. 35, PX4, pp. 141-142, 298-299). On April 26, 2017, Dr. Abusharif performed a cervical epidural steroid injection at C6/7 (TE., p. 35-36, PX5, pp. 71-74). On May 10, 2017, Dr. Rinella performed cervical x-rays and prescribed another surgery (TE., p. 36, PX4, p. 140, 297, PX8, p. 526).

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On July 26, 2017, Dr. Rinella prescribed physical therapy three (3) days per week for four (4) - six (6) weeks (TE., pp. 36-37, PX4, p. 138). Petitioner began physical therapy at Team Rehabilitation PT on August 7, 2017 (TE., p. 37, PX6, pp. 223-226). On August 23, 2017, Dr. Rinella referred him to Urology to discuss hematuria related to the treatment of the cervical spine because he had blood in his urine after the surgery (TE., p. 37, PX4, p. 137, PX6, pp. 159-202). The petitioner did see Urologist Dr. Andros, who had provided him with medications that resolved the issue (TE., pp. 37-38). On October 4, 2017, Dr. Rinella performed cervical x-rays, refilled Norco and Soma prescriptions, and prescribed more PT to include the left shoulder (TE., p. 38, PX4, p. 99, pp.134-135, PX6, pp. 105-158, PX8, p. 939).

On January 31, 2018, Dr. Rinella performed cervical x-rays, prescribed work conditioning, and prescribed Imitrex for his Migraine headaches (TE., p. 38, PX4, pp. 122-126, PX8, 954). Petitioner completed physical on February 2, 2018 at Team Rehab and began work conditioning on February 5, 2018 (TE., pp. 38-39, PX6, pp. 24-31, 285-286). On April 26, 2018, Dr. Rinella refilled his Norco prescription, started him on cyclobenzaprine, and released him to light duty restrictions with a 30-pound lifting restriction effective April 30, 2018 (TE., p. 39, PX4, p. 111-115). Petitioner completed work conditioning on April 27, 2018 (TE., p. 39, PX6, pp. 227-229).

Petitioner in fact returned to work in a light duty capacity on April 30, 2018 (TE., pp. 39-40). On May 31, 2018, Dr. Rinella released him to full duty (TE. p. 40, 49, PX4, pp. 107-108). When he returned to work full duty on May 31, 2018, he was working as a Ramp agent again in the same position as prior his June 21, 2016 accident (TE. p.41). On July 5, 2018, Dr. Rinella performed cervical x-rays and released him at maximum medical improvement. (TE., p. 40, PX4, pp. 101-102, PX8, p. 968).

Dr. Neal's August 6, 2019 report contains a 6% whole person impairment rating (WPI), pursuant to the 6th edition of the AMA's Guide to the Evaluation of Permanent Impairment. He noted that the petitioner underwent an anterior cervical discectomy, C3-5, anterior cervical fusion, C3-5, anterior spinal instrumentation C3-5, anterior interbody cage, C3-5, spinal allograft, surgical microscope, and fluoroscopy; and an anterior cervical discectomy, C5-7, anterior cervical fusion, C4-7, anterior spinal instrumentation C3-7, anterior interbody cage, C5-7, spinal allograft, removal of instrumentation, exploration of fusion, local spinal autograft, surgical microscope, and fluoroscopy (RX1, pp. 5-6, 11).

In his January 30, 2020 Section 12 examination report, Dr. Phillips opined the following: petitioner likely had an underlying degenerative cervical condition with an acute exacerbation of symptoms, including radiculopathy and weakness related to the June 21, 2016 lifting incident; his diagnosis was post-fusion neck stiffness and discomfort causally related to the June 21, 2016 injury; his current symptoms were causally related to the June 21, 2016 work accident; treatment to date was reasonable and necessary; that he had reached maximum medical improvement; and, he was released to full duty work with no restrictions (PX9).

Petitioner testified has not seen any other doctors for his neck since he was released from medical care (TE., p.41). Petitioner did not have a subsequent injury to his neck and did not have any prior injuries to the neck (TE., pp. 21, 41). Prior to the October 15, 2015 and June 21, 2016 accidents, he had received chiropractic adjustments for his neck and back and had been working full duty with no work restrictions (TE., pp. 41-42). Petitioner still works full duty with no restrictions for respondent in the same position as a Ramp Agent and is now earning more due to increases per the union pay scale (TE., pp. 41, 48).

Petitioner has difficulty with repetitive overhead activities, pulling and lifting at work (TE., p. 42-43). He is more careful since the injuries (TE., p. 43). Petitioner has some stiffness, soreness, a loss of range of motion, and is affected by weather changes (TE., p. 42). After

working a full day, he rates his pain as a 5-6 on a pain scale of 10 (TE., p. 43). At rest, petitioner rates his pain as a 3-4 on a pain scale of 10 (TE., pp. 43-44). He does not play pool or shoot darts anymore since the injuries, which were hobbies he enjoyed prior to these accidents (TE., p. 44). However, he continues to work through the pain, occasionally taking Aleve as well as Cyclobenzaprine, Meloxicam, and Imitrex, which were all prescribed by his primary care doctor (TE., pp. 44-45). Petitioner did use ice packs and heating pads for the neck and shoulders at times when in pain and would also use massage oils and /or get massages (TE., p. 45). The petitioner did do home exercises and stretches as he was taught in physical therapy (TE., pp. 45-46).

Petitioner's testimony was clear and unequivocal and corroborated by the medical records entered as exhibits. Respondent did not present any convincing evidence or witnesses to the contrary. The AMA rating of Dr. Neal, as discussed above, agreed with all other medical records that evidenced petitioner's residual pain and limitations. Petitioner's complaints, supported by the medical records, evidences a disability as indicated by Commission decisions regarded as precedents pursuant to Section 19(e) of the Act. The arbitrator places great weight on the foregoing factor when making the permanency determination.

Therefore, based on these factors listed above, the record as a whole, the credible testimony of petitioner, the medical records that corroborate his testimony, and by disability findings as indicated by Commission decisions regarded as precedents pursuant to Section 19(e) of the Act, the arbitrator finds that Petitioner sustained permanent partial disability to the extent of 0% loss of use of the person a whole pursuant to section 8(d)2 of the Act for the 16 WC 20437 case and 40% loss of use of the person as a whole pursuant to section 8(d)2 of the Act for the 16 WC 20438 case.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY BRUEGGEMANN,

Petitioner,

vs. NO: 17 WC 4842

MUELLER WATER PRODUCTS, INC.,

20IWCC0654

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, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on November 1, 2016. The Commission also finds that Petitioner's condition is causally related to said accident. The Commission awards Petitioner all reasonable and necessary medical expenses, as well as TTD benefits from February 1, 2017 to February 14, 2017 and March 13, 2017 through June 4, 2017, representing 14 weeks. As to PPD benefits, the Commission awards 15% loss of use of the right hand.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. The Petitioner, Gary Brueggemann, has been employed by the Respondent as an Angle Meter 1 Cell since 2003. He machined and assembled ¾ inch and 1 inch valves by hand. This required him to machine the bodies and keys, and assemble all the parts, test them, put the finishing goods on the parts, and then box them out. T.14. He would have to twist

the valves together, drill a hole, and tap them with a hammer. He would also rotate it twice to make sure the valve was lubricated. He would make about 130 valves per day. T.16.

2. Petitioner testified that the larger the valve, the more pressure that was required to open and close the valve because of the key size. T.17. The assembled valve weighed about 2.875 pounds. T.18. Between 2003 and 2011, he worked on heavier valves and would only work on a certain part of the process. They would rotate the process daily during that period. T.20.

3. Ms. Jennifer Horath testified on behalf of the Respondent. She is the lead production supervisor. She stated that 130 valves per day would be a high average. T.43.

4. Petitioner is right-handed. He began to notice issues in his right arm in 2015 that have progressively worsened. He stated that his pain got better when he was off work for 11 days around Christmas but it returned while working. T.21. He would experience shooting pain when he hammered the pin. *Id.*

5. Petitioner presented Dr. Petersen of HSHS Medical Group on November 1, 2016 for right wrist pain. The injury date was listed as October 26, 2016. Petitioner reported a 6-month history of right wrist pain. He recalled that his right wrist was hurting in December 2015 but he was going to be off work for 2 weeks and thought it would get better. It did get a little better but has felt worse within the last 6 months. His wrist pain was located in the right and left deQuervain's area. He reported that his issues began on December 1, 2015. It was now constant and made worse by repetitive use. Examination was positive for tingling and negative for numbness, clumsiness and weakness. The diagnosis was synovitis and tenosynovitis of the left and right hand, and ankylosis. The medical causation was listed as related to work activities. He was given work restrictions to avoid forceful griping and repetitive flexion and extension of the wrists. He was to wear a wrist brace while working and sleeping. Therapy was recommended. PX.1.

6. Petitioner presented to HSHS on November 29, 2016. He was unable to move his right wrist backwards without pain and was experiencing tingling in his fingers at rest. He could lift only if he kept his wrist straight. He had some left wrist pain only because he was using it more to compensate the right. He underwent 12 physical therapy visits and did not have a lot of pain but his range of motion was diminished. Examination revealed a positive Finklestein's test. He had limited range of motion to 10 degrees of extension, 30 degrees of flexion, 10 degrees of inversion and 5 degrees of eversion. The diagnosis was synovitis and tenosynovitis of the left and right hand, and ankylosis. The medical causation was listed as related to his work activities. He was given restricted work duties of no forceful gripping, no lifting more than 5 pounds, and to avoid supination/pronation activity with the right wrist. PX.1.

7. Petitioner was last seen at HSHS on January 3, 2017. He had completed 22 therapy visits. He continued to have pain when he twisted or flexed his wrist. It was now noted that the cause of his problem appeared to be, in part, related to his work activities. PX.1.

8. Petitioner was seen by Dr. Jeffrey Smith on January 17, 2017 for his right wrist issues that have been present for the past year and have progressively worsened. He could not recall any specific aggravation but has had multiple aggravations. Examination revealed swelling to the right wrist and limited range of motion with wrist flexion to about 20 degrees and wrist extension to about 30 degrees. He had maximum tenderness over the dorsal aspect of the scapholunate interval. He had a positive shift test. The MRI revealed a scapholunate ligament tear, TFC tear and Stage II SLAC wrist findings. The impression was right wrist scapholunate insufficiency with Stage II SLAC wrist findings. Dr. Smith recommended a right wrist proximal row carpectomy with a PIN ligation and radial styloidectomy. PX.1.

9. Respondent obtained a musculoskeletal investigation report from Richard Wyatt on January 25, 2017. The report indicated that the time Petitioner spent performing his tasks were varied, cycle times were expanded, forces were below the referenced levels and no extreme deviated postures were observed. There was no increase likelihood of developing bilateral carpal tunnel from the job. The nature, duration and frequency of his job would not qualify as repetitive or traumatic. The weight was less than 2 pounds and the cycle time was 4.32 minutes and there were breaks. His job did not meet the level for NIOSH standards for repetition. There was no force/repetition, or posture present in the job. The work processes as analyzed were well within the ergonomic levels and did not present risk factors at a level to result in a cumulative trauma or repetitive motion injury to the hands, wrists, or fingers. RX.2.

10. Petitioner underwent a right proximal row carpectomy on March 13, 2017.

11. Respondent obtained a records review from Dr. David Brown of the Orthopaedic Center of St. Louis on February 26, 2018. Per the report, Petitioner underwent right proximal row carpectomy, partial radial styloidectomy and PIN nerve ligation at the wrist for the SLAC wrist. He was released and returned to work on June 5, 2017. He diagnosed Petitioner with a SLAC wrist (scapholunate advanced collapse wrist). Dr. Brown noted this was a common pattern of wrist arthritis and was often due to untreated scapholunate ligament tear. He noted that the MRI finding was consistent with a torn scapholunate ligament tear. He stated that if the musculoskeletal investigation report was accurate, and, if in fact Petitioner had a SLAC wrist secondary to a scapholunate ligament tear, then it does not appear to be causally related. RX.2.

12. Dr. Brown authored an addendum on May 31, 2018. Based upon his review of the imaging, the MRI of the right wrist was consistent with SLAC wrist. The review of the imagining did not change his opinion from the prior report. RX.2.

13. Petitioner testified that his workers' compensation benefits were stopped once surgery was recommended. T.24. He paid $2,966 in out-of-pocket expenses. T.25. All his bills have been paid. *Id.* He was off work for 12 weeks and released back to the same job. Now he uses a longer handled wrench to turn the body. This is similar to a ratchet and socket and requires much less force. T.26. He also uses his left hand more to hammer and drive the pins and key into the cap. T.27. He can move his right hand 20 to 25 degrees and does not have as much grip strength. T.29. He denied any prior injuries.

14. On cross-examination, he first saw Dr. Smith on January 17, 2017 and denied a specific injury to the right wrist. T.31. He described his work to Dr. Smith and believes he told him how he was postured while working. T.32. He never told him how many valves he inspected and machined per day. T.33. He disagreed with Dr. Wyatt's report as the report only referenced 60 parts per shift whereas he assembled 130 per shift. T.34.

15. Dr. Jeffrey Smith is board-certified in orthopedic surgery with an added certification for hand problems. He was deposed April 11, 2019. He saw the Petitioner on January 17, 2017 for right wrist pain. Petitioner was a machinist and his wrist had been bothering him for a year or two. PX.2. pg.8. He does not recall if the Petitioner described his specific duties. He had a lot of swelling over the right wrist and his range of motion was limited with wrist flexion to 20 degrees and extension to 30 degrees. He had tenderness over the dorsal aspect of the scapholunate interval and a very positive scaphoid shift maneuver. PX.2. pg.9. All the testing indicated Petitioner had a scapholunate ligament disruption and he was developing arthritis in the wrist as well as some triangular fibrocartilage wear. PX.2. pg.10. He recommended surgery as conservative treatment would not reverse the arthritis. *Id.* He performed a proximal row carpectomy, a radial styloidectomy and a posterior interosseous nerve ligation on March 13, 2017. PX.2. pg.11. Petitioner continued to follow-up post-surgery and was returned to work on June 1, 2017 and discharged from care on November 9, 2017. PX.2. pg.13. Dr. Smith noted that Petitioner was back to work and performing a lot of other activities around his house. He was doing well and his extension was to 40 degrees and supination and pronation was to 80 degrees. Everything was in good position. PX.2. pg.14. Dr. Smith saw the Petitioner on December 2018 for right hand numbness and loss of strength. PX.2 pg.14.

16. Dr. Smith noted that Petitioner's condition can be caused by a host of different things including repetitive motion and an acute injury. PX.2. pg.15. He stated that over time as the ligament stretches and does not function with motion, the wrist moves in an out of its balanced situation. This causes an increased wear to the joint between the scaphoid and the radius and leads to premature wear to the point of painful arthritic condition. PX.2. pg.16. He stated that repetitive motion, when the wrist is loaded of a flexion-extension nature, can contribute to the condition. *Id.* The person can develop a bone-on-bone situation after time, as Petitioner has, and require surgical treatment.

17. On cross-examination, Dr. Smith noted that Petitioner did not tell him what type of machinist he was and he does not have a recollection of what Petitioner did. PX.2. pg.18. Petitioner did not report the actual job duties he was performing when he developed right wrist pain. PX.2. pg. 19. He assumed Petitioner performed a lot of repetitive grasping and gripping to work the machines. PX.2. pg.20. He had no idea of the postures of the Petitioner. *Id.* He did not know the speed which Petitioner worked or how many valves he inspected.

18. During surgery, Dr. Smith found Petitioner had significant osteoarthritis and slack wrist arthritis, Stage 3. PX.2. pg.22. Osteoarthritis is the most common joint disorder in the US. Slack arthritis takes about 5 to 8 years to develop. PX.2. pg.24. He stated that an ergonomic assessment could be helpful to provide an opinion as to the cause of the right wrist condition. *Id.* He stated that all activities of the wrist were cumulative and could lead to arthritic changes. PX.2. pg.25. Petitioner used his hands 40 hours a week at work. PX.2. pg.27.

19. Dr. Wyatt is board-certified in CPE ergonomics and was deposed July 29, 2019. He performed an ergonomic assessment of a valve assembler or angle meter coordinator in January 2017. RX.3. pg.13. He observed the posture of the employee performing the job and asked about the workspace. He measured a lot of the forces with a force gauge. They also tried to get the actual production rates to determine the repetitiveness of the job. RX.3. pg.14. He had production data from November 2016. RX.3. pg.15. The production sheet revealed that an employee built about 14 valves per hour. He determined that this was not repetitive as the NIOSH standard for repetitive is a cycle time of less than 30 seconds and using the same motion. RX.3. pg.15. In this case, a person was using a lot of different motions in a 4-minute cycle. This was a lot slower than a faster pace position. RX.3. pg.16. He stated that the valve bodies weighed one pound. *Id.* He stated that the only forceful portion of the job was using wrenches; however, when measured the force was not really high because of the valve size. The wrench pull force was less than 3 pounds. RX.3. pg.18. There was no high force found in the job. He stated a high force would be 30 to 40 pounds with a bad posture. *Id.* He stated that there were really good ergonomic futures in the work cells. The valves were located in a tipper which eliminated a lot of the awkward posture and bending over to obtain the parts. RX.3. pg.21. There was also no exposure to vibration. RX.3. pg.22. He did not find any evidence that would lead to a hand or wrist disorder. RX.3. pg.23. He stated that the job was just not repetitive. *Id.* There was no evidence this job would lead to a musculoskeletal disorder. *Id.* The completed box of parts weighed 36 pounds but this was only moved a few times per shift and was a horizontal move. RX.3. pg.24.

20. On cross-examination, he did not know Petitioner started his job in 2003. RX.3. pg.29. He was not aware that during the first 10 years there were three people in this team and they would kick out 450 units per day. RX.3. pg.29. He was not aware that they later went down to 2 people and 300 units per day. He did not observe the Petitioner. He did not know that

some of the valves did not fit together properly. RX.3. pg.30. He did not know that the amount of force varied depending on whether the valves fit together properly or whether they had to be redone. RX.3. pg.31. He was not aware that the company doctor stated this issue was work related. RX.3. pg.32 He did not know that the Petitioner had surgery. RX.3. pg.33. He did not know that the surgeon stated that the work duties could have caused his condition. RX.3. pg.34.

21. On re-direct, even assembling the 450 valves with three people would be considered below the cycle time. RX.3. pg.38.

22. Dr. Brown is a board-certified orthopedic surgeon with a specialist in hand surgery. RX.3. pg.6. He performed a records review and was deposed on August 23, 2019. He stated that Petitioner complained of a gradual onset of right wrist pain with no specific injury. RX.3. pg.9. He diagnosed Petitioner with right SLAC wrist which was due to untreated scapholunate ligament tear or to degenerative arthritis. The MRI was consistent with a torn scapholunate ligament tear. It was likely due to an untreated scapholunate ligament tear. RX.3. pg.10. The injury certainly pre-dated the injury date. There was evidence of advanced arthritis that was present for some time. *Id.* Based upon the musculoskeletal investigation report, there was no evidence the work would cause, accelerate or aggravate a scaphoid ligament injury or SLAC wrist. RX.3. pg.11. The fact that the left wrist was unaffected was significant as it demonstrated that the right wrist was due to untreated scapholunate tear occurring in the past. RX.3. pg.13.

23. On cross-examination, he only performed a records review and no examination. RX.3. pg.15. The surgery was appropriate. *Id.*

The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n,* 291 Ill. App. 3d 734, 740 (4th Dist. 1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972). The Commission reverses the Arbitrator's Decision in its entirety and finds the evidence establishes that Petitioner sustained injury to his right wrist due to his repetitive work duties.

In *Edward Hines Precision Components v. Indus. Comm'n*, 356 Ill. App. 3d 186 (2005), the Appellate Court explained the origin of the term repetitive trauma. "The phrase 'repetitive trauma' was developed in order to establish a date of accidental injury for purposes of determining when limitations statutes, and notice requirements, begin to run." *Edward Hines Precision Components* at 194. The Court further stated that the term is a characterization of an injury which develops over time as opposed to those arising from a single identifiable event. The Court added, "There is no requirement that a certain percentage of time be spent on a task in order for the duties

to meet a legal definition of 'repetitive.' The issue at hand is causation. The question before the Commission was whether the job activity was repeated sufficiently to cause the injury." *Id.*

The Commission notes that there is conflicting evidence as to the frequency of Petitioner's job duties. Petitioner testified that he assembled about 130 valves per day while Ms. Horath testified that the 130-figure was on the higher end. Dr. Wyatt based his opinion on an even lower production rate.

The Commission, however, is not persuaded by Dr. Wyatt's opinion. Dr. Wyatt was not aware of the production rates during the first 10 years of Petitioner's employment. Further, Dr. Wyatt was unaware of the fact that the valves would not always fit together properly. He also did not know that the force required to work on the valves varied depending on whether the valves fit together properly or not.

The evidence supports that Petitioner's job duties required him to use his hands consistently on a daily basis and that his duties were forceful in nature. The Commission finds that Petitioner's job duties were repeated sufficiently enough to cause his injury.

In *Sisbro, Inc. v. Indus. Comm'n (Rodriguez)*, 207 Ill. 2d 193, the court held that, it has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982).

The court further explained that, it is axiomatic that employers take their employees as they find them. *Baggett*, 201 Ill. 2d at 199. "When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment." *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36. Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967).

The evidence supports that Petitioner's pre-existing condition was aggravated by his job duties. He testified that his condition improved while he was off work for 11 days and then progressively worsened upon his returned to work. Respondent's company physician indicated that the work activities were a cause in his condition. Dr. Smith, who performed the surgery, also testified that the work activities were a cause in his condition. Dr. Smith explained that repetitive

motion, when the wrist is loaded in a flexion-extension nature, can contribute to Petitioner's condition. The Commission finds the opinion of Dr. Smith more persuasive than Dr. Brown's opinion. Dr. Brown performed a record review only and his opinion was premised, in part, upon the accuracy of the musculoskeletal investigation report prepared by Dr. Wyatt. As stated above, the Commission finds Dr. Wyatt's opinions were based upon an incomplete understanding of Petitioner's work history.

Based upon the evidence as a whole, the Commission finds that Petitioner established accident and causal connection. Petitioner is therefore entitled to TTD benefits from February 1, 2017 to February 14, 2017 and March 13, 2017 through June 4, 2017, representing 14 weeks of disability. Petitioner is also entitled to all reasonable and necessary medical expenses.

As Petitioner's accident occurred after September 1, 2011, §8.1b applies. Section 8.1b(b) requires permanent partial disability be determined following consideration of five factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. *820 ILCS 305/8.1b(b).*

(i) Impairment Rating: The Commission gives no weight to this factor as an impairment rating was not offered into evidence.

(ii) Occupation of Injured Employee: The Commission gives some weight to this factor as Petitioner returned to work and was able to perform his usual job duties with some modification.

(iii) Petitioner's Age: The Commission gives some weight to this factor. The Petitioner is an older worker with fewer work years left to experience the effects of the injury.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to a reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Commission assigns greater weight to this factor. Petitioner underwent surgery as the result of his work-related injury. He testified that he can move his right hand 20 to 25 degrees and does not have as much grip strength. Dr. Smith noted that Petitioner had extension to 40 degrees and supination and pronation to 80 degrees. Dr. Smith noted he examined the Petitioner in December 2018 for right hand numbness and loss of strength.

Considering the foregoing factors, with no single enumerated factor being the sole determinant of disability, the Commission awards 15% loss of use of the right hand.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 26, 2019 is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $606.66 per week for a period of 14 weeks, from February 1, 2017 through February 14, 2017 and March 13, 2017 through June 4, 2017, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

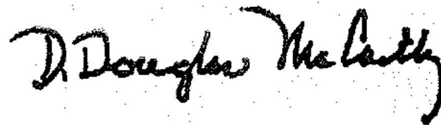
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $546.00 per week for a period of 30.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 15% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses totaling $2,699.82, pursuant to Sections 8(a) & 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 $23,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.



DATED: NOV 1 2 2020

D. Douglas McCarthy

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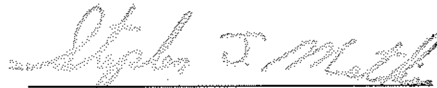


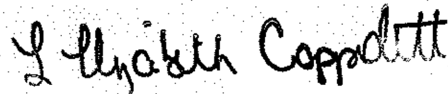
Stephen Mathis

DISSENT

Save the Arbitrator's inadvertent misstatement of the standard of proof relative to repetitive trauma, I would affirm and adopt the decision of the Arbitrator. Certainly, there is no legal requirement that Petitioner present evidence as to the percentages of a day a certain task is

preformed, or the force required. *Edward Hines Precision Components v. Industrial Commission*, 356 Ill. App. 3d 186, 194 (2005). The Commission, though, must consider the evidence, or lack thereof, as to whether Petitioner's job duties are sufficiently repetitive to support a finding of accident. See *Williams v. Industrial Commission*, 244 Ill. App. 3d 204, 614 N.E.2d 177 (1993). Further, as the Court 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."

More importantly, as correctly noted by the Arbitrator, it is imperative the medical experts possess an accurate understanding of Petitioner's job duties. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶ 24 ("An expert opinion is only as valid as the reasons for the opinion." (Internal quotation marks omitted.)). As the Arbitrator, I believe Petitioner failed to present sufficient evidence to support a finding of a compensable accident based upon a repetitive trauma theory of recovery as Petitioner's degenerative right SLAC wrist was not aggravated by his work duties. Therefore, I respectfully dissent.



L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRUEGGEMANN, GARY Case# **17WC004842**
Employee/Petitioner

MUELLER WATER PRODUCTS INC
Employer/Respondent

20IWCC0654

On 11/26/2019, 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 1.58% 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:

1406 WILLOUGHBY ZACHARY & FORBES PC
JAMES E ZACHRY
420 E PRAIRIE ST SUITE 200
DECATUR, IL 62523

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

STATE OF ILLINOIS)
)SS.
COUNTY OF **SANGAMON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GARY BRUEGGEMANN,
Employee/Petitioner

v.

MUELLER WATER PRODUCTS, INC.,
Employer/Respondent

Case # **17** WC **4842**

Consolidated cases: ______

20IWCC0654

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **10/29/19**. 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. [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 **11/1/16**, 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*** 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 $**45,932.50**; the average weekly wage was $**910.00**.

On the date of accident, Petitioner was **63** 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**4.757.10** for other benefits, for a total credit of $**4,757.10**.

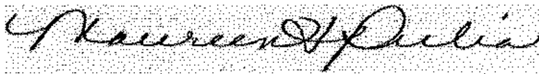
Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The petitioner has failed to prove by preponderance of the credible evidence that petitioner sustained an accidental injury to his right hand/wrist that arose out of and in the course of his employment by respondent on 11/1/16, and that petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his right hand/wrist is causally related to the injury on 11/1/16.

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

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



Signature of Arbitrator

11/21/19
Date

NOV 2 6 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 63 year old angle meter 1, alleges he sustained an accidental injury to his right hand and wrist, due to repetitive work activities, that arose out of and in the course of his employment by respondent, and manifested itself on 11/1/16. Petitioner has worked for respondent in this position or in the position of an angle meter 2 since 2003. Petitioner is right hand dominant.

Petitioner testified that he worked for respondent since 2003 and assembled valves. He testified that he has assembled two different valves over the years. He testified that one was a ¾ inch valve, and the other was a 1 inch valve, which was heavier and larger than a ¾ inch valve. Petitioner would machine and assemble the valves. He would machine the bodies and key, then assemble and test the valves, and box up the finished product. Petitioner testified that to assemble the valve he would do twisting activities with his hands. He testified that the 1 inch valve required more force than the ¾ inch valve. He also stated that the valves did not always go together properly and had to be tested before they were shipped. He stated that some of the valves failed the test. When this happened he would have to take the valves apart, reassemble them and then retest them. The petitioner stated that this increased the amount of activity involved on those valves. Petitioner stated that the pain in his right wrist developed over a period of several months.

Petitioner testified that from 2003 to 2011 there were three employees working the area, and they machined all the different parts. From 2011 to about 2013 there were two employees making 150-200 valves per day. Since then petitioner has worked by himself and he makes 130 valves a day. The parts weigh from about 1-3 pounds. Petitioner testified that from 2003 to date, his job has remained essentially the same.

On 11/1/16 petitioner presented to Dr. Jon Petersen at HSHS Occupational Health. He reported that for at least 6 months he had been having pain in his right wrist. He recalled that in December of 2015 his right wrist was hurting, but since he was going to be off for 2 weeks, he thought it would get better. He stated that it did get a little better, but within the last 6 months it felt worse. He was unable to move his right wrist backwards without pain, and at rest he has tingling in his fingers. He reported that he was able to lift it, but only if he kept his wrist straight. He stated that his left wrist has some, but only because he was using it more because he was favoring his right wrist. He rated his pain at rest at 1/10, and much more with activity. He reported that he had 12 physical therapy visits, and does not have a lot of pain, but his range of motion was diminished. Petitioner reported his pain as moderate aching. Dr. Petersen was of the opinion that the cause of his problem was work related activities. Dr. Petersen noted that petitioner's primary problem was his right wrist pain located in the right and left deQuervain's area. Following an examination Dr. Petersen's diagnoses were right and left hand synovitis and tenosynovitis, and ankylosis. He placed petitioner on light duty restrictions that included no forceful gripping or repetitive flexion, and no extension of the wrists. He was told to wear his braces while at work and sleeping. Petitioner was prescribed a course of physical therapy.

On 11/29/16 petitioner returned to Dr. Petersen. Dr. Petersen was of the opinion that the cause of his problem was work related activities. He recommended light duty that consisted of no forceful gripping, no lifting more than 5 pounds, and avoiding supination/pronation with the right wrist. Petitioner was continued in physical therapy.

On 12/20/16 petitioner returned to Dr. Petersen for his right wrist pain. He noted that he had slow progress with respect to range of motion and decreased pain. He noted slight improvement with therapy. Petitioner complained of moderate pain with right wrist extension, flexion, and forceful gripping. He also reported some "tingling" in his fingertips not consistent with specific median or ulnar distribution. Dr. Peterson continued petitioner in restricted duty, and in physical therapy.

On 1/3/17 petitioner reported to Dr. Petersen that he had some improvement in his strength and range of motion. He also reported that he was tolerating his work restrictions. Dr. Petersen examined petitioner and continued him on restricted duty. He noted that petitioner's restrictions were temporary. He told petitioner to wear his wrist brace, and refrain from lifting more than 5 pounds with the right hand. He also restricted petitioner from forceful gripping of the right hand. Petitioner was continued in physical therapy.

On 1/17/17 petitioner was evaluated by Dr. Jeffrey Smith. Petitioner reported that he was a machinist for respondent. He reported problems with his right wrist for the past year, that had progressively worsened. He could not recall any specific injury to the right wrist, but recalled many aggravations. An examination revealed swelling of the right wrist; limited range of motion with wrist flexion to about 20 degrees; and, wrist extension to about 30 degrees. He had normal finger motion, and maximum tenderness over the dorsal aspect of the scapholunate interval. A scaphoid shift test was positive. An MRI of the right wrist showed a scapholunate ligament tear, TFC tear, and Stage II SLAC wrist. Dr. Smith's impression was right wrist scapholunate insufficiency with State II SLAC wrist findings. Dr. Smith recommended a right wrist proximal row carpectomy with a PIN litigation and radial styloidectomy. He recommended an injection into the right wrist while waiting for surgical authorization to see if this helps alleviate his symptoms.

On 1/25/17 the Musculoskeletal Investigative Report of Richard Wyatt, Board Certified Professional Ergonomist and Senior Consultant, Aon Global Risk Consulting, Ergonomics Consulting, was issued regarding petitioner, and his hand/wrist injury on 1/5/17. The report summarized the results. It noted that petitioner's time spent performing his tasks as a Valve Assembler is varied, cycle times are expanded, and forces are below the reference levels. No extreme deviated postures were observed. It was found that there was no increased likelihood of developing bilateral carpal tunnel syndrome from the job performed by petitioner. It was determined that the nature, duration, and frequency of the job required would not qualify it as being repetitive or traumatic. It was determined that petitioner and his fellow employees have the ability to rotate to various positions in the cell, the finished part weight is less than 2 pounds, cycle times were an average of 4.32 minutes

long, and employees designated break schedules are self paced and employees can take micro breaks as needed. The findings were that petitioner's job duties do not produce evidence that the ergonomic risk factors would result in bilateral carpal tunnel syndrome. The nature, duration, and frequency of the job required were found to not qualify as being repetitive or traumatic. It was determined that with petitioner's job as a valve assembler, repetition does not meet or exceed the NIOSH reference levels, force is well below the defined ergonomic reference levels, and no extreme postures were identified. It was noted that the two factor interactions of force/repetition, force/posture, and posture/repetition, did not exist in petitioner's job. Therefore, it was found that a single or combination of ergonomic risk factors were not present and the petitioner did not appear to be at a higher risk of a work-related musculoskeletal injury, specifically carpal tunnel syndrome, than the general public. In summary it was determined that the petitioner's work processes, as analyzed at the time of the evaluation, were well within the ergonomic reference levels and do not present risk factors at a level to result in cumulative trauma of repetitive motion injury to the hands/wrists/fingers.

On 3/13/17 petitioner underwent a proximal row carpectomy. Petitioner followed-up post-operatively with Dr. Smith, on 3/28/17, 5/2/17, and 6/1/17. On 6/1/17 petitioner was not complaining of any pain, and seemed to be doing good. Dr. Smith was of the opinion that petitioner had good alignment of the wrist; had pretty good range of motion; had wrist range of flexion and extension of 40 and 50 degrees; had grip strength of 50 pounds in therapy on the right and 100 on the left; and had good pinch in both hand. Dr. Smith released petitioner on an as needed basis, and returned him to full duty work.

On 11/9/17 petitioner returned to Dr. Smith. He reported that he was back to work and doing a lot of other activities around the house. Dr. Smith noted that petitioner stated that he was doing some remodeling. Petitioner had minimal pain. He extension and flexion were to about 40 degrees. His supination and pronation were to 80 degrees each. X-rays showed everything was in good position.

On 2/26/18 Dr. David Brown performed a record review on behalf of respondent. Dr. Brown performed a review of petitioner's records that included a plant job description for the job title "Work Center Coordinator – Angle Meter", a musculoskeletal investigation report dated 1/25/17; records from HSHS Medical Group Occupational Health & Wellness from 11/1/16-1/3/17; report of MRI of the right wrist dated 12/6/16; Dr. Smith records from 1/17/17-6/1/17, an operative report for surgery on the right wrist dated 3/13/17, and therapy records from 11/4/17-12/30/16.

Based on his review Dr. Brown diagnosed a SLAC wrist. He was of the opinion it is a common pattern of wrist arthritis, often due to an untreated scapholunate ligament tear. Dr. Brown noted that petitioner was initially diagnosed with synovitis tenosynovitis, but once he was seen by Dr. Smith there were no further left wrist complaints. Dr. Brown opined, based on the musculoskeletal investigation report and petitioner's

diagnosis of a SLAC wrist secondary to a scapholunate ligament tear, that petitioner's SLAC wrist would not be causally related to his work activities for respondent.

On 5/31/18 Dr. Brown drafted an addendum report after reviewing a CT calcium coronary scan dated 7/7/10, x-rays of the left foot dated 1/10/10, and an MRI of the right wrist dated 12/6/16. He noted that the MRI of the right wrist revealed severe degenerative changes in the wrist at the radiocarpal joint. He also noted that there was a DISI deformity, findings consistent with a SLAC wrist, and some signal changes within the TFCC. He opined that the MRI of the right wrist was consistent with the diagnosis of a SLAC wrist. He noted that his review of these studies did not change any of his prior opinions.

In December of 2018 petitioner returned to Dr. Smith due to some concerns about his right hand numbness and loss of strength. Dr. Smith did not think petitioner had any neurologic damage. His impression was that petitioner was doing okay. His range of motion was 80 degrees of supination and pronation, wrist flexion of 30 degrees, and wrist extension of 30 degrees. Dr. Smith noted some tendinitis in his thumb that was causing petitioner some difficulty with gripping.

On 4/11/19 the evidence deposition of Dr. Jeffrey Smith, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Smith testified that he did not recall petitioner giving him any details about his job duties. Petitioner testified that he did not report the particulars of his job to Dr. Smith, including the number of valves he was inspecting and machining every day. Dr. Smith attributed petitioner's current condition of ill-being to either repetitive trauma or acute injury. He opined that repetitive motion, when the wrist is loaded of a flexion-extension nature, contributed to his condition of ill-being. Dr. Smith was of the opinion that after enough wear and tear occurs, like in petitioner's case, there is bone on bone, and surgery like the one he performed is required. Dr. Smith was of the opinion that as a result of the surgery petitioner only regained 30-40 degrees of motion, and 30-40 degrees of wrist flexion and extension, which is less than the 50 degrees and 70 degree, respectively, that are normal. Dr. Smith noted that petitioner's grip strength was diminished by 20-25%.

On cross-examination Dr. Smith noted that petitioner reported no left hand symptoms. He also noted that petitioner did not report a specific injury. Dr. Smith did not know what type of machinist petitioner was in 2016. Dr. Smith testified that petitioner did not report to him the actual job duties he was performing when his right wrist pain began. He also did not have any understanding as to the history of jobs petitioner had while working for respondent. Dr. Smith testified that petitioner did work where he would flex his wrists, pick up weights, and move things around. He stated that he is not familiar with all the activities of a machinist, but imagined that there was a fair amount of repetitive grasping and gripping to work and adjust machines. He did not know what type of postures were required by petitioner to do his machinist job duties. He also did not know the speed that petitioner was expected to work at, or how many valves he was inspecting or creating each day. Dr. Smith noted that when he performed surgery on petitioner's right hand he found significant osteoarthritis

and SLAC wrist arthritis Stage 3. He noted that less than 5% of patients with osteoarthritis in the wrists have SLAC wrists. He was of the opinion that the typical mechanism of injury for someone with a SLAC wrist is usually unknown, but something somewhere along the line injures the ligament. He noted that the arthritis of SLAC wrist is a malalignment situation, and the wear is accelerated, and arthritis develops prematurely. To get a SLAC wrist Dr. Smith was of the opinion that petitioner had to have osteoarthritis for 5-8 years. He was of the opinion that since petitioner is a machinist he must use his hands so his condition is related to his work. But also noted that there are activities outside of work that contributed to petitioner's right wrist condition.

On 7/29/19 the evidence deposition of Dr. Richard Wyatt, PhD, was taken on behalf of respondent. Dr. Wyatt has a BS in Industrial Engineering, a Master's Degree in Engineering Management, a PhD in Industrial Systems Engineering, a PE license in Industrial Engineering, a CPE designation in ergonomics, and a CQE designation which shows proficiency in quality engineering. Dr. Wyatt is board certified in ergonomics. He stated that he has been doing this work since 1988. Wyatt went through the job of valve assembler or angle meter coordinator, which was petitioner's job, and reviewed petitioner's actual production numbers. It showed he built 13-14 valves per hour, and determined it was not repetitive and the required force was not great. He stated that the only forceful part of the job was using wrenches, and the wrench pull force was not high, and was less than 3 pounds. He was of the opinion that a high force would be 30-40 pounds in a bad posture. Dr. Wyatt testified that he looked at all of petitioner's job duties. He testified that he found that the valve bodies that are fed to the work area are on a tipper, and this eliminates a lot of awkward posture and bending over when obtaining the parts. Dr. Wyatt was of the opinion that petitioner had no vibration in his job.

Dr. Wyatt was of the opinion that petitioner's job involved both automated machinery and hand-assembling. He noted that petitioner will put the part into an automated C&C, and the C&C will run the part. Once the SOB assemblies are finished, then petitioner puts the valve together. Dr. Wyatt evaluated the wrist posture involved with assembling the valve, and wrist posture using the wrench to tighten the valve up.

Dr. Wyatt opined that petitioner's job included no combination of factors that would lead to a hand/wrist type of disorder. He noted that petitioner's cycle job took 4 minutes, and for there to be a possible hand/wrist type of disorder the cycle job would take 30 seconds. He further opined that there was no evidence or job duties that he evaluated, that were found to potentially cause any work-relatedness of musculoskeletal disorders. He opined that petitioner did not have any single risk factor, much less a combination for these type of hand injuries. He found the maximum number of valves created per day for one person was 137 a day. Dr. Wyatt opined that if 3 people did 450 units a day, and 2 people did 300 valves a day, that cycle would be at least 3 ½ minutes. Dr. Wyatt noted that this is consistent with petitioner's daily valve creation numbers of 80 to 142 per day.

On cross-examination Dr. Wyatt testified that he was not a medical doctor, or DO. He also testified that he did know that petitioner started his job with respondent in 2003, and for the first ten years there were three people on the team, and they kicked out 450 units a day. He also testified that he was unaware that for the next 5 years there were two people on the team and they kicked out 300 units a day. Dr. Wyatt did not observe petitioner working. He testified that he was at the site for about 2 hours. He testified that he did not know that all the valves don't automatically get put together right, and some of them had to be taken apart and redone, and the force would vary depending on the valve. Dr. Wyatt did his evaluation on 1/18/17.

On 8/23/19 the evidence deposition of Dr. David Brown, a hand surgeon, was taken on behalf of respondent. Dr. Brown was of the opinion that petitioner was claiming a 6 month history of a gradual onset of right wrist pain prior to his accident date of 11/1/16. Dr. Brown opined that petitioner's right SLAC wrist is due either to an unrelated scapholunate ligament tear or to degenerative arthritis. He opined that petitioner's right wrist condition predated 11/1/16, and was present for some time based on the diagnostic tests. Based on the detailed musculoskeletal investigation report, Dr. Brown opined that there is no evidence that the work described in that report would cause, accelerate, or aggravate a scaphoid ligament injury or SLAC injury. He opined that repetitive activity does not cause, aggravate or contribute to a SLAC injury. He opined that a SLAC wrist is due to a torn ligament that if not repaired, has a natural history of no matter what you do, be it office work, not use your hands, or do repetitive work or not. He opined that a SLAC injury is the natural history over time of a torn ligament that is not repaired. He opined that the fact that petitioner's left wrist was fine and his right wrist had severe arthritis is consistent with the right SLAC wrist being due to an untreated scapholunate tear that occurred sometime in the past and was untreated. He further opined that since petitioner's job duties involved both hands and wrists, the fact that his injury is to just one wrist suggests that a specific event occurred in that wrist, which is consistent with the MRI findings, and that it is less likely due to degenerative arthritis because the left wrist was normal.

On cross examination, Dr. Brown was of the opinion that if musculoskeletal investigation is not an accurate depiction of petitioner's job duties, that could possibly change his opinions.

Petitioner testified that currently he has to modify the way that he performs his job. He stated that he uses his left hand more. He stated that he can only move his right wrist 20-25 degrees, and has lost approximately 40% of his grip strength in his right hand. He reported difficulty picking stuff up with his right fingers.

Jennifer Horath, lead production supervisor for respondent, was called as a witness on behalf of respondent. Horath has only worked for respondent for 4 years. She stated that she was familiar with petitioner and his job duties as an Angle Meter 1. She was of the opinion that the average valve count for this position was 135, and 90 for an Angle Meter 2.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?
F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims he sustained an accidental injury to his right hand/wrist that arose out of and in the course of his employment by respondent on 11/1/16, and that his current condition of ill-being as it relates to his right hand/wrist is causally related to the injury on 11/1/16. The respondent disputes these claims.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case ... where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming injuries to his right hand/wrist, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

In the case at bar, petitioner is claiming a manifestation date of 11/1/16. The arbitrator finds this was the date petitioner was first informed by a physician that the condition he was claiming was work related. On this date petitioner presented to Dr. Petersen. He reported that for at least 6 months he had been having pain in his right wrist. He recalled that in December of 2015 his right wrist was hurting, but since he was going to be off for 2 weeks, he thought it would get better. He stated that it did get a little better, but within the last 6 months it felt worse. He was unable to move his right wrist backwards without pain, and at rest he has tingling in his fingers. He reported that he was able to lift it, but only if he kept his wrist straight. He stated that his left wrist

has some pain, but only because he was using it more because he was favoring his right wrist. He rated his pain at rest at 1/10, and much more with activity. Dr. Petersen was of the opinion at that time that the cause of petitioner's problem was his work related activities.

In Peoria County Belwood Nursing Home the Supreme Court held that it is imperative that the claimant place into evidence specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc. In the case at bar the petitioner did provide some evidence regarding the frequency, duration and manner in which he performed his duties.

However, it is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities. Petitioner was seen and treated by Dr. Petersen and Dr. Smith. Based on the credible evidence the arbitrator finds Dr. Petersen did not have a detailed and accurate understanding of the petitioner's work activities. With respect to Dr. Smith, the arbitrator finds that Dr. Smith testified that he did not recall petitioner giving him any details about his job duties, and he did not know what type of machinist petitioner was in 2016. Dr. Smith testified that petitioner did not report to him the actual job duties he was performing when his right wrist pain began. He also did not have any understanding as to the history of jobs petitioner had while working for respondent. Dr. Smith testified that petitioner did work where he would flex his wrists, pick up weights, and move things around, but was not familiar with all the activities of a machinist. Dr. Smith only "imagined" that there was a fair amount of repetitive grasping and gripping to work and adjust machines. He did not know what type of postures were required by petitioner to do his machinist job duties. He also did not know the speed that petitioner was expected to work at, or how many valves he was inspecting or creating each day.

Respondent had an ergonomics evaluation performed by Dr. Wyatt. Dr. Wyatt went and observed the job of an Angle Meter I on 1/18/17. Dr. Wyatt in his report provided specific details regarding petitioner's work activities, including the frequency, duration, manner of performing, etc. Dr. Brown based his opinions in part of Dr. Wyatt findings as they relate to petitioner's job duties.

Based on the records and opinions of Dr. Petersen, Dr. Smith, Dr. Wyatt and Dr. Brown, the arbitrator finds that the only doctors that had any details and an accurate understanding of the petitioner's work activities were Dr. Wyatt and Dr. Brown. The arbitrator finds no credible evidence to support a finding that Dr. Petersen or Dr. Smith had a detailed and accurate understanding of the petitioner's work activities.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by preponderance of the credible evidence that petitioner sustained an accidental injury to his right hand/wrist that arose out of and in the course of his employment by respondent on 11/1/16.

With respect to causal connection the arbitrator notes that causal connection opinions were offered by both Dr. Petersen and Dr. Brown. The arbitrator finds the opinions of Dr. Smith with respect to a causal

relationship between petitioner's current condition of ill-being as it relates to his right wrist/hand, and his alleged injury on 11/1/16, less persuasive than those of Dr. Brown, given the fact that Dr. Smith admitted that he had no details or an accurate understanding of the petitioner's work activities.

In the alternative, the arbitrator finds Dr. Brown had a detailed and accurate understanding of petitioner's work activities, as well as more information regarding petitioner's right wrist condition. Dr. Brown was of the opinion that petitioner was claiming a 6 month history of a gradual onset of right wrist pain prior to his accident date of 11/1/16. However, Dr. Brown opined that petitioner's right SLAC wrist is due either to an unrelated scapholunate ligament tear or to degenerative arthritis, given that petitioner's right wrist condition predated 11/1/16, and was present for some time based on the MRI performed in December of 2016. Dr. Brown opined that there is no evidence that petitioner's work duties would cause, accelerate, or aggravate a scaphoid ligament injury or SLAC injury. He further opined that repetitive activity does not cause, aggravate or contribute to a SLAC injury. He opined that a SLAC wrist is the natural progression of a scapholunate ligament tear that is not repaired, no matter what you do, be it office work, not use your hands, or do repetitive work or not. He opined that the fact that petitioner's left wrist was fine and his right wrist had severe arthritis, is consistent with the right SLAC wrist being due to an untreated scapholunate tear that occurred sometime in the past and was untreated. He further opined that since petitioner's job duties involved both hands and wrists, the fact that his injury is to just one wrist suggests that a specific event occurred in that wrist, which is consistent with the MRI findings, and that it is less likely due to degenerative arthritis because the left wrist was normal.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Brown more persuasive than those of Dr. Smith, and finds the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his right hand is casually related to his alleged repetitive injury on 11/1/16.

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?

Having found the petitioner failed to prove by preponderance of the credible evidence that petitioner sustained an accidental injury to his right hand/wrist that arose out of and in the course of his employment by respondent on 11/1/16, and that petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his right hand/wrist is causally related to the injury on 11/1/16, the arbitrator finds these remaining issues moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HERBERT TAYLOR,

Petitioner,

vs.

NO: 13 WC 24808

CITY OF CHICAGO,

Respondents.

20IWCC0655

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary disability and credit and being advised of the facts and law, corrects the Corrected Decision to properly reflect the parties' stipulations and otherwise affirms and adopts the Corrected Decision of the Arbitrator, which is attached hereto and made a part hereof.

On the Request for Hearing, the parties stipulated Petitioner was temporarily and totally disabled from June 11, 2014 through June 5, 2018, and Respondent was entitled to a credit of $187,634.73 for associated benefits paid. ArbX1. The Corrected Decision does not accurately mirror the parties' stipulations. Therefore, the Commission corrects the decision to award the stipulated Temporary Total Disability benefits from June 11, 2014 through June 5, 2018, along with Respondent's credit of $187,634.73 for associated benefits paid. The Commission further notes the parties subsequently agreed all temporary total disability benefits were paid in full.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed April 21, 2020, 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 $902.66 per week for a period of 208 weeks, representing June 11, 2014 through June 5, 2018, that being the stipulated period of temporary total incapacity for work under §8(b). Respondent shall have credit of $187,634.73 for payments already made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses of $8,291.82, representing the outstanding balance from Northwest Orthopedics and Petitioner's out-of-pocket prescription expenses as detailed in Petitioner's Exhibit 7, as provided in §8(a) and subject to §8.2 of the Act.

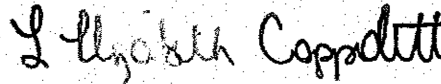
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 50% loss of use of the person as a whole.

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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to file a bond. As such, Respondent is exempt from the bonding requirement. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 1 2 2020



L. Elizabeth Coppoletti

LEC/mck

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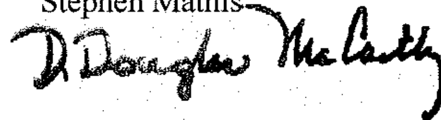
Stephen Mathis



D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

TAYLOR, HERBERT
Employee/Petitioner

Case# **13WC024808**

CITY OF CHICAGO DEPARTMENT OF STREETS AND SANITATION
Employer/Respondent

20IWCC0655

On 4/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0010 CITY OF CHICAGO
DANIEL KALLIO
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20IWCC0655

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
CORRECTED ARBITRATION DECISION

Herbert Taylor
Employee/Petitioner

Case # **13 WC 24808**

v.

Consolidated cases: ______

City of Chicago, Department of Streets and Sanitation
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 **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **9/18/2018 & 12/28/2018**. 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. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ______

FINDINGS

On **2/4/2013**, 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 claimed he earned $**73,716.76**, which included over-time, for an average weekly wage of $**1,417.63**. The Arbitrator finds that Petitioner earned $**70,408.00** for regular time, for an average weekly wage was $**1,354.00**.

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

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

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

Respondent shall be given a credit of $**110,517.50** for TTD, $**0** for TPD, $**77,117.23** for maintenance, and $**0** for other benefits, for a total credit of $**187,634.73**.

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

ORDER

Respondent shall pay Northwest Orthopedics outstanding balance of $8,241.00 and Petitioner's out-of-pocket prescription expenses submitted in Petitioner's Exhibit # 7, totaling $50.82, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act.

Respondent shall pay Petitioner total temporary disability benefits of 223 & 1/7 weeks, for the periods of June 11, 2014 through May 11, 2018 and from May 26, 2018 through June 4, 2018, at a rate of $902.66/week, for which Respondent is entitled to a credit of $110,517.50 for benefits previously paid, as stipulated by the parties.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for **250 weeks** because the injuries sustained caused a **50% loss of person-as-a-whole**, pursuant to §8(d)2 of the Act.

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

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

Signature of Arbitrator

April 17, 2020
Date

APR 2 1 2020

Herbert Taylor v. City of Chicago – Department of Water
13 WC 24808

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?; ***L:*** What is the nature and extent of the injury?

The parties stipulated that Petitioner was entitled to TTD benefits from June 11, 2014 through May 11, 2018 and from May 26, 2018 through June 4, 2018, 223 & 17 weeks, as provided in §8(b) of the Act.

FINDINGS OF FACT

On February 4, 2013, Petitioner Herbert Taylor was 60 years old and a Motor Truck Driver for the City of Chicago. He was primarily employed as a driver for the Water Department but testified that he also performed seasonal work for the Department of Streets and Sanitation performing seasonal snow removal. Petitioner testified that the seasonal work with Streets and Sanitation was through a voluntary program whereby Motor Truck Drivers were able to earn overtime performing snow removal on an "as needed" basis during winter months.

Petitioner's hourly rate was $33.85 (PX #8).

Petitioner testified that his primary duties were to drive a hydro truck and would often support the Fire Department with a crew which included an engineer, a plumber, and laborers. He would have to get in and out of the vehicle which had 2 high steps and a handrail multiple times a day. The floor of the truck was between belly and chest height. He would grab the rail and then pull himself up into the truck.

Petitioner operated a snowplow truck during and after snowstorms for the Department of Streets and Sanitation.

Petitioner testified that that the snowplowing program Streets and Sanitation was voluntary but, if accepted and placed into the snow removal program, you were on call and had to be available in the event of a storm or a snow removal emergency. He

testified that during the winter when there was any chance of snow he would be on call 24/7. Petitioner testified that he drove a snowplow for many years.

The hearing on this matter was bifurcated so that Respondent could gather evidence or secure a witness to testify to the snowplowing program at issue. Rather than present live testimony, the parties agreed to stipulate that, if called, an administrator for the City of Chicago would testify that participation in the snow program was voluntary but, if accepted into the program, the employee must be available to work on the snow removal crew as needed.

On February 4, 2013, Petitioner was performing snow removal duties for Respondent. He was plowing in an area where he was unfamiliar and was on a cul-de-sac near an expressway. He hit a curb or a wall that jarred the truck, causing him to hit the steering wheel with his left arm and knocked out of his seat. He driver's door of the cab with his left shoulder. He felt pain in his left arm and hand. He finished the day working 3 to 4 additional hours. He testified that he was sore, yet continued to work another few days.

After filing an accident report, Petitioner was evaluated at MercyWorks on February 14, 2013, complaining of left arm pain since February 4. He also complained of slight numbness in the left arm. Petitioner was diagnosed with left arm pain and sprain, given medication, and released to full duty. Petitioner followed up at MercyWorks until February 28, 2013, when he was referred to Dr. McCall for an orthopedic evaluation. Dr. McCall was unavailable at that time. Petitioner was then referred to Dr. Remington. He was also released to full duty work.

Dr. Todd Rimington saw Petitioner on March 8, 2013 and noted left arm and hand pain. He recommended conservative care but allowed full duty work. On April 16 Dr. Rimington injected Depo-Medrol in Petitioner's biceps tendon at the shoulder. On May 7, 2013 the doctor recommended an EMG because of his concerns about radiating pain. He also gave a subacromial injection of Celestone. Dr. Rimington also ordered a left shoulder MRI.

By June 18, 2013 Petitioner had undergone both the EMG and the MRI. Dr. Rimington reviewed the results and diagnosed left carpal tunnel syndrome and a full thickness tear of the supraspinatus and infraspinatus tendons with retraction. He also found a biceps tendon tear. He recommended a left carpal tunnel release and a left rotator cuff repair.

Petitioner saw Dr. Anthony Romeo of Midwest Orthopedics at RUSH for a second opinion regarding the surgical recommendation on August 26, 2013. Dr. Romeo noted Petitioner's course of conservative care, including 2 corticosteroid injections in the left glenohumeral joint, as well as an EMG consistent with median nerve compression neuropathy and a left shoulder MRI demonstrating a full thickness tear of the supraspinatus and a partial tear of the biceps tendon. Dr. Romeo noted Petitioner's injury was work related. He agreed with the recommendations for the rotator cuff repair, open biceps tenodesis, and carpal tunnel release. Petitioner decided to return to Dr. Rimington to address both issues during the same surgery. Petitioner continued to work full duty while awaiting authorization for surgery.

On June 11, 2014, Dr. Rimington performed an arthroscopic debridement of the biceps tendon including the superior labrum, an open rotator cuff repair, subacromial decompression, distal clavicle excision, and an open carpal tunnel release.

On September 30, 2014 Petitioner complained to Dr. Rimington of pain and weakness in his left shoulder. The doctor recommended an MR arthrogram. The November 14, 2014 procedure demonstrated a complete tear of the supraspinatus tendon with retraction and postoperative changes. Additional surgery was recommended.

On February 25, 2015 Dr. Rimington performed a revision left rotator cuff repair, an open transfer of the latissimus dorsi and teres major, additional distal clavicle excision and an open biceps tenodesis. Petitioner followed with post-operative physical therapy throughout 2015.

On October 20, 2015 Dr. Rimington noted that Petitioner was completing physical therapy and had pain radiating down the arm and numbness. He recommended an MRI to rule out a cervical spine issue. The December 22, 2015 note indicated that Petitioner had cervical spondylosis from C4 to C6 with mild herniations and impingement on the C6 nerve root. The doctor wanted an EMG. He noted that Petitioner had developed rotator cuff arthropathy. Dr. Rimington discussed a left shoulder reverse arthroplasty on January 22, 2016. The February 11, 2016 EMG was suggestive of left C6 radiculopathy.

Respondent referred Petitioner for a §12 IME with orthopedic surgeon Dr. Guido Marra of Northwestern Medicine on March 17, 2016. Dr. Marra noted Petitioner's history of rotator cuff repair and carpal tunnel release by Dr. Rimington on June 11, 2014. A subsequent MRI documented a recurrent tear. Dr. Marra also noted Petitioner's latissimus dorsi transfer with bicep tenodesis in February 2015, followed by

physical therapy and numerous cortisone injections but with minimal improvement. A reverse shoulder replacement had been recommended.

Dr. Marra diagnosed persistent impingement and pain following a latissimus dorsi tendon transfer. He noted the injury was related to Petitioner's work accident. Dr. Marra recommended an MR arthrogram, which was done June 8, 2016 and revealed a large recurrent defect along with a failure of the latissimus dorsi tendon transfer.

On June 28, 2016, Dr. Rimington recommended a left shoulder reverse total arthroplasty.

Dr. Marra wrote an addendum dated July 7, 2016, where he agreed that reverse arthroplasty should be considered, with consideration of a revision of the latissimus dorsi tendon transfer.

Petitioner was unsure about whether he wanted this surgery at first agreeing to set a date and then cancelling. He considered a stem cell therapy and ultimately decided he did not want any more medical care. He underwent an FCE on September 15, 2016 at Athletico. It was noted that petitioner put forth consistent performance/acceptable effort Petitioner displayed physical capabilities and tolerances to function at least the Medium physical demand level. Petitioner did not demonstrate the physical capabilities and down and tolerances to perform all the essential job functions of the job.

On September 22, 2016 Dr. Rimington adopted the permanent restrictions of the FCE and noted Petitioner was at MMI.

Respondent hired Joe Belmonte of Vocamotive to provide vocational services to Petitioner. Petitioner began working with Mr. Belmonte and his associates on December 20, 2016. Their efforts resulted in a successful placement at Enterprise Rent a Car. An offer was made in late May 2018. Petitioner was to begin work June 5, 2018. Petitioner's daughter had health issues and he ultimately decided not to take the job. The job was to pay $12/hour for 40 hours per week. Petitioner instead elected to retire at the end of June 2018.

Petitioner testified that he still has pain in his left shoulder along with a loss of motion and strength. He testified that the shoulder makes it very difficult to sleep as he cannot get into a comfortable position. He changes positions many times per night. He is able to drive a passenger vehicle but cannot drive a truck because he cannot lift himself into the cab. Petitioner testified that he had a prior right shoulder surgery and a prior left elbow injury.

CONCLUSIONS OF LAW

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

This issue was not genuinely disputed. It was undisputed that Petitioner was injured in a motor vehicle accident that arose out of and in the course of his employment. Petitioner testified credibly that he had immediate pain in his left shoulder and arm but continued working. Although Petitioner waited 10 days before seeking his initial medical care, the temporal gap is not such, given Petitioner's credibility, that the causal connection was broken. The course of Petitioner's medical care and the opinions of his treating physicians further bolster this finding.

Therefore, the Arbitrator finds that Petitioner proved that his current condition of ill-being is causally related to his work accident on February 4, 2013.

G: What were Petitioner's earnings?

Petitioner was employed by Respondent as a Motor Truck Driver for the Water Department. His regular rate of pay was $33.85 per hour. In addition, Petitioner volunteered to also work for the Department of Streets and Sanitation as a seasonal snowplow driver, for which he was paid an overtime rate. Petitioner claims that his average weekly wage should be computed with his overtime pay included. As such, Petitioner claims earnings of $73,716.67, which computes to $1,417.63 average weekly wage (ArbX #1). On the other hand, Respondent claims that Petitioner's previous year's earnings were $70,408.00, which computes to a $1,354.00 average weekly wage (ArbX #1).

Petitioner argues that the overtime pay he earned as a seasonal snowplow driver for the Department of Streets and Sanitation was mandatory as contemplated by §10 of the Act. For overtime pay to be considered and computed into average weekly wage the overtime hours must be a condition of employment, mandatory, regular, and consistent. The Arbitrator finds that Petitioner proved none of these factors.

Petitioner offered no evidence by testimony or document that showed working as a seasonal snowplow driver was a condition of his employment for Respondent's Water Department. Petitioner testified that he volunteered for the seasonal snowplow driver position. He did imply, without evidence, that once he volunteered continued participation in the seasonal snowplow driver program was mandatory. However, there was no evidence that Petitioner would suffer any repercussions if he chose to opt out of the volunteer snowplow driver program with Streets and Sanitation.

Moreover, there was no evidence that overtime hours as a seasonal snowplow driver were either regular or consistent. Indeed, snowplow drivers are subject to the vagaries of weather, which are neither regular nor consistent.

Petitioner's regular hourly rate was $33.85, making Petitioner's base yearly salary as a Motor Truck Driver for the Department of Water $70,408.00. Based on the foregoing, the Arbitrator finds that overtime pay is not to be included in the computation of Petitioner's average weekly wage.

Therefore, the Arbitrator finds that Petitioner's average weekly wage is $1,354.00.

There is a question of whether Petitioner may be entitled to a wage differential pursuant to §8(d)1 of the Act. Petitioner was earning $33.85/hour at the time of the accident. Petitioner's Exhibit #6 noted Petitioner's negotiated hourly rate at the time of trial would have been $36.45 (PX #6). Through the services of vocational counselling by Vocamotive, Petitioner was offered a job in May 2018 for $12/hour. Petitioner chose to retire rather than accept that job offer.

The Arbitrator finds that Petitioner failed to prove that he was entitled to a §8(d)1 wage differential. Although Petitioner could have earned $12/hour he removed himself from the workforce when he retired.

J: <u>Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?</u>

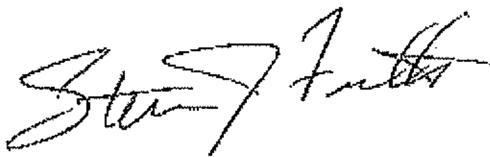
The Arbitrator has found that Petitioner's current condition of ill-being is causally related to Petitioner's work accident. Petitioner was required to receive extensive medical, which in the absence of evidence to the contrary, the Arbitrator finds was reasonable and necessary. Respondent shall pay Petitioner's out-of-pocket prescription expenses submitted in Petitioner's Exhibit # 7, totaling $50.82, to be adjusted in accord with the medical fee schedule provided in §8.2 of the Act. The Arbitrator notes that PX #7 included 3 copies of a $7.44 prescription charge for 2/14/13.

L: <u>What is the nature and extent of the injury?</u>

The Arbitrator assessed Petitioner's permanent partial disability in accord with §8.1b of the Act:

i) No AMA Impairment Rating was offered in evidence. The Arbitrator cannot give any weight to this factor.
ii) Petitioner was a Motor Truck Driver for Respondent but has since retired. Petitioner's injuries to his shoulder and wrist were so severe that he was unable to return to that job. The Arbitrator gives great weight to this factor.
iii) Petitioner was 60 years old on the date of the accident. He had a statistical life expectancy of approximately 21 years. Petitioner will be disabled by limitations with use of his injured shoulder and wrist for the remainder of his life. The Arbitrator great weight to this factor.
iv) Petitioner's future earning capacity has been affected by his injuries. Petitioner was unable to return to employment with Respondent as a Motor Truck Driver. Vocational counseling was able to find a job which paid $24.45/hour less than his job with Respondent. Petitioner opted to take his pension instead, The Arbitrator notes that Petitioner has since retired and is collecting a pension. The Arbitrator gives moderate weight to this factor.
v) The treating medical records corroborate Petitioner's injuries. Petitioner sustained injuries which required an arthroscopic debridement of the biceps tendon including the superior labrum, an open rotator cuff repair, subacromial decompression, distal clavicle excision, and an open carpal tunnel release. When Petitioner did not achieve recovery, he had a revision left rotator cuff repair, an open transfer of the latissimus dorsi and teres major, additional distal clavicle excision, and an open biceps tenodesis. An MR arthrogram revealed a large recurrent defect along with a failure of the latissimus dorsi tendon transfer. A left shoulder reverse total arthroplasty has been recommended. Petitioner has permanent restrictions which prevented him from returning to his former employment with Respondent. The Arbitrator gives great weight to this factor.

Based on all the evidence, the Arbitrator awards 50% loss of person-as-a-whole, 250 weeks, as provided in §8(d)2 of the Act due to the nature of the injuries and a loss of trade.



Steven J. Fruth, Arbitrator

January 31, 2020

STATE OF ILLINOIS	)	[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elkanah Balfour,

Petitioner,

20 IWCC0656

vs.

NO: 16 WC 035082

Performance Foodservice,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent partial disability, benefit rates, any and all issues raised at trial 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 March 4, 2020 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.

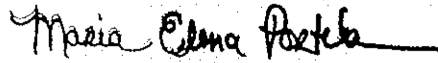
20IWCC0656

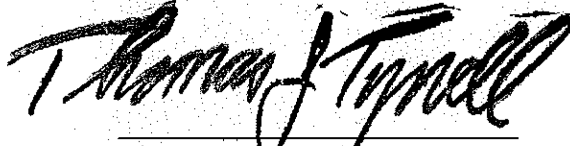
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

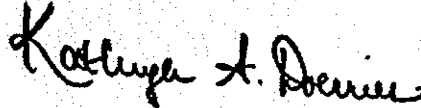
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 12 2020
o091520
MEP/ypv
049


Maria E. Portela


Thomas J. Tyrrell


Kathryn A. Doerries

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

BALFOUR, ELKANAH
Employee/Petitioner

Case# **16WC035082**

20 IWCC0656

PERFORMANCE FOODSERVICE
Employer/Respondent

On 3/4/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2542 BRYCE DOWNEY & LENKOV LLC
JUSTIN T NESTOR
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

20IWCC0656

STATE OF ILLINOIS)
) SS
COUNTY OF KANE)

- [ ] 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) 8(a)

Elkanah Balfour
Employee/Petitioner

Case # 16 WC 35082

v.

Performance Foodservice
Employer/Respondent

Corrected Decision

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city **Geneva**, on **September 12, 2019**. 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. And, corrected by the Honorable Joseph D. Amarilio, Arbitrator of the Commission.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

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

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. X Is Petitioner entitled to any prospective medical care?

L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD

M. X Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other ____

FINDINGS

On the date of accident **June 18, 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 **$71,427.20**; the average weekly wage was **$1,373.60**

On the date of accident, Petitioner was **24** years of age, **married** with **4** dependent children.
Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Prospective Medical benefits

Respondent shall authorize and pay for the surgeries and associated care to Petitioner's right wrist and elbow, as prescribed by Dr. Wolf, pursuant to the fee schedule and in accordance with §8 and § 8.2 of the Act.

Temporary Total Disability

Respondent shall pay the additional **TTD** for the period from **February 27, 2019 through March 24, 2019,** which is **3-6/7 weeks @ $915.33 per week.**

Penalties and Attorneys' Fees

Respondent shall pay penalties of **$5,910.00 pursuant to §19l** and $1,765.22 JOA **pursuant to 19k,** and **attorneys' fees of** $2,241.13 JOA **pursuant to §16 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]

March 2, 2020 JOA
Date

IC ArbDec19(b)

MAR 4 - 2020

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elkanah Balfour	)
Petitioner,	)
vs.	) **No. 16 WC 35082**
Performance Foodservice	)
Respondent.	) Corrected Decision

[illegible] Addendum

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

A previous hearing under §19b/§8a of the Act by Arbitrator Flores was held on December 11, 2017. At issue in that hearing was whether the surgery to petitioner's right wrist and elbow as prescribed by petitioner's treating orthopaedic surgeon, Dr. Jennifer Wolf, was reasonable and necessary. An award was entered by Arbitrator Flores finding the surgery was reasonable, necessary and causally connected to petitioner's work accident of June 18, 2016 was entered on January 17, 2018. No review was filed and Arbitrator Flores' decision became final.

Thereafter, another hearing under §19b/§8a of the Act was heard by this Arbitrator on February 26, 2019. An award was entered on August 5, 2019 for prospective medical for treatment recommended by Dr. Wolf, which included physical therapy, possible nerve blocks, a MRI-arthrogram, pain management and associated care. An award for TTD, which included the previous award, was also entered for the period from December 28, 2016 to August 1, 2018 and August 15, 2018 to February 26, 2019. A review was filed on this decision.

This matter proceeded again under §19b/§8a of the Act in Geneva on September 12, 2019. At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether petitioner is entitled to payment for prospective medical treatment.
3. Whether petitioner is due TTD.
4. Whether penalties and attorneys' fees should be imposed upon respondent.

FINDING OF FACTS

After the second arbitration hearing but before this Arbitrator issued the decision as to the February 26, 2019 hearing, Petitioner was re-examined at Respondent's request by Dr. Tulipan on March 25, 2019. Dr. Tulipan felt that it would be reasonable for Petitioner to undergo both the MRI and the EMG in order to provide objective support for Petitioner's ongoing subjective complaints. He felt that Petitioner should be limited to light duty and he characterized Dr. Wolf as a "well-respected hand surgeon." (RX 1)

Based on Dr. Tulipan's report, Respondent authorized the MRI and the EMG, and reinstated Petitioner's TTD benefits effective March 25, 2019, thus leaving unpaid the benefits for the period January 11, 2019 through March 24, 2019.

Petitioner underwent the MRI of his right wrist on April 17, 2019. It revealed a full-thickness tear of the TFCC (triangular fibrocartilage complex). (PX 3)

Petitioner underwent the EMG of his right arm on April 22, 2019. It revealed both median neuropathy (carpal tunnel syndrome) and ulnar neuropathy (cubital tunnel syndrome.) (PX 4)

On April 23, 2019, Dr. Wolf reviewed the updated diagnostic tests. She felt that the EMG showed slight worsening from the 2018 study. She recommended a revision ulnar nerve transposition with likely wrapping of the nerve, along with arthroscopic evaluation of the TFCC tear. (PX 1, p. 71) In the meantime, Dr. Wolf maintained the light duty restrictions that had previously been in effect. (PX 2)

On May 7, 2019, Petitioner was examined at Respondent's request by Dr. Kenneth Candido, a pain management physician. Dr. Candido concluded that Petitioner did not have CRPS, but that he had a recurrent TFCC tear which required surgery. He felt that this was causally connected to Petitioner's accident. He also felt that Petitioner would be capable of performing light-to-medium duty, with no lifting over 35 lbs. (RX 3, p. 32-34)

Petitioner was scheduled for surgery on May 30, 2019, but Dr. Wolf noted that it had not been approved. (PX 1, p. 83, 85)

On June 4, 2019, Dr. Tulipan reviewed Petitioner's recent EMG. He indicated that he would be hesitant to proceed with further surgery unless a repeat EMG in three to four months showed further deterioration of the nerve compression. Dr. Tulipan also stated that this surgery, if required, would be related to Petitioner's work accident. (RX 2)

On August 5, 2019, this Arbitrator filed the decision stemming from the Section 19(b) hearing of February 26, 2019. That decision held that Petitioner's right wrist and elbow problems remained causally connected to his accident; that he was entitled to TTD benefits and that he was entitled to undergo the diagnostic testing (MRI/EMG) as prescribed by Dr. Wolf. The Arbitrator also denied a petition for penalties.

On September 10, 2019, Dr. Tulipan further commented on Petitioner's condition. He found that the MRI findings supported Petitioner's complaints of pain and that arthroscopic surgery was not unreasonable. He also felt that re-exploration and rewrapping of Petitioner's ulnar nerve would be "probably a worthwhile exercise," but he continued to believe that Petitioner's elbow condition was not causally connected to the accident. (RX 4) This causation opinion directly contradicted what Dr. Tulipan had stated in his report of June 4, 2019. (RX 2)

Petitioner testified that he remains under the care of Dr. Wolf; that he desires to undergo the recommended surgeries; that no physician has released him to return to full duty work as a truck driver; and that he has had no intervening accidents or injuries since he last testified on February 26, 2019

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator makes the following conclusions of law:

The issue of causation was decided in the initial Section 19(b) hearing of December 11, 2017. That decision—never reviewed and long since final—determined that the pathology in Petitioner's right wrist and right elbow were causally connected to the accident of June 18, 2016. In the absence of an intervening accident, therefore, that determination is *res judicata* and Respondent is collaterally estopped from attacking it.

Petitioner testified that he has had no intervening accidents or injuries. There is nothing contained in the medical records and reports to suggest otherwise.

All doctors—including Respondent's examining doctors—agree that Petitioner's right wrist problems are causally connected to the accident. There is literally no evidence to the contrary. The only voice of dissent on the issue of causation comes from Dr. Tulipan as it related to Petitioner's ulnar neuropathy, the same dispute that was raised before and decided by Arbitrator Flores on December 11, 2017. Even this opinion was equivocal, with Dr. Tulipan admitting causation in his report of June 4, 2019 and denying causation in his report of September 10, 2019. (RX 2, RX 4)

The causation question was determined by the Arbitrator's earlier determination. The continuity of care and the lack of any intervening accident means that nothing has changed.

Based on the foregoing, the Arbitrator concludes that Petitioner's right wrist and elbow condition remain causally connected to the accident of June 18, 2016.

K. With respect to the issue regarding prospective medical care, the Arbitrator makes the following conclusions of law:

Dr. Wolf has recommended revision surgeries to Petitioner's right wrist and elbow. Dr. Tulipan agrees, but feels that Petitioner's elbow condition is unrelated to the accident. However, this opinion as stated in his September 10, 2019 is completely contrary to his earlier opinion as stated in his June 5, 2019 report. In addition, this contrary opinion of Dr. Tulipan conflicts with the prior, final determination that Petitioner's right elbow pathology is causally connected to the accident. There is no medical evidence to suggest that Petitioner has attained MMI or that surgery is unwarranted.

Based on the foregoing, the Arbitrator awards the reasonable costs of the surgeries and associated care to Petitioner's right wrist and elbow, as prescribed by Dr. Wolf, in accordance with the fee schedule and in accordance with §8 and §8.2 of the Act.

L. With respect to the issue regarding TTD, the Arbitrator makes the following conclusions of law:

The parties agree that all TTD benefits have been and are being paid, excepting only for the period from January 11, 2019 through March 24, 2019. The Arbitrator has previously determined that Petitioner was temporarily totally disabled for the period from January 11, 2019 through the hearing date of February 26, 2019. The Arbitrator will focus, therefore, on the period between the last hearing date and March 24, 2019. During that block of time, Petitioner remained under the care of Dr. Wolf who had imposed restrictions upon his ability to return to work.

On March 25, 2019, Petitioner was re-examined at Respondent's request by Dr. Tulipan. Following that exam, Dr. Tulipan concluded that Petitioner was not at MMI, that his treatment had been reasonable and that he was limited to light office work. (RX 1) There is nothing to suggest that Petitioner's inability to work was any different during the period from February 26, 2019 and March 25, 2019 than it was before or after those dates.

Based on the foregoing, the Arbitrator concludes that in addition to the TTD periods previously awarded, Petitioner is entitled to have and receive TTD benefits for the period from February 27, 2019 (the day following the most recent arbitration hearing) through March 25, 2019 (the day before Dr. Tulipan's examination.) This is an additional 3-6/7 weeks TTD at the rate of $915.33 per week.

M. With respect to the issue regarding penalties and attorneys' fees, the Arbitrator makes the following conclusions of law:

This is the third time that Petitioner has had to arbitrate his case in order to obtain TTD benefits and/or medical treatment in the wake of his undisputed accidental injury. At the time of the first hearing, it was neither unusual nor unreasonable for Respondent to question whether Petitioner's elbow problems stemmed from the accident at work. Dr. Wolf indicated that they were; Dr. Tulipan indicated that they were not. Indeed, Petitioner did not request an award of penalties at that time.

At the time of the second hearing, Petitioner requested penalties based on Respondent's refusal to pay TTD or authorize additional treatment following a failed FCE. Although the Arbitrator found in Petitioner's favor regarding the underlying benefits, penalties were denied as Respondent had a basis for the denial.

Respondent's current denials are completely unsupported. Following the second arbitration hearing, Dr. Tulipan indicated that the additional diagnostic tests prescribed by Dr. Wolf—an MRI and an EMG—would be reasonable. Respondent authorized those tests. They were reviewed by both Dr. Wolf and Dr. Tulipan. Both doctors felt that the results were pathologic: the MRI revealed a recurrently torn TFCC in Petitioner's right wrist; the EMG revealed recurrent ulnar neuropathy in Petitioner's right elbow. Both doctors felt that surgery was needed. Both doctors felt that work restrictions were indicated which would preclude Petitioner's return to work as a truck driver.

Upon receipt of this information, Respondent resumed the payment of Petitioner's weekly TTD benefits, but not retroactively. They left a "donut hole" of sorts for the period from January 11, 2019 through March 24, 2019. At the time of the second arbitration hearing on February 26, 2019, the Arbitrator gave Respondent the benefit of the doubt based upon the information that was available at that time. Since then, however, additional information (the MRI/EMG results and the opinions of Drs. Wolf/Tulipan) remove all doubt as to Petitioner's entitlement to TTD and medical benefits. It is a mystery why Respondent has not paid the TTD for the period from February 27, 2019 through March 24, 2019, because there is no medical or other evidence in the record which would support an ongoing denial.

Based upon the foregoing, the Arbitrator finds respondent was not justified in failing to pay TTD and awards penalties pursuant to §19(l) of the Act in the sum of $5,910.00 (197 days [February 27, 2019 to September 12, 2019] x $30.00 per day).

The Arbitrator further finds respondent's action to be unreasonable, unjustified and vexatious and awards penalties pursuant to §19(k) of the Act in the sum of $1,373.43 (50% of the unpaid TTD of $2,746.85 [February 27, 2019 to March 25, 2019]).

The Arbitrator further orders Respondent to pay Petitioner's attorneys' fees of ~~$[illegible]~~ $2,241.13 JOA pursuant to §16 of the Act, which is 20% of the total award of $10,030.28 [$2,746.85 for TTD + $5,910.00 for §19l penalties + ~~$[illegible]~~ $1,765.22 JOA for §19k penalties]. $13,446.78

Dissent

I respectfully dissent from the majority. I would find that Petitioner has not sustained her burden of proving that she is permanently and totally disabled as a result of her August 29, 2010, accident. Rather, Petitioner's permanent total disability is because of her progressive multiple sclerosis (MS) disease, diagnosed after her work-related accident and after she had returned to work as a registered nurse. While I empathize with Petitioner's suffering, for the following reasons I would award permanency on the basis of §8(d)2, for an aggravation of her non-operated pre-existing herniated cervical disc at C5-C6 and a slight disc bulge/herniation at C6-C7 with permanent restrictions.

Prior §19(b) Hearing and Award

Before the work accident of August 29, 2010, Petitioner underwent a cervical spine MRI on January 22, 2010, and was diagnosed with neck pain and right cervical radiculopathy secondary to a herniated disc at C5-C6 for which she treated with Dr. Brayton, a neurologist, and Dr. Cherala, in Respondent's pain management clinic. (ArbX2, 1, PX1) After a §19(b) hearing, the Arbitrator deemed the August 29, 2010, accident resulted in: 1) an *aggravation* of a pre-existing herniated disc at C5-C6; and 2) a new disc herniation at C6-C7. (ArbX2, 4) (emphasis added)

The Arbitrator's §19(b) Decision notes that Petitioner underwent a cervical MRI on February 9, 2011, at Dr. Brayton's recommendation, to determine whether the C5-C6 herniation had worsened. "The radiologist's impression was that there was little change from the previous MRI *with the possible slight decrease in size of the C5/6 right disc herniation.*" (ArbX2, 2) (emphasis added)

The Arbitrator's §19(b) Decision further notes Dr. Butler's second IME of Petitioner on February 17, 2011, which states, "[t]he MRI finding *had actually improved to some degree.* Her symptoms were primarily subjective in nature and there was no objective neurologic deficit." (ArbX2, 3) (emphasis added) In the §19(b) award, the Arbitrator noted the improvement detected by the cervical MRI of February 17, 2011, most notably at C5-C6.

The Arbitrator awarded physical therapy (P.T.) as reasonable medical treatment and specifically denied the epidural steroid injection (ESI) that Dr. Brayton recommended concluding that, "Petitioner failed to prove the ESI prescribed by Dr. Brayton are (sic) reasonable and necessary medical treatment. However, she has not reached MMI and is entitled to further treatment with Dr. Brayton....Dr. Brayton has prescribed P.T., which is reasonable treatment for Petitioner's exacerbation." (ArbX2, 4-5)

The §19(b) Decision was appealed to the Commission where it was later affirmed and adopted. (ArbX2)

Post §19(b) Medical Treatment and Return to Work

After the §19(b) award, Petitioner called Dr. Brayton on August 1, 2011, and requested a release to return to work. Dr. Brayton imposed work restrictions of no lifting greater than 10 pounds, and to avoid excessive pushing and pulling. (PX1) On August 10, 2011, Petitioner saw

Dr. Yang at Delnor for pain management to obtain a repeat ESI, despite the Arbitrator's denial of the ESI. (PX2) Dr. Yang reviewed the MRI from February 9, 2011, and noted a "C6-7 minimal disc bulge." There is no evidence that Petitioner ever attended the P.T. awarded by the Arbitrator intended to address her cervical issues.

Petitioner began working full-time as a nursing supervisor at Loretto Hospital on August 12, 2011. (T, 25-26)

Petitioner returned to Delnor pain management clinic on October 21, 2011, and saw Dr. Hanna where Petitioner's past medical history was positive for migraines, chronic neck and back pain, chronic bronchitis, DVT, asthma, sleep apnea, IBD, Crohn's disease, hypothyroidism, anxiety/depression, ADD, obsessive-compulsive disorder, fibromyalgia, and endometriosis. (PX10, 10/21/11). Review of systems on that same day reflects that Petitioner complained of some nausea, stress incontinence, and joint swelling. Dr. Hanna noted only her pre-existing cervical disc at C5-C6 on the right side, omitting any reference to the C6-C7 level. Dr. Hanna found that a large segment of her pain is also myofascial related. Thus, he administered trigger point injections to the bilateral levator scapular muscles. (PX2)

On November 9, 2011, Petitioner saw Dr. Hanna for an ESI and medication management. Dr. Hanna administered a cervical ESI at C7-T1 and trigger-point injection to her bilateral levator scapular muscles. On December 12, 2011, Dr. Hanna administered additional trigger-point injections at the same level. Dr. Hanna noted a new diagnosis of "Abnormal neurologic examination with clonus. And Dysphagia."

Petitioner continued working full-time as a nursing supervisor for Loretto Hospital. On February 15, 2012, Dr. Hanna noted Petitioner's dysphagia has been increasing, and she had to bend her head forward or tuck her neck to swallow and that Petitioner has an abnormal neurologic exam with clonus. Dr. Hanna recommended a repeat cervical MRI and administered trigger point injections. (PX2)

Petitioner underwent the cervical spine MRI scan on February 16, 2012. The findings at C5-C6 were as follows:

> "There is a posterior disc osteophyte complex an associated right paracentral small posterior disc protrusion. The overall posterior extent of this disc protrusion *has not significantly changed* although there is slight broadening at the base of the protrusion and presence of an annular tear now identified. Mild effacement of the ventral CSF space is again noted. There is slight right facet degeneration resulting in minimal thinning of the right neural foramen, stable." (PX2) (emphasis added)

The radiologist's impression states: "The posterior disc protrusion and at C5-C6 *is slightly more broad-based on the current exam than when compared to previous although the posterior extent of the protrusion is stable. Remainder of findings are unchanged.*"(PX2) (emphasis added)

Dr. Brayton authored a letter to Dr. Branshaw, Petitioner's PCP, dated March 2, 2012. He notes that she "[h]as an extensive history of pain and radicular symptoms after a work related

injury of her neck causing a C5-C6 disc herniation on August 29, 2010. … concerning symptoms of swallowing dysfunction, increasing spasticity of her upper and lower extremities especially noted in her lower extremities…. There is also hyperreflexia at the patellar tendon including crossed adductor reflexes and distribution of reflexes. There is an exaggerated wrist extensor reflex as well as brachioradialis reflex in the upper extremities, again with distribution of reflexes. There is sustained clonus bilaterally. There is also Babinski sign." (PX1)

Dr. Brayton advised the cervical spine results showed, "the *slight* progression in the C5-C6 (disc) along with the pronounced annular tear explains some of her increased neck symptoms and pain. Increased facet arthropathy and inflammatory change of the MRI explains her focal spine tenderness but it certainly does not explain her pathologic reflexes, hyperreflexia, clonus, and Babinski signs. There is no evidence of intrinsic cord lesion on the presented cervical MRI scan, but I am concerned that *she has evidence of diffuse upper motor dysfunction*." (PX1)

Dr. Brayton further wrote, "In summary, the patient's neck pain may be explained by the *relatively modest changes* of the C5-6 disk herniation which does not exert any further compression of the neural elements combined with the facet disease at C5-6 and C6-C7, but it certainly does not explain the patient's rather concerning finds consistent with diffuse upper motor dysfunction." (PX1) (emphasis added)

On March 2, 2012, an MRI of the brain confirmed a brain lesion at the right aspect of the pons and loss of the surrounding white matter material around the brain stem. Thereafter, on March 30, 2012, a spinal tap and lumbar puncture ordered by Dr. Santwani was performed because of the brain lesion, or abnormal mass in Petitioner's brain, the clonus and the increased reflexes. The spinal tap confirmed multiple abnormal bands consistent with a clinical diagnosis of MS. (RX1, 19-21, PX4)

During this work-up that diagnosed MS, Petitioner continued working full-time as a nursing supervisor. However, Petitioner was terminated from her position at Loretto Hospital for labor/union reasons unrelated to her physical condition on May 20, 2012. Petitioner testified that she continued to look for work in the nursing field. (T, 26, 33) The fact that the Petitioner was still looking for work at this juncture shows the work injury did not disable Petitioner from working at that time, and further, that her work-related condition was stable and not worsening.

On August 23, 2012, Petitioner advised Dr. Brayton she wanted to return to work and requested new, more lenient restrictions. Dr. Brayton assigned restrictions of lifting 50 pounds frequently and 100 pounds occasionally. (T, 31) Petitioner testified that essentially if she went into the doctor and said, "I feel like I can do this" they were willing to adjust her restrictions so she could take a job she located. (T, 66)

Petitioner underwent an EMG/NCV some nine months later, on May 28, 2013, which showed "evidence of a *trace*, acute, C5 radiculopathy on the right and a *mild,* acute C6 radiculopathy on the left. There is no definitive electrophysiological evidence of a brachial plexopathy or peripheral neuropathy affecting the upper extremities at this time." (PX4) (emphasis added) This is at the level of Petitioner's pre-existing C5-C6 disc herniation, and the findings are

the same or similar to the EMG/NCV of October 20, 2010. These objective tests do not explain Petitioner's ongoing symptoms and complaints.

In 2013, Petitioner applied for Social Security Disability Insurance (SSDI) benefits. (T, 67)

Petitioner began working full-time as a float nurse on September 9, 2013, at DuPage Convalescent Center. (T, 18) Petitioner continued to work until January 5, 2014, at which time Dr. Santwani provided an off-work slip excusing Petitioner from work through January 9, 2014, citing a flare-up of her MS condition or from multiple falls. Dr. Santwani further excused Petitioner from work on February 23, 2014, February 26, 2014, and February 27, 2014, and February 23 through March 9, 2014, again for flare-ups of her MS condition, or from multiple falls. No off work slips were related to her work-related cervical condition. (PX4, work status notes)

On February 25, 2014, Petitioner underwent a cervical MRI which showed her objective results were unchanged from previous scans. By that time, however, Petitioner was exhibiting symptoms of left foot drop. According to Dr. Allen, absent lumbar spine disease, which was confirmed by MRI on February 25, 2014, the lesion causing this symptom had to be above that level, at the neck or in the brain. In fact, she had findings both in the neck, but particularly in the brain, that would explain the foot drop. (RX1, 25)

Dr. Santwani released Petitioner to return to light duty work on March 12, 2014, after an MS flare-up. Petitioner was released to return to work *with no* restrictions on March 13, 2014. (PX4) (emphasis added) Thereafter, on March 30, 2014, April 2, 2014, and April 3, 2014, Dr. Santwani excused Petitioner from work after multiple falls attributable to her MS and unrelated to her cervical condition. She also received an off work note from Dr. Santwani on April 5 and April 6, 2014, again for MS exacerbation and severe falls. (PX4) On April 21, 2014, Petitioner reported to Dr. Santwani that she was hospitalized for an MS flare up. Petitioner reported that her legs were weak, she reported frequent falling and memory problems, increased dysphagia and choking on liquids, her vision was blurred, and her body was weak with generalized pain. (PX4)

Petitioner testified that she was terminated from her position at DuPage Convalescent Center in May 2014, "for missing work for medical reasons." When asked if she missed work because of issues regarding her cervical spine, Petitioner testified that she did. (T, 32) However, Dr. Santwani's off-work notes from January, February, March, and April 2014, indicate Petitioner missed work because of MS flare-ups or falls and not the work-related cervical condition. (PX4))

Petitioner testified that she looked for work in nursing management thereafter until she was awarded SSDI benefits in 2015. (T, 71) Petitioner never looked for work after her award of SSDI. (T, 67)

Petitioner had not seen Dr. Brayton in two years, since he wrote Dr. Branshaw in 2012 and referred her to Dr. Santwani at that time. On August 19, 2014, however, Petitioner returned to Dr. Brayton. After reviewing the August 1, 2014, cervical MRI, Dr. Brayton advised Dr. Branshaw that the continued herniation at the C5-C6 level *has not progressed much* and does not significantly compress the neural elements and suggested a provocative discography of the cervical spine both

at the C5-6 level and control levels. (PX1) He did not mention the disc at C6-C7. Dr. Brayton saw Petitioner only two more times, on February 12, 2015 and on January 21, 2016.

Petitioner underwent a discogram at Kendall Pointe Surgery on October 22, 2014. The discogram report states, "[a]t both the C4-C5 and C5-C6 discs, the patient experienced posterior bilateral cervical pain. (PX8) The pain experienced was equal at both levels. At the C6-C7 disc, the disc appeared normal, and no pain was produced." (PX8) On February 12, 2015, Dr. Brayton reviewed the discogram.

On December 2, 2014, Dr. Santwani ordered a functional capacity evaluation (FCE) to assess Petitioner's capabilities at that time. Petitioner never underwent the FCE to quantify her work capabilities.

Before trial, on March 28, 2018, Petitioner underwent another cervical MRI. The radiologist's impression states, "small central protrusion of the disc at C2-3 and C5-6 contributing to mild central stenosis; 2) multilevel degenerative disease of the cervical spine; 3) no abnormal signal or enhancement of the visualized spinal cord."

Dr. Allen's Medical Opinion

Petitioner was seen by Dr. Neil Allen at Respondent's request pursuant to §12. Dr. Allen authored two reports dated December 29, 2014, and February 26, 2015, and testified via evidence deposition on August 10, 2015. Dr. Allen is board certified in both internal medicine and neurology but also published and involved in presentation and research of MS for 15-20 years. (RX1, 8-9) He testified that he reviewed Dr. Brayton's medical records from 2002 noting that seven years prior to 2003, Petitioner was kicked in the head during a soccer game and had migraine type headaches including in the back of her head. (RX1, 15, 84) Dr. Allen reviewed the August 29, 2010, cervical MRI and confirmed the only new finding was the C6-C7 diffuse disc bulge. (RX1, 16)

Dr. Allen agreed with Dr. Brayton's assessment of her symptoms and that the February 16, 2012, cervical MRI showing that the C5-C6 protrusion was slightly more broad-based than on earlier examination and that the "MRI didn't explain her increased reflexes and clonus in her legs, difficulty walking, and problems swallowing." (RX1, 19) An MRI of the brain was performed on March 2, 2012, which showed a brain lesion at the right aspect of the pons which turned out to be a demyelinating area, an area of local inflammation, and loss of the surrounding white matter material around the nerves of the actual spinal—of the actual brain stem itself, consistent with MS. (RX1, 20) She underwent a spinal tap or a lumbar puncture because of the clonus in her ankles, the abnormal mass in the brain and increased reflexes. The puncture showed multiple abnormal bands, consistent with MS. (RX1, 21)

Dr. Allen opined that Petitioner's falling was from the lesion noted in the pons of the brain. Her increase in memory problems could be from the narcotic medications; the difficulty swallowing was likely from the lesion in the pons as was the occasional choking on liquids. Petitioner's problems finding words and lack of coordination were from narcotics and the MS. (RX1, 27-28, 34)

Dr. Allen also testified that lesions in the brain can be caused by the MS, migraines and encephalitis. (RX1, 37) Petitioner's hyperreflexia was caused by interruption in the transmission of impulses from the brain stem spinal cord to lower extremities. It is a manifestation of MS, the tumor, and a vitamin B-12 deficiency, which Petitioner had in the past. (RX1, 38) There was no evidence of myelomalacia (spinal cord damage) or spinal cord compression. The physical examination of February 26, 2015, revealed Petitioner complained of migraines dating to 1995 when she suffered a Grade 2 concussion. (RX1, 41-42, 84).

Dr. Allen's impression after the February 2015 examination was that her current condition of ill-being appeared to be a loss of balance, increased frequency of headaches, occurring two to three times a week, and the cowl-like discomfort she has over her shoulders secondary to the cervical spine injuries that have been previously adjudicated. It was his opinion that none of the conditions of MS, hyperreflexia in her legs or fibromyalgia were related to the work accident. (RX1, 50) He opined any work restrictions that she has at this time would be related to migraines and would not be related to her work accident. (RX1, 52)

Dr. Allen opined the only symptoms related to her work injury, were "[p]ain in her neck, pain in her arm, any numbness or weakness that she had in her upper arm as found by other examiners which I did not go into since that information had already been adjudicated." (RX1, p. 53) No lower extremity findings, headaches, intermittent and episodic dizziness, light sensitivity, sound sensitivity, nausea, her gait, spasticity of her lower extremities, weakness, lack of attention, and difficulty with memory are related. (Rx1, 53-56)

When asked if Petitioner was capable of working with regard to her injury which had been adjudicated in the §19(b) hearing, Dr. Allen opined that, "[i]t was documented that she returned to work subsequent to her neck injury in 2010, and she returned to work in 2011. She was performing her full duties as a nurse at Loretto Hospital when she did, in fact, return to work and was also capable of exercising up to three time per week. (RX1, 56) Dr. Allen testified that on August 23, 2012, Dr. Brayton released Petitioner to return to work with restrictions of lifting 50 pounds and occasional lifting of up to 100 pounds, consistent with the duties of a registered nurse and he was in agreement with those restrictions. (RX1, 23, 88)

Dr. Brayton's Medical Opinion

On January 21, 2016, Dr. Brayton opined that Petitioner continued to be disabled by pain requiring high-dose analgesics, procedural pain treatment, and recumbency for alleviation of her neck pain, scapular pain, and cervicogenic headaches, caused by her work injury which is a separate condition from her MS. He also opined that Petitioner's MS was triggered by her work injury and disc herniation. Dr. Brayton further stated that the cervical disc herniation persists at C5-C6 and has not healed or improved but does not progress. Dr. Brayton described her disc disease at C2-3 and C3-4 levels that are unrelated to the August 29, 2010, work accident. He advocated avoiding surgery. Dr. Brayton provided one work status note that was handwritten that states, "Permanent work restrictions no lifting, frequent breaks with recumbency, high dose narcotic pain meds all prohibit work/gainful employment-permanent. He also provided a hand-written note on a prescription pad that documents, "Permanent Disability."

Dr. Brayton never testified regarding his January 21, 2016, opinions.

Dr. Herman's Medical Opinion

Petitioner underwent a second §12 exam by Dr. Martin Herman, a neurosurgeon, at Respondent's request in May 2016. Dr. Herman testified that Petitioner has three ongoing problems: 1) a pre-existing condition of long-standing neck pain since 1995 with cervical degenerative disease; 2) the disc herniation (C6/7) that occurred in 2010; and 3) progressive neurological abnormalities due to her MS. The pre-existing disc disease and the herniated disc did not prevent her from working as a registered nurse. The symptoms from the MS would prevent her from returning to work as a registered nurse. (RX2, 42-43) Dr. Herman opined that her (C6-C7) disc herniation was very small according to her reports and it is not possible to attribute the large number of not associated symptoms and signs that she's having to this disc herniation because people with disc herniations do not get loss of coordination, blurry vision, memory loss, or the kind of weakness she's describing. (RX2, 43-45) Dr. Herman testified that a 50-pound and a 100-pound restriction at medium duty, roughly two years after her injury was completely reasonable in regard to her work-related condition. (RX2, 22) He found that Petitioner had reached MMI when she was returned to work with the restrictions Dr. Brayton imposed of 50-pounds and 100-pounds occasionally. Petitioner did not need additional treatment for her work-related condition. (RX2, p. 17)

Analysis and Conclusions

The majority finds that, "The evidence shows a progressive worsening of Petitioner's condition both symptomatically and per the objective diagnostic studies." I disagree. The medical records show Petitioner's work-related condition was stable and this stable work-related condition did not prevent Petitioner from working. Also, the condition that was progressively worsening was her MS condition that Petitioner stipulated was not causally related to the work accident.

The sole new finding resulting from the work accident, the disc at C6-C7, was non-symptomatic. Moreover, the February 16, 2012, cervical MRI confirmed the pre-existing C5-C6 disc was almost completely stable and unchanged. Objectively, Petitioner's work-related conditions at C5-C6 and C6-C7 were stable some two years post-accident. Also, the May 28, 2013, EMG/NCV (6/8/18 Hearing, PX4) documents the same or similar results as the October 20, 2010, EMG/NCV. (6/29/11 Hearing, PX1)

Petitioner was able to return to work and did, in fact, return to work. Petitioner worked as a full-time registered nurse after the accident from August 12, 2011 – May 20, 2012. Shortly thereafter, in August 2012, Dr. Brayton updated his employability assessment imposing more lenient restrictions, 50-pounds frequently and 100-pounds occasionally. Petitioner was working from September 9, 2013 – January 5, 2014, until taken off by Dr. Santwani because of her progressively worsening MS symptoms that even required hospitalization. (PX4) Dr. Santwani's treatment from April 23, 2012, solely addressed Petitioner's progressing MS symptoms. The only condition that was progressively worsening both symptomatically and per the objective diagnostic studies was Petitioner's non-work-related MS condition not her work-related cervical condition.

It is noteworthy that only after the progressively worsening non work-related MS condition, did Dr. Brayton change her work restrictions and find she was unemployable.

The majority's reliance on *Sisbro* to award PTD benefits is misplaced. (citations omitted) The majority asserts that the Petitioner's cervical condition is a "contributing cause" to her permanent and total disability. It is the responsibility of the claimant to establish that he or she is entitled to permanent total disability benefits. *Federal Marine Terminals, Inc. v. Illinois Workers' Compensation Comm'n*, 371 IllApp.3d 1117, 1129, 864 N.E.2d 838, 309 Ill.Dec. 597 (2007). A claimant is required to establish the elements of his right to compensation under the Workers' Compensation Act. *Certified Testing v. Industrial Com'n.*, 305 Ill.Dec. 797, 856 N.E.2d 602, 367 Ill.App.3d 938 (2006). In order to establish entitlement to PTD benefits, a claimant must establish that she is incapable of performing services except for those for which there is no reasonable stable labor market because of the effects of the work injury. *Federal Marine*.

The Appellate Court in *Alano v. Industrial Commission* stated:

> [T]he focus of the Commission's analysis must be upon the degree to which the claimant's medical disability impairs his employability, and 'if an employee is qualified for and capable of obtaining employment without seriously endangering his health or life, such employee is not totally and permanently disabled.' *Alano v. Industrial Com'n.*, 282 Ill.App.3d 531, 668 N.E.2d 21 (1996) citing *E.R. Moore Co. v. Industrial Com'n*. (1978), 7 Ill.2d 353, 361, 17 Ill.Dec. 207, 376 N.E.2d 206.

In this case, Petitioner's work-related medical disability is her cervical condition at C5-C6 and C6-C7. However, the C5-C6 disc was stable and did not prevent her from returning to work, albeit with restrictions, in 2011, 2012, 2013 or thereafter. In fact, Petitioner returned to work full duty at Loretto Hospital in 2011 until she was terminated in 2012, and also at DuPage Convalescent Center, until she was terminated in 2015. The condition of disability preventing Petitioner from gainful employment was the progressively worsening and debilitating non-work related MS condition. Petitioner has failed to show her work-related medical disability impaired her employability.

Dr. Brayton is the only doctor who opined that Petitioner is permanently and totally disabled as a result of the August 29, 2010, work injury. Dr. Brayton's credibility is tainted for a multitude of reasons. First, he allowed the Petitioner to dictate her work restrictions on multiple occasions. Second, Dr. Brayton did not testify and thus never provided the basis for his opinion, that the aggravation of a pre-existing herniated disc at C5-C6, which was stable or smaller on the cervical MRI on February 10, 2011, caused Petitioner's permanent disablement. Finally, Dr. Brayton's opinion on Petitioner's employability regarding her cervical spine restrictions, lacks foundation, and the purview of that opinion belongs to a certified vocational counselor. The Appellate Court specifically rejected a medical opinion regarding an injured employee's employability in *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 865 N.E.2d 342 (2007). In *Westin,* the court held:

> As far as we can tell, Dr. Coe had not ordered or reviewed any vocational or rehabilitative tests, conducted a labor-market survey on claimant's behalf,

> attempted to find claimant a position within his restrictions, or prescribed a functional capacity evaluation. In fact, Dr. Coe acknowledged on cross-examination that he never reviewed a job description for claimant's position, that claimant only told him "in general in his limited way" what his job duties entailed, and that he never ordered any vocational evaluation of claimant. Although Dr. Coe emphasized that claimant's limited knowledge of the English language restricted his ability to be rehabilitated in an occupation other than a painter, our supreme court has suggested that one's language skill is insufficient to support a finding of odd lot. *Valley Mould & Iron Co.*, 84 Ill. 2d at 548. [***41]

Westin Hotel v. Indus. Comm'n, 372 Ill. App. 3d 527, 544-545, 865 N.E.2d 342, 358, (2007).

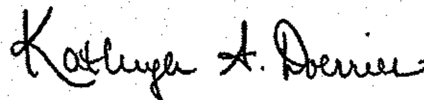
The evidence is clear Petitioner's work-related cervical condition had stabilized and she was able to return to gainful employment until her progressively worsening MS rendered her unable to do so. Therefore, Petitioner did not sustain her burden of proving that she was permanently and totally disabled as a result of the injuries caused by the work accident.

Therefore, I find that the opinions of Dr. Allen and Dr. Herman are more credible than Dr. Brayton's unsubstantiated opinion that Petitioner is permanently and totally disabled as a result of the work injury. Dr. Herman opined Petitioner sustained a disc herniation from the August 29, 2010, accident but it had been effectively treated and she was at maximum medical improvement with her return to work with 50/100 pound lifting restrictions imposed by Dr. Brayton in 2012, comporting with Dr. Allen's opinion. He further opined that as of May 2016 Petitioner was *not* capable of returning to work but because of the MS and not because of the work-related condition. (Rx2, 47-48, 60) Further, the off work notes provided by Dr. Santwani in 2014 for MS flare-ups are consistent with Dr. Herman's opinion that Petitioner could not work because of her MS, not her cervical condition.

Several Commission Decisions support the proposition that when a Petitioner is disabled from another medical condition(s) unrelated to the work accident, it is the Petitioner's burden to prove that she is entitled to an award of permanent and total disability for her work accident. See, *Hamilton v. A T & T*, 99 IIC1127, (Petitioner was diagnosed with carpal tunnel syndrome and she ultimately underwent bilateral carpal tunnel releases for her condition. Subsequent to her surgeries, Petitioner was diagnosed with left reflex sympathetic dystrophy and later with bilateral epicondylitis and fibromyalgia. Eventually Petitioner was diagnosed with sarcoidosis. In denying benefits, the Arbitrator found, and the Commission upheld, that Petitioner was taken off work completely due to an unrelated lung condition in February of 1997); *Tidemann v. Homes By Hemphill*, 09 IWCC 0330 (Commission reversed the Arbitrator's decision regarding permanent and total disability, finding that Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent, however that Petitioner failed to prove a causal connection between her work related injuries of August 14, 1989, and her current condition of ill-being with respect to her nose, left hip, right and left feet, and pre-existing rheumatoid arthritis and awarded permanency on the basis of §8(d)2 and §8(e)); and *Karen McCurrie v. Grove Dental*

Associates 09 IWCC 0050 (Commission upheld Arbitrator's denial of permanent and total disability award, where Petitioner had a compensable accident on December 10, 2002, which did aggravate an underlying condition in her lower back. She also had prior to that work accident complaints of headaches and chronic fatigue among other symptoms, which eventually were diagnosed in 2005 as fibromyalgia and chronic fatigue syndrome. In reviewing the treating records following the accident of December 10, 2002, the Arbitrator/Commission held that Petitioner's condition of ill-being about her lower back was related to the accident of December 10, 2002, but her prior and subsequent and present complaints diagnosed as fibromyalgia, chronic fatigue syndrome, and headaches are unrelated to the accident of December 10, 2002. While the Petitioner may very well be unable to work at the present time, that inability to work is related to the non-work related conditions of fibromyalgia, chronic fatigue syndrome, and headaches.)

Based on a careful review of the evidence, I would award Petitioner permanency on the basis of loss of use of a person-as-a whole under §8(d)2, for an aggravation of her non-operated pre-existing herniated cervical disc at C5-C6 and a slight disc bulge/herniation at C6-C7, resulting in permanent restrictions. Therefore, I respectfully dissent.



Kathryn A. Doerries

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DELLA DOWNING,

Petitioner,

20IWCC0657

vs.

NO: 11 WC 9902

DELNOR COMMUNITY HOSPITAL

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 causation, medical expenses, temporary total disability benefits, nature and extent, maintenance, and permanency 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 vacates the award of maintenance and strikes paragraph 2 of the Order section of the Arbitrator's Decision.

Additionally, the Commission replaces paragraph 3 of the Order section of the Arbitrator's decision with the following:

> Respondent shall pay Petitioner the reasonable and necessary unpaid medical expenses ($4,987.77) incurred for the cervical spine as identified in Px1, Px2, Px4, Px5, Px6, Px7, Px8, Px9, Px10, Px11, and Px12 pursuant to Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule.
>
> Respondent shall be given a credit for all medical benefits they have paid and Respondent shall hold Petitioner harmless for any claims by any medical providers for services for which Respondent is receiving this

> credit, as provided in Section 8(j) of the Act. Respondent shall further hold Petitioner harmless for any payments made by Medicare, Medicaid, Illinois Public Aid, and Illinois Department of Healthcare and Family Services relating to Petitioner's cervical issues. The measure of Respondent's liability is limited to the negotiated rate.

Lastly, the Commission strikes paragraph 4 of the Order section of the Arbitrator's decision and replaces it with the following:

> Respondent shall pay Petitioner permanent total disability benefits of \$1,080.12 per week commencing on January 20, 2016, as provided in Section 8(f) of the Act. Commencing on the Second July 15th after the entry of this Award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act. Respondent shall pay Petitioner compensation that has accrued from January 20, 2016 through June 8, 2018.

Regarding page 6 of 22 of the Arbitrator's decision, the Commission strikes the second sentence of the first paragraph. Referring to page 17 of 22 of the Arbitrator's decision, the Commission strikes the last paragraph of Section (J) in its entirety, and replaces it with the following:

> Respondent shall pay Petitioner the reasonable and necessary unpaid medical expenses (\$4,987.77) incurred for the cervical spine as identified in Px1, Px2, Px4, Px5, Px6, Px7, Px8, Px9, Px10, Px11, and Px12 pursuant to Sections 8(a) and 8.2 of the Act and subject to the medical fee schedule.
>
> Respondent shall be given a credit for all medical benefits they have paid and Respondent shall hold Petitioner harmless for any claims by any medical providers for services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall further hold Petitioner harmless for any payments made by Medicare, Medicaid, Illinois Public Aid, and Illinois Department of Healthcare and Family Services relating to Petitioner's cervical issues. The measure of Respondent's liability is limited to the negotiated rate.

Referring to the last paragraph under Section (K) at page 19 of 22 of the Arbitrator's decision, the Commission strikes the last two sentences of said paragraph. The Commission also strikes page 22 of the Arbitrator's decision.

Lastly, in the fourth sentence of the last paragraph at page 13 of 22 of the Arbitrator's decision, the Commission corrects a scrivener's error and revises "board-based" to "broad-based".

Petitioner met her burden of proving that her current condition of ill-being regarding her cervical spine is causally related to injuries sustained in the work accident of August 29, 2010, and that this condition has rendered her permanently and totally disabled.

The award of permanent total disability is supported by a consistent and continuing course of treatment relating to Petitioner's cervical spine from the time of the initial 19(b) hearing on June 9, 2011, through the date of trial. The evidence shows a progressive worsening of Petitioner's condition both symptomatically and per the objective diagnostic studies.

Following the 19(b) hearing, Petitioner continued treating with her neurosurgeon, Dr. Brayton, for her cervical spine condition (Px1), and at various pain clinics. (Px2, Px5, Px 10) Petitioner continued these visits up through the date of trial. (Px10)

In February 2012, Petitioner underwent another cervical MRI, the prior one having been performed on February 9, 2011. The MRI study of the cervical spine performed on February 16, 2012 revealed: "the posterior disc protrusion at C5-C6 is slightly more broad-based with the presence of an annular tear." (Px2)

On March 2, 2012 Dr. Brayton reviewed the MRI results and noted "the slight progression in the C5-C6 along with the pronounced annular tear explains some of her increased neck symptoms and pain. Increased facet arthropathy and inflammatory change of the MRI explains her (Petitioner) focal spine tenderness..." (Px1) However, as Dr. Brayton observed other findings requiring further explanation, he referred Petitioner to Dr. Santwani, a neurologist, for further testing.

In March 2012, Dr. Santwani diagnosed the Petitioner with multiple sclerosis. Significantly, Dr. Santwani also noted Petitioner's increased neck pain and arm paresthesias. (Px4) Petitioner makes no claim that her multiple sclerosis or treatment for same is related to the August 29, 2010 work accident.

Although Petitioner missed some of her appointments at the pain clinic between March and October 2012, she consistently continued to complain of neck and arm pain. By December 31, 2012, Petitioner was presenting with continued pain, worse in her neck and shoulders. (Px2) Through mid-2013 Petitioner continued to voice complaints and received treatment at the pain clinic for same. (Px2)

On May 28, 2013 Petitioner underwent an EMG/NCV of the upper extremities. This was an abnormal study indicating acute C5 radiculopathy on the right and C6 radiculopathy on the left. (Px4)

On May 30, 2013 Petitioner began treating at the pain clinic at Kishwaukee Hospital for chronic neck pain. History reflects the "pain began in August 2010 when she was lifting a patient." (Px5) She treated with Dr. Gregory Arnold at the clinic through 2013. (Px5) He diagnosed Petitioner with cervical radiculopathy, fibromyalgia syndrome and prescribed opioid therapy along with cervical trigger point injections. (Px5)

By the end of 2013, Petitioner switched pain management clinics as her insurance would no longer cover visits to Dr. Arnold and she began treating with Dr. Todd Hagle.

On December 26, 2013 Petitioner was seen by Dr. Hagle whose diagnosis included

chronic neck pain and at which time he noted "she has clear signs of cervical radiculopathy and timing of an injury which seems to be the cause of this." (Px10) Petitioner continued to see Dr. Hagle on a monthly basis with complaints of pain in her neck and into her arms ranging from 8/10 to 10/10. (Px10)

On February 10, 2014 Petitioner complained of pain in her neck, shoulders and arms. She noted the pain was "severe, chronic and disabling." (Px10)

An updated cervical MRI performed on February 25, 2014 revealed persistent multi-level degenerative findings and disc bulges with no significant change in previously noted small central C4-C5 disc protrusion and annular tear as well as right paracentral C5-C6 disc protrusion. (Px1)

In August 2014 Dr. Brayton related Petitioner's "severe, unremitting neck pain and cervicogenic headaches" to the work injury. (Px1)

A repeat cervical MRI performed on August 1, 2014 revealed a C4-C5 central disc protrusion and C5-C6 right paracentral disc protrusion. (Px7)

On October 22, 2014 Petitioner underwent provocative discography ordered by Dr. Brayton resulting in a positive provocation discogram at C4-C5 and C5-C6. (Px8)

On December 29, 2014 Dr. Hagle noted Petitioner's persistent chronic neck and upper extremity pain secondary to cervical stenosis. Throughout 2015 Petitioner continued to see Dr. Hagle on a monthly basis to refill her pain medications. (Px10)

On December 29, 2014 Dr. Neil Allen conducted a medical records review at the Respondent's request. He did not examine Petitioner on this date. Although Dr. Allen opined Petitioner's current state of ill-being was related to multiple sclerosis, even he related Petitioner's upper extremity pain and in the back of her neck to the work injury. (Rx1)

On February 12 ,2015 Dr. Brayton met with Petitioner to review the results of the provocative discogram, the last MRI and to discuss further treatment options.

At the time of this visit, Dr. Brayton noted Petitioner had sustained a work injury on August 29, 2010 leading to a cervical disc herniation at C5-C6 followed by progressive spondylitic changes at C4-C5 and C5-C6. (Px1) Dr. Brayton also noted Petitioner had been diagnosed with multiple sclerosis and had dysesthetic pain in both the lower and upper extremities. (Px1) Discography revealed strongly positive concordant pain at C4-C5 and C5-C6 with a negative control level at C6-C7. The MRI revealed a progressive large, broad-based annular bulge at C5-C6 combined with a posterior vertebral body and uncovertebral joint osteophytes which had progressed since her last imaging study. (Px1) There was also an increase in the annular bulge and ventral CSF effacement at C4-C5 and modest spondylitic change of a left-sided uncovertebral joint osteophyte at C6-C7. It was Dr. Brayton's impression that Petitioner was experiencing persistent pain attributable to the C5-C6 injury with a strongly positive concordant provocative discogram at C4-C5 as well as progressive changes at C4-C5.

(Px1)

In terms of future treatment, among options discussed were surgical intervention involving a C4-C5 anterior cervical decompression and fusion including the risk of accelerated spondylitic changes at C6-C7. (Px1) Petitioner chose to defer surgery and continue with pain management.

On February 26, 2015 Petitioner was evaluated by Dr. Allen at Respondent's request. Dr. Allen included the "cowl-like discomfort she has over her shoulder" as part of Petitioner's current state of ill-being. (Rx1) Dr. Allen also conceded that the decrease in pin-prick to both upper extremities and the cowl of her shoulders was consistent with Petitioner's work injury. (Rx1, p. 73) Dr. Allen also referenced a cervical MRI Petitioner underwent specifically indicating an early annular tear at C4-C5 which he testified explained neck pain. Dr. Allen also testified annular tears are very painful and some people are actually confined to bed with annular tears. (Rx1, p. 23) Dr. Allen also acknowledged that he never reviewed the discogram of Petitioner's cervical spine as he didn't understand them, was never trained in them and has a hole in his knowledge. (Rx1, pp. 88-89)

On January 21, 2016 Petitioner saw Dr. Brayton who noted Petitioner "continues to be disabled by pain requiring high-dose narcotic analgesics, procedural pain treatment, and recumbency for alleviation of her neck pain, scapular pain and cervicogenic headaches." Dr. Brayton opined these conditions were caused by her work accident on August 29, 2010 and were conditions distinct from her multiple sclerosis. (Px1)

Dr. Brayton further noted cervical disc herniation persists at C5-C6 and had not healed or improved. There was ventral effacement of the canal, anterior CSF space and neural foramina. (Px1) Disc disease was noted at the C2 through C4 levels which he deemed permanent. (Px1)

Overall, it was Dr. Brayton's opinion that Petitioner had a permanent disc injury at C5-C6. Considering Petitioner's concurrent multiple sclerosis diagnosis, Dr. Brayton was not in favor of surgery given the potential for flare-up caused by surgical stresses as well as adjacent segment disease which may be caused to be progressive by the cervical fusion needed at C5-C6. (Px1) Dr. Brayton cautioned that surgery remained a future potential need but presently, he would advocate against surgery.

Dr. Brayton further indicated Petitioner would require "comprehensive and procedural pain management, chronic pain control and permanent disability as a consequence to her injury." (Px1)

Dr. Brayton determined Petitioner was "permanent disability" and issued a script dated January 21, 2016 indicating "permanent work restrictions of no lifting, frequent breaks with recumbency, high-dose narcotic pain meds all prohibit work/gainful employment – permanent." (Px1)

In May 2016 Petitioner underwent a second Section 12 exam by Dr. Martin Herman at Respondent's request. Dr. Herman opined Petitioner sustained a disc herniation as a consequence

of the August 29, 2010 accident but it had been effectively treated and she was at maximum medical improvement subsequent to her return to work with restrictions issued by Dr. Brayton. He further opined that in May 2016 Petitioner was *not* capable of returning to work but related same to the multiple sclerosis and not the work-related injuries. (Rx2, pp. 47-48, 60)

Dr. Herman failed to review films of the MRIs Petitioner underwent on February 16, 2012, May 5, 2013, August 1, 2014, January 21, 2015 and December 3, 2015, and the discogram performed on August 20, 2014. (Rx2, pp. 30-31) Dr. Herman also acknowledged that Petitioner's condition was multi-factorial. (Rx2, p. 43)

Petitioner continued to refill her pain medications with Dr. Hagle throughout 2016, 2017, and 2018. (Px10) She has continued to complain of neck pain radiating into her arms, as well as tingling and numbness. (Px10)

An accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. *Sisbro v. Industrial Comm'n*, 207 Ill.2d 193, 205 (2003) *citing Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d 123, 127 (1967).

Notwithstanding Petitioner's ability to return to restricted work at various times subsequent to the work accident, Petitioner's work-related cervical condition continued to gradually worsen both in terms of the severity of her symptoms and as confirmed by multiple diagnostic tests.

Given the totality of the evidence, the Commission finds Petitioner's work-related cervical spine condition was a contributory cause in rendering her permanently and totally disabled. The Commission further finds Petitioner was permanently and totally disabled commencing on January 21, 2016 based on Dr. Brayton's opinion of permanent disability rendered on said date.

Additionally, the Commission vacates the award for maintenance benefits. Having found Petitioner was permanently and totally disabled effective January 21, 2016, the issue of Petitioner's entitlement to maintenance benefits subsequent to that date is moot.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,080.12 per week for a period of 169 1/7 weeks, commencing June 10, 2011 through August 11, 2011; May 21, 2012 through September 19, 2013; and May 5, 2014 through January 20, 2016, 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 $1,080.12 per week for life commencing on January 20, 2016, as provided in §8(f) of the Act, for the reason that the injuries sustained caused the Petitioner to be permanently disabled. Commencing on the second July 15th after the entry of this award, Petitioner may

20IWCC0657

become eligible for cost-of-living adjustments, paid by the rate adjustment fund, as provided in §8(g) of the Act.

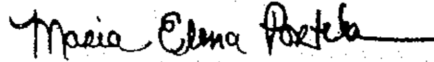
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the reasonable and necessary unpaid medical expenses ($4,987.77) incurred for the cervical spine as identified in Px1, Px2, Px4, Px5, Px6, Px7, Px8, Px9, Px10, Px11, and Px12 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. 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: NOV 12 2020



Maria E. Portela

Thomas J. Tyrrell

MEP/dmm
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOWNING, DELLA Case# **11WC009902**
Employee/Petitioner

DELNOR COMMUNITY HOSPITAL **20IWCC0657**
Employer/Respondent

On 8/10/2018, 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 2.18% 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:

1876 CZAPLA LAW
EDWARD A CZAPLA
1821 WALDEN OFFICE SQ STE 400
SCHAUMBURG, IL 60173

2965 KEEFE CAMPBELL & ASSOC LLC
SHAWN R BIERY
118 N CLINTON STE 300
CHICAGO, IL 60661

20IWCC0657

STATE OF ILLINOIS)

)SS.

COUNTY OF DUPAGE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ XXNone of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DELLA DOWNING
Employee/Petitioner

Case # **11** WC **9902**

v.

Consolidated cases:

DELNOR COMMUNITY HOSPITAL
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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Wheaton** , on **6/8/18**. 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

FINDINGS

On **8/29/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$84,249.36**; the average weekly wage was **$1,620.18**.

On the date of accident, Petitioner was **36** 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

1. RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $1,080.12/WEEK FOR 169 1/7 WEEKS, COMMENCING JUNE 10, 2011 THROUGH AUGUST 11, 2011; MAY 21, 2012 THROUGH SEPTEMBER 19, 2013; AND MAY 5, 2014 THROUGH JANUARY 20, 2016, AS PROVIDED IN SECTION 8(b) OF THE ACT.

2. RESPONDENT SHALL PAY PETITIONER MAINTENANCE BENEFITS OF $1,080.12/WEEK FOR 124 AND 1/7 WEEKS, COMMENCING JANUARY 21, 2016 THROUGH JUNE 7, 2018, AS PROVIDED IN SECTION 8(a) OF THE ACT.

3. RESPONDENT SHALL PAY PETITIONER THE REASONABLE AND NECESSARY MEDICAL EXPENSES INCURRED FOR THE CERVICAL SPINE AS IDENTIFIED IN PX.1., PX.2, PX.4, PX.5, PX.6, PX.7, PX.8, PX9, PX 10, PX.11, PX.12, PURSUANT TO SECTION 8 (A) AND 8.2 OF THE ACT AND SUBJECT TO THE MEDICAL FEE SCHEDULE.

4. **RESPONDENT SHALL PAY PETITIONER PERMANENT AND TOTAL DISABILITY BENEFITS OF $1,080.12/WEEK FOR LIFE, COMMENCING ON JUNE 8, 2018, AS PROVIDED IN SECTION 8(f) OF THE ACT. COMMENCING ON THE SECOND JULY 15TH AFTER THE ENTRY OF THIS AWARD, PETITIONER MAY BECOME ELIGIBLE FOR COST-OF-LIVING ADJUSTMENTS, PAID BY THE RATE ADJUSTMENT FUND, AS PROVIDED IN SECTION 8(g) OF THE ACT. RESPONDENT SHALL PAY PETITIONER COMPENSATION THAT HAS ACCRUED FROM 8/29/10 THROUGH 6/8/18, 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.

KSSteffen **July 28, 2018**

Signature of Arbitrator Date

AUG 10 2018

PROCEDURAL HISTORY

On June 9, 2011, a prior 19(b) Petition for Immediate Hearing was heard before an Arbitrator. The Arbitrator found that Petitioner's current condition was causally related to her undisputed work accident of August 29, 2010. Specifically, Petitioner was found to have sustained a new disc herniation of C6/7 and aggravation of a pre-existing herniated disc at C5/6. (Arbitrator Ex.2) Petitioner was awarded temporary total disability benefits commencing September 10, 2010 through November 11, 2010; February 3, 2011 through February 4, 2011; February 27, 2011 through March 10, 2011; March 12, 2011 through March 16, 2011; and March 19, 2011 through the June 9, 2011 19(b) hearing. (Arbitrator's Ex. 2) The Arbitrator determined Petitioner had not reached maximum medical improvement and was entitled to further medical treatment with Dr. Brayton (Arbitrator's Ex.2).

The Arbitrator's 19(b) decision was affirmed and adopted by the Commission on August 2, 2012 (Arbitrator's Ex.2) A transcript of the 19(b) hearing was admitted into evidence. (Arbitrator's Ex.2)

On June 8, 2018, the matter was heard by the Arbitrator Ketki Steffen. The issues of accident, notice and causation were previously decided Petitioner stipulated that there was no claim for multiple sclerosis attributable to the August 29, 2010 accident at work.

Unpaid medical charges and unpaid lost time in the form of TTD and maintenance were alleged at hearing along with the request for a finding related to Nature & Extent if the Arbitrator were to agree that the evidence presented supports a finding of Petitioner having reached a state of Maximum Medical Improvement. Petitioner alleged odd-lot permanent disability applies in regard Nature & Extent.

Petitioner further stipulated that Respondent was entitled to a credit pursuant to Section 8(j) of the Act for any payment of Petitioner's medical expenses. Respondent's counsel acknowledged that he was not disputing Petitioner's claim for permanent total disability benefits pursuant to Section 8(f) of the Act.

FACTUAL HISTORY

Petitioner is a licensed nurse and had worked in that capacity at the time of her accident on August 29, 2010 when sustained a new disc herniation of C6/7 and aggravation of a pre-existing herniated disc at C5/6.

The following history entails the medical and other relevant facts after the prior 19B/8A hearing and decision:

On July 14, 2011 Petitioner telephoned Dr. Brayton complaining of left and right arm numbness and pain. (PX.1.) Dr. Brayton's August 1, 2011 office note reflects Petitioner "called in req release to work still has neck and arm SX but must RTW due to financial situation." (PX.1) Dr. Brayton released Petitioner back to work at her request with a 10-pound lifting restriction and no excessive pushing/pulling (PX.1.)

On August 12, 2011 Petitioner went to work at Loretto Hospital as a nursing supervisor. Petitioner worked full-time until May 20, 2012 when she was terminated. The nursing staff unionized and Petitioner lost her job.

Petitioner continued to experience radiating neck pain and was referred by Dr. Brayton to the Delnor Hospital pain clinic for a series of cervical epidural steroid injections. (PX.1.) Dr. Yang examined Petitioner on August 10, 2011 and noted Petitioner's neck pain radiating to her bilateral upper extremities (PX.2.) Petitioner complained of numbness in all 5 fingers on both hands. Dr. Yang reviewed the

February 9, 2011 cervical MRI which showed a C5-C6 right sided paracentral disc herniation, C4-C5 small disc protrusion and C6-C7 disc bulge. (PX.2.) Petitioner was diagnosed with cervical radiculopathy, secondary to spinal stenosis, cervical degenerative disc disease with overlying myofascial pain. (PX.2.)

On August 17, 2011 Petitioner received the first of a series of cervical epidural steroid injections at Delnor Hospital. Dr. Hanna prescribed Vistaril, Zanaflex and Norco for Petitioner's cervical pain. (PX.2)

On October 21, 2011, Dr. Hanna prescribed a Duragesic patch for Petitioner's cervical pain and Petitioner received trigger point injections to the bilateral scapular and a second cervical epidural steroid injection. (PX.2) On November 9, 2011, Petitioner received a third cervical epidural steroid injection and bilateral scapular trigger point injections. (PX.2.)

Petitioner returned to see Dr. Hanna on December 12, 2011, complaining of increasing neck pain. While Petitioner reported pain relief with the injections and Duragesic patch she continued to experience muscle spasms along the neck, upper shoulders and lots of right arm pain. (PX.2.) Dr. Hanna continued to prescribe Norco, Zanaflex, Vistaril along with the Duragesic patch for Petitioner's chronic neck pain and cervical radiculitis. (PX.2.) Petitioner received 5 trigger point injections to the scapula, trapezius and cervical paraspinal muscle.

Petitioner saw Dr. Hanna on February 15, 2012 complaining of *"worsening neck pain down both arms with numbness and tingling into the hands."* (PX.2.) Dr. Hanna refilled Petitioner's Duragesic patch, Norco, and Zanaflex. Petitioner received bilateral trigger point injections to the trapezius and levator scapula for her myofascial pain. (PX.2.)

MRI study of the cervical spine performed on February 16, 2012 revealed:

"The posterior disc protrusion at C5-C6 is slightly more broad based with the presence of an annular tear." (PX.2.)

Dr. Brayton reviewed the MRI results with Petitioner on March 2, 2012 and noted *"the slight progression in the C5-C6 disc along with the more pronounced annular tear explains some of her increased neck symptoms and pain. The increased facet arthropathy and inflammatory change of the MRI explains her (Petitioner) focal cervical spine tenderness, but it certainly does not explain her pathologic reflexes, hyperreflexia, Clonus and Babinski signs."* (PX.1) Petitioner was referred to Dr. Santwani, a neurologist, for electrophysiologic testing.

Dr. Santwani performed a number of tests including a lumbar puncture and spinal tap and ultimately diagnosed Petitioner with multiple sclerosis. (PX.4.) Petitioner stipulated at the onset of the hearing that treatment for the multiple sclerosis was unrelated to her August 29, 2010 injury at work.

Dr. Hanna continued to refill Petitioner's narcotic pain medications throughout 2012. (PX.2,3) Dr. Hanna noted on December 31, 2012 that the *"pain was severe with significant impact on functions and quality of life."* (PX.2.) Petitioner returned to Dr. Hanna on February 25, 2013 "*complaining of worsening pain in her fingertips, with neck pain across both shoulders, radiating down both of her arms with spasms on 9-10-out of 10 in severity, constant numbness and tingling into the arms."* (PX.2.) Dr. Hanna continued the narcotic pain treatment.

Cervical MRI study performed on May 5, 2013 revealed:
C4-C5 small central disc protrusion with minimal early annular tear;

C5-C6 disc desiccation and mild loss of disc height with broad-based central right paracentral disc protrusion which moderately indents the ventral sac with the associated central annular tear; and C6-C7 small lateral spurs.

Petitioner's last treatment with Dr. Hanna was May 13, 2013. Petitioner's insurance changed and she needed to switch to a pain physician in her network. Petitioner's medications were refilled and she was referred by her primary care physician, Dr. Branshaw, to Kishwaukee Hospital for pain management. (PX.2.)

On May 30, 2013, Petitioner presented to the pain clinic at Kishwaukee Hospital for her chronic neck pain. History reflects the *"pain began in August 2010 when she was lifting a patient".* (PX.5.) Petitioner described the pain as aching, burning, constant, numb, pressure, radiating, sharp, squeezing, tingling, and tiring. Petitioner successfully underwent an opioid assessment to determine if she was an appropriate candidate for continued opioid therapy. (PX.5.) On June 12, 2013, Dr. Gregory approved long term opioid therapy and prescribed the Fentanyl Duragesic patch and Norco for breakthrough pain. (PX.5.)

Petitioner treated with Dr. Gregory at the Kishwaukee Pain Clinic throughout 2013. (PX.5.) He diagnosed Petitioner with cervical radiculopathy and fibromyalgia syndrome. On August 8, 2013, Petitioner received 4 cervical trigger point injections for her neck pain. (PX.5.) Patient reported that off of opioid medications she is not able to get out of bed and function, but with the medications, she is able to function. (PX.5.)

On September 20, 2013, Petitioner went to work as a *"floating"* nurse at the DuPage Convalescent Center. Petitioner testified she worked there through May 4, 2014 when she was let go because of missing work.

On October 31, 2013, Dr. Gregory noted that Petitioner's pain has been worse since she has been back to work. (PX.5.) Dr. Gregory continued to prescribe the

Duragesic patch and Norco. In December 2013, Petitioner had to switch pain management physicians because of insurance coverage.

On December 26, 2013, Petitioner saw Dr. Todd Hagle for her chronic neck and back pain. (PX.10) Petitioner was referred to Dr. Hagle, a pain management anesthesiologist, by Dr. Branshaw. Dr. Hagle diagnosed Petitioner with chronic neck and back pain and noted *"she has clear signs of cervical radiculopathy and timing of an injury which seems to be the cause of this."* (PX.10) Dr. Hagle initially prescribed Lyrica and Baclofen for Petitioner's neck pain but she experienced side effects with Lyrica and it was discontinued. Thereafter, Dr. Hagle prescribed the Duragesic patch, Norco and Baclofen for Petitioner's neck pain. (PX.10)

Petitioner treated with Dr. Hagle on a monthly basis for her chronic neck pain. On February 10, 2014, Petitioner complained of pain in her neck, shoulders, and arms. Petitioner noted the pain was *"severe, chronic and disabling."* (PX.10) Dr. Hagle continued to prescribe the Duragesic patch, Baclofen and Norco for Petitioner's neck pain. Dr. Hagle's May 12, 2014 office note states ***"she*** (Petitioner) ***lost her job recently due to many falls/sick days."*** (PX.10)

A February 25, 2014 cervical MRI revealed persistent multilevel degenerative findings and disc bulges with no significant change in previously noted small central C4-C5 disc protrusion and annual tear as well as right paracentral C5-C6 disc protrusion. (PX.1.)

Petitioner returned to Dr. Brayton on August 14, 2014 to discuss the recent MRI findings. Dr. Brayton noted that while recovering from her cervical disc herniation she was diagnosed with multiple sclerosis. Petitioner complained of severe painful dysesthesias in her arms and legs as well as severe unremitting neck pain and

cervicogenic headaches. (PX.1.) Dr. Brayton noted Petitioner has persistent pain associated with her work injury causing a C5-C6 disc herniation. (PX.1.) Dr. Brayton ordered provocative discography at C5-C6 which was performed at Kendall Pointe Surgery Center on October 22, 2014. Discography demonstrated posterior bilateral cervical pain at C4-C5 and C5-C6. (PX.8.) Petitioner continued to see Dr. Hagle on a monthly basis to refill her pain medications.

An August 1, 2014 cervical MRI revealed a C4-C5 central disc protrusion and C5-C6 right paracentral disc protrusion. (PX.7.)

On December 29, 2014, Dr. Hagle noted Petitioner's persistent chronic neck and upper extremity pain secondary to cervical stenosis. Petitioner was also experiencing diffuse pain secondary to her multiple sclerosis. Petitioner continued to see Dr. Hagle on a monthly basis throughout 2015 to refill her pain medications. (PX.10)

Dr. Brayton discussed the results of the discogram with Petitioner on February 12, 2015. He noted at that time that Petitioner had incurred a work injury on August 29, 2010 leading to a cervical disc herniation at C5-C6 followed by progressive spondylitic change at C4-C5 and C5-C6. (PX.1.) Dr. Brayton further noted that Petitioner had been diagnosed with multiple sclerosis and had dysethetic pain in the upper and lower extremities. (PX.1.) Discography revealed strongly positive concordant pain at C4-C5 and C5-C6. MRI revealed a progressive, large, broad based annular bulge at C5-C6 combined with a posterior vertebral body and uncovertebral joint osteophytes which have progressed since her last imaging study. (PX.1.) There was also an increase in the annular bulge and central CFS effacement at C4-C5 and modest spondylitic change of a left-sided uncovertebral joint osteophyte at C6-C7. It was Dr. Brayton's impression that Petitioner was experiencing persistent pain attributable to the C5-C6 injury with a

strongly positive concordant provocative discogram at C4-C5 as well as progressive changes at C4-C5. (PX.1.) Surgical intervention involving a C4-C5 anterior cervical decompression and fusion with plating was discussed including the risk of accelerated spondylitic changes at C6-C7. (PX.1.) Petitioner wished to defer surgery and continue with pain management.

Petitioner continued to refill her pain medications with Dr. Hagle on a monthly basis throughout 2015. (PX.10) Petitioner was awarded Social Security Disability benefits in 2015. MRI of the cervical spine completed on December 3, 2015 revealed no significant interval change.

Petitioner returned to Dr, Brayton on January 21, 2016 to discuss the MRI results. Dr. Brayton noted that Petitioner *"continues to be disabled by pain requiring high-dose narcotic analgesics, procedural pain treatment, and recumbency pain, and cervicogenic headaches. These are caused by her work injury which is a separate condition from her M.S."* Examination revealed continued myelopathy with spasticity in both upper extremities. Cervical disc herniation persists at C5-C6 and has not healed or improved. There was ventral effacement of the canal, anterior CSF space and neural foramina. (PX.1.) There were also disc disease at C2-C3 and C3-C4 which is permanent. (PX.1.)

Dr. Brayton noted that *"overall it appears the patient has a permanent disc injury at C5-C6 I would favor against surgery given the concurrent diagnosis of MS and the potential for flare-up caused by surgical stresses as well as adjacent segment disease which may be caused to be progressive by the surgical fusion needed at C5-C6." (PX.1.)* Dr. Brayton further noted that Petitioner *"will need comprehensive and procedural pain management, chronic pain control, and permanent disability as a*

consequence to her injury." (PX.1.) Petitioner was issued ***"Permanent work restrictions of no lifting, frequent breaks, with recumbency, high-dose narcotic pain meds all prohibit work/gainful employment – permanent."*** (PX.1.)

Petitioner refilled her pain medications with Dr. Hagle throughout 2016. (PX.10.) A follow-up cervical MRI performed at Kishwaukee Hospital on November 23, 2016 revealed some mild degenerative changes at C5-C6. (PX.10)

Petitioner continued to refill her pain medications with Dr. Hagle throughout 2017 and 2018. (PX.10). On January 16, 2017 Dr. Hagle stated *"I don't have much I can help or offer Della if she doesn't want to consider interventional therapy in the form of CESI or medial branch blocks." (PX.10).* Dr. Hagle continued to fill Petitioner's prescription for Norco, Baclofen and the Fentanyl patch. (PX.10) MRI of cervical spine performed on March 26, 2018 revealed a small central protrusion of the disc at C2-C3 contributing to the mild central canal stenosis and a small board-based central disc protrusion and mild osteoarthritis at C5-C6. (PX.10) Based upon the new MRI findings and Petitioner's persistent headaches and chronic neck pain Dr. Hagle recommended a cervical epidural steroid injection to relieve Petitioner's inflammatory radicular pain. (PX.10) Petitioner received the C7-T1 injection on June 1, 2018.

FINDINGS/ANALYSIS

WITH RESPECT TO ISSUE (F) IS THE PETITIONER'S CURRENT CONDITION OF ILL-BEING OF THE CERVICAL SPINE CAUSALLY RELATED TO THE AUGUST 29, 2010 INJURY AT WORK, THE ARBITRATOR FINDS AS FOLLOWS:

The Commission affirmed and adopted the Arbitration Decision and Findings that Petitioner's current condition of the cervical spine causally related to her undisputed work accident of August 29, 2010, having sustained a new herniation of C6/7 and aggravation of a pre-existing herniated disc at C5/6. (Arbitrator's Ex. 2.) Respondent does not dispute the causal relationship between Petitioner's cervical spine and the injury at work. However, Respondent denies that Petitioner's multiple sclerosis is causally related to the August 29, 2010 injury at work. Petitioner stipulated at the onset of the hearing that she was not making any claim relating to multiple sclerosis diagnosis and that her claimed injuries were confined to the cervical spine.

The Arbitrator notes that Petitioner has consistently sought medical treatment for her cervical spine through the June 9, 2011 19(b) hearing. The treating medical records admitted into evidence document Petitioner's chronic neck pain and bilateral cervical radiculopathy resulting from her August 29, 2010 injury at work. Dr. Brayton noted on February 12, 2015 that Petitioner had incurred a work injury on August 29, 2010 leading to a cervical disc herniation at C5-C6 followed by progressive spondylitic change at C4-C5 and C5-C6. (PX.1.) Discogram revealed concordant pain at C4-C5 and C5-C6 consistent with the MRI findings which demonstrate a progressive, large, broad based annular bulge at C5-C6, annular bulge at C4-C5 and continued spondylitic changes at C6-C7. (PX.1.)

On January 21, 2016, Dr. Brayton noted that Petitioner *"continues to be disabled by pain requiring high-dose narcotic analgesics, procedural pain treatment, and recumbency for alleviation of her neck pain, scapular pain, and cervicogenic headaches. These are caused by her work injury which is a separate condition from her MS"* (PX.1.)

The Arbitrator has carefully reviewed and considered all medical evidence along with the credible testimony of the Petitioner. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she sustained injury to her cervical spine which is causally related to the August 29, 2010 accident at work. It is undisputed that Petitioner injured her cervical spine lifting a patient at work. The Commission previously found that Petitioner sustained a disc herniation at C6-C7 and aggravation of a pre-existing herniated disc at C5-C6. (Arbitrator's Ex. 2) The medical records clearly document that progression of Petitioner's cervical disc disease which include permanent disc disease at C2-C3, C3-C4, and C4-C5. (PX.1.)

The Arbitrator finds the opinions of Dr. Brayton, a neurosurgeon, to be credible and persuasive. Moreover, the Petitioner credibly testified to the progression of her symptoms associated with her cervical disc disease. The Arbitrator finds it significant that Petitioner sustained no subsequent trauma to her cervical spine after the August 29, 2010 injury at work. Therefore, based upon the credible medical evidence along with Petitioner's uncontradicted testimony, the Arbitrator finds that the current condition of Petitioner's cervical spine is causally related to the August 29, 2010 accident at work. Additionally based on the testimony of Dr. Allen (RX.1.) and Dr. Herman (RX.2.), the Arbitrator finds that Petitioner's multiple sclerosis is not related to the August 29, 2010 accident at work.

The Arbitrator further finds that the lower back and any care related to the multiple sclerosis diagnosis, or any other diagnoses unrelated to the cervical spine condition is specifically determined to have no causal connection to the work injury alleged and awarded.

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 having found that Petitioner's current condition of the cervical spine is causally related to the August 29, 2010 accident at work further concludes that Petitioner has proven by a preponderance of the evidence that the medical treatment Petitioner received for her cervical spine was reasonably required to diagnose, treat, relieve and cure Petitioner from the effects of her cervical injuries and the medical services are causally related to her work injury. Respondent shall pay Petitioner all the reasonable and necessary medical services related to treatment of the cervical spine as contained in Petitioner's Exhibits No. 1, 2, 4, 6,7,8,9, 10, 11 and 12 (listed below), as provided in Section 8(a) and 8.2 of the Act, and subject to the medical fee schedule. Respondent shall be given a credit for all medical benefits that have been paid and Respondent shall hold Petitioner harmless for any claims by any medical providers for services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner's Medical Exhibits

- PX1-Neurosurgery and Spine Surgery Dr. Brayton--$0.00 per statement
- PX2-Delnor Hospital--$0.00 per statement

- PX4-Suburban Neurology Group--$1,699.42 total which includes $423.81 for 2012 codes 99215($145.71) & 99255($278.10); $707.79 for 2013 codes 95886(POC53.2=$148.96 x 2) & 95910(POC53.2=$308.03) & 99214($101.84); and $567.82 for 2014 codes 99213($67.02) & 99232($91.85 x 3) & 99254($225.25).
- PX6-Kishwaukee Hospital--$0.00 per statement
- PX7-Center for Diagnostic Imaging--$0.00 per statement
- PX8-Kendall Pointe Surgery Center--$1,478.49 for 2014 code 62291 ($490.82 x 3)
- PX9-Interventional Pain Specialists--$1,701.68 for 2014 code 62291($490.82), code 72285($837.20), code 77003($218.26), code 99144($81.11), & code 99202($74.29)
- PX10-APAC Centers for Pain Management—$108.18 for 2018 code 99214
- PX11-Fox Valley Medical Associates/Dr. Branshaw--$0.00 per statement
- PX12-Tri City Radiology--$0.00 per statement

In conclusion, $4,987.77 is awarded per Fee Schedule with regard to the exhibits entered into evidence in conjunction with the findings related to causal connection for cervical issues only.

WITH RESPECT TO ISSUE (K) WHAT TEMPORARY BENEFITS ARE IN DISPUTE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner continued to be restricted from all work activities following the June 9, 2011 19(b) hearing. Respondent continued to deny Petitioner's weekly TTD benefits. Consequently, on August 1, 2011, Petitioner requested Dr. Brayton release her back to work with a 10 # lifting restriction and no excessive pushing/pulling. (PX.1.) Petitioner testified that she went to work for Loretto Hospital as a nursing supervisor on August 12, 2011. Petitioner worked full time until she was fired on May 20, 2012.

From May 21, 2012 through September 19, 2013, Petitioner remained unemployed and restricted to 10# lifting with no excessive pushing/pulling. Petitioner testified she looked for work as a nursing supervisor. On September 20, 2013 Petitioner went to work as a *"floating"* nurse at the DuPage Convalescent Center. Petitioner testified she worked there through May 4, 2014 when she was terminated for missing work. Dr. Hagle's May 12, 2014 office note states "**she lost her job recently due to too many falls/sick days.**" (PX.10) Petitioner has not worked since that time despite looking for a nursing supervisor position. Petitioner was awarded SSDI benefits in 2015.

On January 21, 2016, Dr. Brayton issued Petitioner the following permanent work restrictions:

"No lifting, frequent breaks with recumbency, high-dose narcotic pain meds all prohibit work/gainful employment – permanent" (PX.10)

Dr. Brayton wrote a script stating this was a ***"permanent disability".*** (PX.10)

Petitioner seeks temporary total disability benefits from June 10, 2011 through August11, 2011; May 21, 2012 through September 19, 2013; and May 5, 2016 through January 20, 2016. When a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized (i.e., whether the claimant has reached maximum medical improvement). Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill. 2d 132,142; 923 N.E.2d 266, 271; 337 Ill. Dec. 707 (2010). The Arbitrator notes that Respondent previously terminated Petitioner on May 7, 2011 and denied her claim for temporary total disability benefits.

Therefore, based on the medical evidence presented at trial along with Petitioner's credible testimony, the Arbitrator finds that Petitioner's condition had not

stabilized and finds that Petitioner is entitled to temporary total disability benefits of $1,080.12 /week for 10 and 1/7 weeks commencing June 10, 2011 through August 11, 2011; 64 and 4/7 weeks commencing May 21, 2012 through September 19, 2013; and 89 3/7 weeks commencing May 5, 2014 through January 20, 2016.

Furthermore, the Arbitrator finds that Petitioner reached maximum medical improvement on January 21, 2016 when Dr. Brayton determined Petitioner was ***"permanent disability*** *as a consequence to her injury"* and issued her permanent work restrictions prohibiting her from gainful employment. (PX.10). Petitioner's subsequent demand for permanent total disability benefits pursuant to Section 8(f) of the Act was ignored by Respondent. (PX.13) Therefore, the Arbitrator finds that Petitioner is entitled to maintenance benefits of $1,080.12/week for 124 and 1/7 weeks commencing on January 21, 2016 through the date of the hearing.

WITH RESPECT TO ISSUE (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY AND ISSUE (O) Other §8(f) PTD BENEFITS, THE ARBITRATOR FINDS AS FOLLOWS:

Section 8(f) of the Workers' Compensation Act provides in part:

> *In case of complete disability, which renders the employee wholly and permanently incapable of work, or in the specific case of a total permanent disability as provided in subparagraph 18 of paragraph e of this Section, compensation shall be payable at the rate provided in paragraph 2 of paragraph (b) of this Section for Life. (820 ILCS 305/8(f))*

Therefore, a Petitioner is entitled to permanent total disability benefits where there is evidence of **"complete disability which renders the employee wholly and permanently incapable of work."** An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of

wages to him. A.M.T.C. of Illinois v. Industrial Commission, 77 Ill.2d 482,487 (1979). Thus, a Petitioner is entitled to permanent total disability benefits if there is medical proof to establish that he cannot work. Continental Drilling Co. v. Industrial Commission, 155 Ill.App.3d 1031, 508 N.E.2d 1246 (5th Dist. 1987).

It is undisputed that Petitioner injured her cervical spine lifting a patient at work on August 29, 2010 sustaining an aggravation of a pre-existing herniated disc at C5-C6 and a new disc herniation C6-C7. (Arbitrator's Ex. 2) The condition of Petitioner's cervical spine continued to progress and has led to permanent disc disease at C2-C3, C3-C4, and C4-C5. (PX.1.) Cervical fusion surgery was discussed with Dr. Brayton who believes the risk is too great considering Petitioner's MS and the potential for flare-up caused by the surgical stress. (PX.1.)

Petitioner continues to receive opioid therapy treatment for her chronic neck pain. On January 21, 2016 Dr. Brayton noted *"she continues to be disabled by pain requiring high-dose narcotic analgesics, procedural pain treatment and recumbency for alleviation of her neck pain, scapular pain, and cervicogenic headaches."*. (PX.1.) Dr. Brayton further noted that ***"She will need comprehensive and procedural pain management, chronic pain control, and permanent disability as a consequence to her injury."*** (PX.1.)

Dr. Brayton determined Petitioner was ***"permanent disability"*** and issued a written script along with ***"permanent work restrictions of no lifting, frequent breaks with recumbency, high dose narcotic pain meds all prohibit work/gainful employment – permanent".*** (PX.1.)

Thereafter, Petitioner requested permanent total disability benefits pursuant to Section 8(f) of the Act. (PX.13) Respondent failed to issue Petitioner's permanent total

disability benefits or prepare a written vocational assessment as required under Section 7110.10 of the Rules Governing Practice before the Industrial Commission.

Petitioner testified she continues to receive the Fentanyl patch along with Norco and Baclofen for her chronic and disabling neck pain. Petitioner sees Dr. Hagle on a monthly basis for her narcotic pain medications. Petitioner testified she experiences muscle spasms across the neck and top of the scapula (paraspinal spasms) on a daily basis. She has pain and stiffness in both arms with ongoing radiculopathy that causes numbness in all five fingers in both hands. Petitioner testified the neck pain *"affects her entire life"*.

Petitioner testified she no longer cooks or performs household activities and relies on her husband and sons to do most of the housework. Petitioner is unable to work in the yard or perform any overhead activities. Petitioner testified she spends most of her time in a recumbent position and lives in her bedroom. Petitioner eats her meals in her bedroom, where she watches TV and can access her computer. Petitioner testified her daily pain level is 6 out of 10.

Therefore, based upon the medical evidence presented at trial along with Petitioner's credible testimony, the Arbitrator finds that Petitioner met the burden of establishing that she is totally and permanently disabled pursuant to Section 8(f) of the Act. This Arbitrator notes §8(f) of the Act provides that compensation shall be payable at the rate provided in subparagraph 2 of paragraph (b) of this Section for life. Respondent shall pay Petitioner permanent and total disability benefits of $1,080.12/week for life, commencing June 8, 2018, as provided in Section 8(f) of the Act.

With regard to the maintenance period of January 21, 2016 to present, the evidence presented does not support an award for maintenance due to the lack of qualification due to the stated lack of vocational effort.

Respondent shall have credit for amounts paid.

STATE OF ILLINOIS)		[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Natividad Rebolledo,

Petitioner,

20IWCC0658

vs. NO: 18 WC 026068

The Calmark Group,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 26, 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.

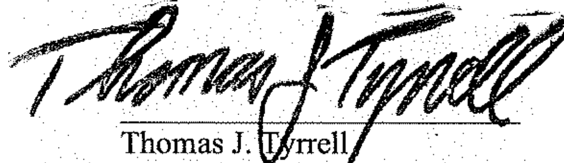
IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

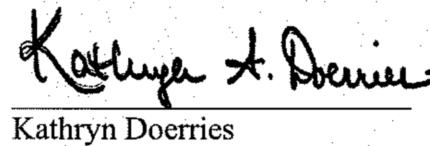
20IWCC0658

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: NOV 1 2 2020
o102020
MEP/ypv
049

Maria E. Portela


Thomas J. Tyrrell


Kathryn Doerries

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

REBOLLEDO, NATIVIDAD
Employee/Petitioner

Case# **18WC026068**

THE CALMARK GROUP
Employer/Respondent

20IWCC0658

On 6/26/2019, 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 2.03% 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 & JONES LLC
PETAR MILENKOVICH
123 W MADISON ST SUITE 1800
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
ANDREW MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

20IWCC0658

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)

NATIVIDAD REBOLLEDO,
Employee/Petitioner

Case # **18 WC 26068**

v.

THE CALMARK GROUP,
Employer/Respondent

Setting: Chicago

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **May 24, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 9, 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 $**23,296.00**; the average weekly wage was $**448.00**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **4** dependent children.

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

Respondent shall be given a credit of $**3,583.43** for TTD, $**0** for TPD, $**0** for maintenance, and $**8,100.47** for medical benefits, for a total credit of $**11,683.90**.

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

ORDER

The Arbitrator finds Petitioner failed to prove by a preponderance of the credible evidence she sustained accidental injuries arising out of and in the course of her employment with Respondent on May 9, 2018. The Arbitrator further finds Petitioner failed to prove by a preponderance of the credible evidence her current condition of ill-being is causally connected to her work for Respondent. Petitioner's claim for benefits, including prospective medical treatment, is therefore denied.

The Arbitrator finds Respondent is owed a credit in the amount of $11,683.90.

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

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

Robert M. Harris

Signature of Arbitrator Robert M. Harris

June 25, 2019
Date

ICArbDec19(b)

JUN 26 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NATIVIDAD REBOLLEDO, Petitioner,	)	
vs.	)	No. 18 WC 26068
THE CALMARK GROUP, Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

Statement of Facts

Petitioner was employed as a Machine Operator for The Calmark Group ("Respondent"). Petitioner testified regarding her job duties for Respondent. Petitioner testified her job duties required her to load envelopes and letters into a machine, take the finished envelopes, sort and pack them into trays (Transcript of Evidence on Arbitration, (Hereinafter "Tr.") p. 13). Petitioner would load fifty to a hundred pieces into the machine. (Tr. pp. 13-14). The materials would weigh between ten to fifteen pounds. (Tr. pp. 14).

Petitioner would use both hands to put the paper into the machine. (Tr. pp. 14). After loading the paper, Petitioner would walk fourteen feet and retrieve the envelopes with the paper inside from the machine. (Tr. p. 15). Petitioner would then take the envelopes and sort them onto trays. (Tr. p. 15). Petitioner would grab twenty to thirty envelopes at a time. (Tr. p.16). Depending on the size of the envelope, five hundred to eight hundred pieces fit into one tray. (Tr. p. 19). The tray was located on a table in front of the assembly line. (Tr. p. 17). The assembly was four feet wide and maybe three feet high up from the ground. (Tr. pp. 17-18). The tray and assembly was located in front of her. (Tr. p. 1).

Once the tray was filled, Petitioner piled the trays together. (Tr. pp. 16-17). In order to stack the trays, she reached over the assembly line with her arms in an upward position to place the tray down. (Tr. pp. 18-19). The entire process of putting the paper into the machine until she finished putting the envelopes in the tray took twenty to thirty seconds. (Tr. p. 19).

Petitioner rotated machines every two weeks while working for Respondent but her job duties remained the same. (Tr. pp. 20-21). Petitioner testified she worked twelve hours per day, sixty-five hours per week. (Tr. p. 21). Petitioner received a half-hour break for lunch. (Tr. p. 21). Petitioner later testified that during the week of May 9, 2018 she only worked forty hours. (Tr. pp. 41-42).

Petitioner testified she first noticed pain and tingling in her right elbow at the end of April and into May 2018. (Tr. pp. 21-22). Petitioner also noticed cramping and paralysis in her fingers. (Tr. p. 22). Petitioner later denied any prior pain in her right elbow. (Tr. pp. 23). Petitioner also denied pain in her wrist prior to May 9, 2018. (Tr. p. 49). Petitioner testified that her pain was due to a specific incident. (Tr. p. 38).

Petitioner testified regarding the mechanism of her alleged injury. On May 9, 2018, Petitioner testified she pulled seven trays to move them to the side. (Tr. pp. 22-23). Petitioner pulled the trays to her. (Tr. p. 38). The trays were three or four feet high and full of the stuffed envelopes. (Id). When Petitioner pulled them she felt pain in her elbow. (Tr. p. 23). Petitioner's palms were up as she pulled the tray. (Tr. pp. 40-41). Petitioner denied any prior left elbow pain. (Tr. pp. 23).

Petitioner believed the trays weighed between thirty and forty pounds on May 9, 2018. (Tr. p. 49). There were five to six trays on top of each other. Id. If the trays had eight hundred to nine hundred pieces of paper the trays would weigh thirty to forty pounds. (Tr. p. 50).

Petitioner corrected her statement and said there was less paper in the trays on May 9, 2018. (Tr. p. 50). There were four hundred to five hundred pieces in each tray that weighed fifteen to twenty pounds each. Id. Petitioner initially reported five to six trays and then reported six to seven trays. (Tr. p. 51-52). Petitioner reported different weights for the trays. (Tr. p. 51-52). Petitioner corrected her statement and testified that the trays weighed thirty to forty pounds all together. (Id.).

Petitioner testified she reported the incident to her supervisor but she did not seek medical treatment until the following week. (Tr. p. 23). Petitioner testified she did not seek treatment because she was waiting for her employer to send her for treatment. (Tr. p. 44). Petitioner testified there was nothing preventing her from seeking treatment on her own. (Id).

Petitioner started her treatment at Concentra on May 16, 2018. (Tr. p. 23). Petitioner testified she reported pain in her right elbow and right wrist. Petitioner testified she was unable to raise her hand and wrist (Tr. pp. 23-24). The Concentra report indicates Petitioner had full range of motion in the right wrist. Petitioner did not report pain in her right hand. (Tr. p. 41).

On May 31, 2018, Petitioner was released back to work full duty. (Tr. p. 44; Px 1). On July 2, 2018, the records from Dr. Davidson at Concentra indicate Petitioner informed Dr. Davidson that she chose not to return to work. (Tr. p. 45, Rx 4). Petitioner testified that on July 2, 2018, she did not tell Dr. Davidson she chose not to return to work, despite this note in the medical records. (Tr. p. 46, Px. 1 p. 120).

Petitioner began treating with orthopedic surgeon Dr. Kevin Tu on July 18, 2018. (Tr. pp. 26-27). Petitioner discussed physical therapy, injections, and surgery with Dr. Tu but Petitioner only elected to proceed with physical therapy. (Tr. p. 27). Petitioner treated with Dr. Speziale who recommended an injection for the right wrist. (Tr. pp. 28-29; Px 1). Petitioner declined the injection because she testified it would only calm the pain for a couple of days and it then would return. (Tr. p. 29).

On August 15, 2018, Dr. Tu recommended an injection in the right elbow and Petitioner declined the injection for the same reason she declined the injection with Dr. Speziale. (Tr. pp. 29-30).

On August 28, 2018, Petitioner sought out her own treatment with a doctor at LaClinica.(Tr. p. 30). Petitioner sought treatment for her right wrist and right elbow. (Tr. pp. 30-31).

On August 30, 2018, Petitioner treated with orthopedic surgeon Dr. Kevin Koutsky at LaClinica. (Px 2). Petitioner reported to Dr. Koutsky that she injured herself on May 9, 2018, while pulling a stack of trays. (Px 2). Petitioner reported to Dr. Koutsky she immediately felt pain in her right hand at the time of accident. (Tr. p. 41). At her initial treatment visit of May 16, 2018, Petitioner did not tell her doctor at Concentra that she immediately felt pain in her right hand. (Tr. p. 41). The May 16, 2018 treatment report does not reflect any complaints of hand pain. (Rx 3).

On October 4, 2018, Dr. Koutsky recommended that Petitioner undergo a carpal tunnel release. (Tr. p. 33). On November 14, 2018, Dr. Koutsky recommended Petitioner undergo elbow surgery. (Tr. pp. 33-34).

Dr. Koutsky on more than one occasion also offered Petitioner injections but Petitioner again declined. (Tr. p. 47). Petitioner testified she declined the injections because it would only calm her pain. (Tr. pp. 47-48). Dr. Koutsky testified that an injection can reduce inflammation. (Px. 6 p. 60). Dr. Koutsky testified there are times when after a patient received injections, they can no longer have pain. (Px. 6 p. 60). Petitioner was informed of Dr. Koutsky's testimony and testified Dr. Koutsky just told her about "relaxers". (Tr. p. 47).

Petitioner testified the January 28, 2019 records from LaClinica finding normal strength in her elbow and wrist are wrong because she does not have normal function. (Tr. p. 48). Dr. Koutsky, an orthopedic surgeon, with a sub-specialty in the spine, was deposed. (Px 6 p. 32). Dr. Koutsky testified he treated patients with hand injuries and performed twelve hand surgeries a year. (Px.6 p. 32). Dr. Koutsky opined Petitioner's diagnosis was lateral epicondylitis with carpal tunnel syndrome. Id. Dr. Koutsky opined Petitioner was a surgical candidate and Petitioner's symptoms were causally related to Petitioner's work injury. Id.

Dr. Michael Vender performed a Section 12 examination at Respondent's request on August 20, 2018. Dr. Vender subsequently gave an evidence deposition (Rx 1). Dr. Vender is a board certified orthopedic surgeon who specializes in hand and upper extremity surgery. (Rx.1 p. 4). Dr. Vender testified he treated patients four days a week and performs surgeries on Friday. Id. Petitioner reported to him that her pain would travel from wrist to elbow with activity and from elbow to wrist with no activity. (Rx.1 p. 9). Dr. Vender opined there was no physiologic explanation for these symptoms Petitioner reported to him. Id. (Rx.1 pp. 9-10). Petitioner reported pain above the elbow and across the arm down into the forearm. (Rx.1 p. 10). Dr. Vender testified that the only potential physiologic explanation for this described pain would be triceps tendinitis, which Petitioner did not have. (Rx.1 pp. 10-11). Petitioner reported pain with both flexion and extension, which Dr. Vender noted as unusual because tennis elbow and ulnar neuropathy do not usually have pain with routine range of motion. (Rx.1 p. 11). Dr. Vender testified

Petitioner's pain complaint with firm gripping is a possible indicator for lateral epicondylitis. (Rx.1 p. 12). However, Petitioner reported pain with the elbow extended and flexed, making the diagnosis less likely. (Rx.1 pp. 12-13). Petitioner's complaints were unusual because pain usually occurs in one or the other and there is a difference in the pain. (Rx.1 p. 13). The diagnosis of lateral epicondylitis was further in question because Petitioner complained of tenderness in other areas of the elbow as well. Dr. Vender opined there is no diagnosis that could explain multiple areas of tenderness like that. (Rx 1, p. 13)

Dr. Vender's examination of the wrist revealed more unusual results. (Rx.1 p. 14). Upon palpation of the wrist, Petitioner reported tenderness dorsally (non-palm side), but when palpating dorsal side, Petitioner reported pain on the other side. Id. Petitioner underwent an EMG on August 20, 2018 and he opined the results were normal. (Rx. 1, pp. 14-15). Dr. Vender testified in considerable detail his basis for this opinion.

Dr. Vender opined Petitioner's mechanism of injury does not support a finding of carpal tunnel syndrome. (Rx. 1 p. 17). Dr. Vender testified carpal tunnel does not arise from a specific injury unless it is something major like a wrist fracture. Id. The activity Petitioner described is not the type of activity that would cause carpal tunnel even if over a prolonged basis. Id. Petitioner demonstrated to Dr. Vender and described that she pulled the tray with her elbows flexed with her palms up and pulling something toward hers. (Rx.1 p. 18). Dr. Vender opined the activity described could not cause lateral epicondylitis. Id. Lateral epicondylitis in a single activity would be the exact opposite of Petitioner's described mechanism. (Rx.1 pp. 18-19). Dr. Vender opined there was no reliable diagnosis based on Petitioner's presentation. (Rx.1 p. 16). Dr. Vender released Petitioner to return to work without restrictions (Rx.1 p. 20).

Conclusions of Law

As to issue C, did Petitioner sustain accidental injuries that arose out of and in course of her employment, the Arbitrator finds and concludes the following:

Initially, there is some question whether this claim is based on a theory of "repetitive trauma" or a theory of Petitioner sustaining a single, acute, specific trauma. This is an important question and issue to clarify as it directly relates to resolving the

disputed issues of both accident and causation; physicians have offered opinions based on the assumption this "accident" was one or the other, or both, as in the case of Dr. Koutsky. This raises obvious problems. A medical expert who offers a causation opinion based only on the assumption of "repetitive trauma" when the case is actually based on a single, acute trauma offers an opinion of little or no value; conversely, a medical expert who offers a causation opinion based only on the assumption of a single, acute trauma when the case is actually based on a claim of "repetitive trauma" also offers an opinion of little or no value

Petitioner's trial testimony offers some of both, a confusing mix. On the one hand, Petitioner testified in detail, offering job activity specifics as to what appears to be an argument or position that her job duties were "repetitive" in nature. To confuse matters even more, Petitioner also testified she felt "a lot of pain" in her right elbow in the end of April into May of 2018, which suggests a theory that the May 9, 20128 claimed accident "aggravated" a pre-existing elbow condition; why else mention elbow pain prior to the claimed accident date? (Tr., p. 21).

However, on the other hand, Petitioner's trial testimony confirmed she was claiming a theory of recovery pursuant to an acute, single trauma theory, as noted - and confirmed - in her cross-examination testimony: Question: "You told the doctor at La Clinica, Dr. Koutsky, and the first doctor at Concentra that you were pulling a tray out when you felt sudden pain in your right elbow; correct." Answer: "Yes." And next, "So we're talking about a specific incident, correct?" Answer: "Yes." (Tr, pp. 37-38.) Dr. Koutsky, who offered deposition testimony with opinions in favor of Petitioner, was not aware of this history, and, in fact, seemed to not care whether his claim was one of a single, acute trauma or repetitive trauma, or even both.

Therefore, based on the above, and after a careful review of the entire record, the Arbitrator finds and concludes Petitioner claims she sustained an acute, single, specific trauma accident on May 9, 2018 when she claims she pulled seven stacked trays and felt pain in her elbow (only – not her wrist).

Further, the Arbitrator finds and concludes that Petitioner has failed to prove by a preponderance of the credible evidence that she sustained accidental injuries that arose

out of and in the course of employment with Respondent while pulling a stack of trays on May 9, 2018. Petitioner's claim for compensation is therefore denied.

In determining this conclusion, the Arbitrator emphasizes the lack of credible proof Petitioner's physicians offered in their causation opinions (such as offering causation opinions based on a "repetitive trauma" theory when this case is not a repetitive trauma claim.) The Arbitrator further notes the many inconsistencies between what Petitioner said, either to physicians or in her trial testimony, and the medical records, medical testimony and physiologic findings. In sum, Petitioner's testimony and is not reliable or credible and presents problems. Specific inconsistencies are as follows:

1. Petitioner told Dr. Koutsky that she had immediate hand pain. (Px. 6, p. 22). The initial treatment record from Concentra of May 16, 2018 reflects no complaints of hand pain. (Rx. 3)
2. Petitioner testified that when she first went to Concentra she could not raise her hand or move her wrist. (Tr. pp. 23-24). The Concentra report, however, lists the following for the right wrist: "Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal." (Rx. 3, p. 2) This record directly contradicts Petitioner's trial testimony. The Arbitrator accordingly finds the medical records are more reliable and credible than Petitioner's contradictory trial testimony.
3. Petitioner told Dr. Koutsky that she worked 12 hours per day, 6 days per week. (Px. 6, p. 21; Tr. p. 47). However, Petitioner initially told the doctor at Concentra that she worked 40 hours per week without overtime. (Rx. 3)
4. The July 2, 2018 report of Dr. Davison states Petitioner told him she had chosen not to return to work. (Px. 1) Petitioner denied saying this to Dr. Davison in her trial testimony (Tr. p. 46) This record directly contradicts Petitioner's trial testimony. The Arbitrator accordingly finds the medical records are more reliable and credible than Petitioner's contradictory trial testimony.

5. Petitioner inexplicably rejected multiple suggestions by her treating physicians to undergo an injection of the elbow. Petitioner testified she was told that an injection would only calm her pain. (Tr. pp. 47-48) Dr. Koutsky, however, testified that the injection could potentially improve her condition to the point she could no longer have pain. (Px. 6, p. 30). The Arbitrator accordingly finds the medical records are more reliable and credible than Petitioner's contradictory trial testimony.
6. At trial Petitioner denied having normal muscle strength in both her elbow and wrist as of her January 28, 2019 visit to Dr. Koutsky. (Tr. pp. 47-48) This is inconsistent with Dr. Koutsky's record for that date, which list normal strength in both the elbow and wrist. (Px. 2) The Arbitrator accordingly finds the medical records are more reliable and credible than Petitioner's contradictory trial testimony.
7. Dr. Koutsky understood that Petitioner had an "evaluation" on the alleged incident date. (Px. 6, p. 23). However, Petitionr's first visit to a medical provider was on May 16, 2018, a week after the alleged incident.
8. Petitioner testified she did not seek treatment on the incident date because she was not told to go to the doctor by her employer. (Tr. p. 44) However, Petitioner acknowledged that when she later sought treatment at La Clinica that she did so on her own without her employer telling her to do so. (Tr. p. 44)
9. According to Dr. Vender, he had no physiologic explanation regarding Petitioner's complaints of pain running from her wrist to her elbow with activity and from her elbow to her wrist without activity. (Rx. 1, p. 9) Similarly, regarding Petitioner's elbow, Dr. Vender testified there is no diagnosis that would explain all of the areas of tenderness she described. (Rx. 1, p. 13)

10. Petitioner changed her testimony regarding how many trays she moved at the time of the alleged incident and how much they weighed. (Tr. pp. 49-52)
11. Petitioner testified she first noticed pain and tingling in her right elbow at the end of April and into May 2018. (Tr. pp. 21-22). She also noticed cramping and paralysis in her fingers. (Tr. p. 22). After describing her claimed accident, Petitioner almost immediately thereafter ***denied*** any prior pain in her right elbow. (Tr. pp. 23). This contradiction shows a lack of credibility.

Based upon the numerous inconsistencies and other problems described above, as well as other evidence, Petitioner's claims are not credible.

The Arbitrator also notes no accident report was admitted into evidence to support Petitioner's claims. Also, Petitioner offered no testimony whether her accident was witnessed and no witness appeared at trial to testify on her behalf.

Further, one last point is that the Arbitrator adopts the opinions of Dr. Vender that the mechanism of injury that Petitioner described is not a competent cause of her condition. Dr. Vender opined Petitioner's mechanism of injury does not support a finding of carpal tunnel syndrome. (Rx. 1 p. 17). Dr. Vender testified carpal tunnel does not arise from a specific injury unless it is something major like a wrist fracture. Id. The activity Petitioner described is not the type of activity that would cause carpal tunnel even if over a prolonged basis. Id. Petitioner demonstrated to Dr. Vender and described that she pulled the tray with her elbows flexed with her palms up and pulling something toward hers. (Rx.1 p. 18). Dr. Vender further opined the activity described could not cause lateral epicondylitis. Id. Lateral epicondylitis in a single activity would be the exact opposite of Petitioner's described mechanism. (Rx.1 pp. 18-19). Dr. Vender opined there was no reliable diagnosis based on Petitioner's presentation. (Rx.1 p. 16).

The Arbitrator finds and concludes Petitioner did not sustain accidental injuries arising out of and in the course of her employment with Respondent on May 9, 2018.

Petitioner's claim for compensation is therefore denied.

As to issue F, is Petitioner's present condition of ill-being causally related to the injury, the Arbitrator finds and concludes the following:

The Arbitrator finds and concludes Petitioner's present condition of ill-being - which itself is not clear - is not causally related to the alleged injury.

In determining questions of accident and causation, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n,* 99 Ill.2d 401, 406–07 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n,* 397 Ill.App.3d 665, 675 (2009); *Fickas v. Industrial Comm'n,* 308 Ill.App.3d 1037, 1041 (1999).

The trial court is not required to blindly accept an expert's assertion that his testimony has an adequate foundation. Rather, the trial court must look behind the expert's conclusion and analyze the adequacy of the foundation." *Simers v. Bickers,* 260 Ill.App.3d at 411 (1994). "The weight accorded an expert's opinion must be measured by the facts supporting the opinion and the reasons given for his or her conclusions." *Doser v. Savage Manufacturing and Sales, Inc.*, 142 Ill. 2d 176, 196 (Ill. Sup. Ct. 1990). If an expert's opinion lacks a factual basis, the opinion deserves little weight. *Ibid.* ***An expert cannot base his opinions on what might have happened.*** *Dyback v. Weber*, 114 Ill.2d 232, 244-45 (Ill. Sup. Ct. 1986). An expert's opinions **cannot** be based on conjecture and guess where he does not possess the necessary factual basis to form his opinion. "Where there is no factual support for an expert's conclusions, his conclusions alone do not create a question of fact." *Damron v. Micor Distributing*, 276 Ill.App.3d 901, 907. That is the scenario here regarding the opinions of Dr. Koutsky (as well as Dr. Tu).

The Arbitrator relies upon the opinions of Dr. Vender over those of Dr. Koutsky, as Dr. Vender has better credentials for the upper extremity treatment and was not provided inaccurate information that was given to Dr. Koutsky. The Arbitrator also discounts Dr. Tu's causation opinion, because Dr. Tu opined causation based on an erroneous theory of recovery, that is, he offered his causation opinion based on the belief and assumption that this is a "repetitive trauma" claim. Therefore, his opinions are based on an irrelevant and mistaken foundation and therefore carry little, if any, weight.

Dr. Vender received a Bachelor of Science with Distinction from Stanford University in 1976. He graduated from the University of Illinois College of Medicine in 1979. He did his orthopedic residency at Northwestern, finishing in 1985. He then went through the fellowship program in hand surgery at Connecticut Combined Hand Services, finishing in 1986. He's been Board Certified in Orthopaedic Surgery since 1988. He's been Certified for Added Qualifications in Surgery of the Hand since 1989. (Rx. 1, Exhibit 1) The latter certification required him to treat a certain number and certain breadth of hand cases. (Rx. 1, pp. 5-6) He performs over 100 carpal tunnel surgeries per year. He estimated doing less than 50 elbow surgeries per year. His practice group is called "Hand Surgery Associates". (Rx. 1, pp. 6-7)

Dr. Koutsky treats low back conditions. (Px. 6, p. 30) The page from his website, which is marked as Exhibit 3 of Px. 6, lists conditions he treats that all have to do with the spine. Nowhere on the Exhibit is there any discussion regarding treatment of the hand or elbow. (Px. 6, pp. 31-32 and Exhibit 3) He later testified that he may perform a dozen carpal tunnel surgeries in a year and treats over 100 patients in a year with elbow and/or carpal tunnel conditions. (Px. 6, pp. 32-33) It is clear that he does not have the expertise of Dr. Vender when it comes to hand and elbow conditions.

Dr. Koutsky stated the carpal tunnel condition he diagnosed was caused by repetitive trauma. (Px. 6, p. 21). However, he has little factual basis to support this opinion. He did not review a job description. (Px. 6, p. 21) He had no idea how many times per hour or per shift the petitioner pulled trays at work. He had no idea how heavy the trays are or how heavy the stacks of trays are. (Px. 6, p. 22) He based his causation opinion on her telling him that she pulled a stack of trays at work and that she works six days a week and 12 hour shifts. (Px. 6, pp. 21-22) Dr. Koutsky also based it upon Petitioner complaining of immediate hand pain. (Px. 6, pp. 22-24) As discussed previously, the hours worked reported by Petitioner to Dr. Koutsky is inconsistent with what was set forth in the initial treatment record of forty hours per week (Rx. 3) as well as her average weekly wage of $448.00 per week. (Arbitrator's Exhibit 1) Petitioner's report to Dr. Koutsky of immediate hand pain is also inconsistent with the initial treatment record, where no hand pain is noted. (Rx. 3) Dr. Koutsky acknowledged that if

given inaccurate information as to the mechanism of injury or when pain started, that this could impact the accuracy of his causation opinion. (Px. 6, p. 25)

Dr. Vender found that Petitioner did not have carpal tunnel syndrome. Dr. Vender explained that he did not diagnose her with carpal tunnel as there was not physiologic explanation for her hand/forearm complaints. (Rx. 1, pp. 9-10, 14) The results of the 8/20/18 EMG testing were normal. (Rx. 1, p. 15-16). Dr. Vender thoroughly explained why the results of the May 25, 2018 EMG test were not significant. (Rx. 1, pp. 31-34)

Dr. Vender explained that the described incident would not cause carpal tunnel. Dr. Vender testified the condition typically does not come from a specific incident unless it's a major event like a wrist fracture, and even that doesn't occur very often. (Rx. 1, pp. 17-18) Even if the activity was done more often, it's not the type of activity, even over a prolonged basis, that would cause carpal tunnel syndrome. (Rx. 1, p. 18) Based upon what is set forth above, the alleged carpal tunnel syndrome is not causally connected to her work incident or repetitive trauma.

Similarly, Petitioner's right elbow condition is not causally connected to her alleged work incident (or repetitive trauma). Dr. Koutsky, when asked whether he thought the elbow condition was the result of a specific incident or repetitive trauma, testified as follows:

> **"It could be either. I can't really tell one way or the other. It can be due to an acute injury; it can be due to repetitive trauma." (Px. 6, p. 21)**

Dr. Koutsky thereby admitted that he had no knowledge - hence no adequate foundation - regarding the cause/etiology of the conditions, nor is he able to offer an opinion with a solid foundation. As set forth previously, offering an opinion from a "repetitive trauma" perspective, Dr. Koutsky knew none of the particulars regarding the number of trays moved or how much they weighed. He reviewed no job description. (Px. 6, pp. 21-22) Dr. Koutsky had erroneous information regarding how many hours Petitioner worked. (Px. 6, pp. 21-22; Rx. 3) Dr. Koutsky did not provide a persuasive causation opinion.

The Arbitrator relies upon Dr. Vender, who testified that the event Petitioner described would be the exact opposite of what one would expect if she were to develop lateral epicondylitis. Development of that condition occurs when working with the elbow straight and palm down. She described the opposite. Her elbows were flexed and she pulled the trays towards her with her palm up instead of down. (Rx. 1, pp. 18-19, Tr. pp. 40-41)

As discussed earlier, the complaints of tenderness in all of the areas of her elbow that she described to Dr. Vender would not constitute lateral epicondylitis. (Rx. 1, p. 13). Her physical examination was nonphysiologic. (Rx. 1, p. 16). Based upon what is set forth above, the alleged right elbow injury is not causally connected to her alleged work incident or repetitive trauma.

As to issue J, were the medical expenses that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes the following:

As Petitioner did not sustain accidental injuries that arose out of and in the course of her employment, and as her present condition of ill-being is not causally connected to the alleged work incident or activities, Petitioner's request for payment of medical bills is denied.

As to issue K, is Petitioner entitled to prospective medical, the Arbitrator finds and concludes the following:

As Petitioner did not sustain accidental injuries that arose out of and in the course of her employment, and as her present condition of ill-being is not causally connected to the alleged work incident or activities, Petitioner's claim for prospective medical treatment is denied.

As to issue L, what temporary benefits are in dispute, the Arbitrator finds and concludes the following:

As Petitioner did not sustain accidental injuries that arose out of and in the course of her employment, and as her present condition of ill-being is not causally connected to

the alleged work incident or activities, Petitioner's request for temporary total disability benefits is denied.

As to issue N, is Rrespondent due any credit, the Arbitrator finds and concludes the following:

As Petitioner did not sustain an accidental injuries that arose out of and in the course of her employment, and as her present condition of ill-being is not causally connected to the alleged work incident or activities, the Arbitrator finds that petitioner was not entitled to receive $3,583.43 in temporary total disability benefits and $8,100.47 in medical benefits previously paid by Respondent. As a result, the Arbitrator finds that Respondent is owed a credit in the amount of $11,683.90.

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: June 25, 2019

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

Angel Valencia,

Petitioner,

20IWCC0659

vs. NO: 16 WC 033990

Seven D Corporation Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 13, 2018 is hereby affirmed and adopted.

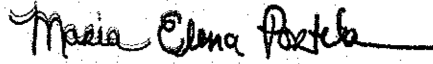
IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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.

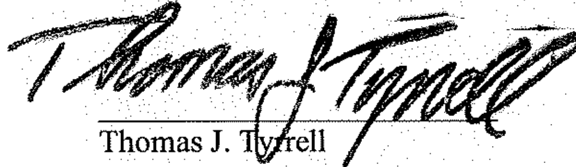
20IWCC0659

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.

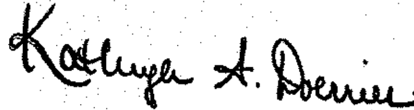
DATED: NOV 1 2 2020
o102020
MEP/ypv
049



Maria E. Portela



Thomas J. Tyrrell



Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VALENCIA, ANGEL
Employee/Petitioner

Case# **16WC033990**

20IWCC0659

SEVEN D CORPORATION COMPANY
Employer/Respondent

On 6/13/2018, 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 2.07% 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:

5755 COSTA IVONE LLC
JORDAN BROWEN
311 N ABERDEEN SUITE 100B
CHICAGO, IL 60607

0210 GANAN & SHAPIRO PC
JOE BRANCKY
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602

20IWCC0659

4/13/18STATE OF ILLINOIS)
)SS.
COUNTY OF)

- [ ] 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

Angel Valencia
Employee/Petitioner

v.

Seven D Construction Company
Employer/Respondent

Case # **16WC 33990** ______

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **4/13/18**. 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. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **6/23/2016**, 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 $**31,265.00**; the average weekly wage was $**601.25**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **4** dependent children.

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

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

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

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

ORDER

The Petitioner did not sustain an accident in the course and scope the employment with Respondent at bar. Respondent is not liable for any benefits.

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

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

#001 Arb George Andros
Signature of Arbitrator

6/12/18
Date

JUN 13 2018

20IWCC0659

STATEMENT OF FACTS 16 WC 033 990

Angel Valencia, (hereinafter "Petitioner") began working for Seven D Construction (hereinafter "Respondent") in 2014. (T. 8). He testified he worked with trees and occasionally cement. (T. 8). He testified this was seasonal work that lasted from April to November of each year, and that during the off season, he would do plumbing work. (T. 26). Petitioner testified that at the time of the accident, he worked only for Respondent. (T. 8). Petitioner testified his supervisor Olegario Escalante would assign him where to work on a daily basis. (T. 32). This could be either at the shop or directly at a job site. (T. 33).

For the pay period prior to the alleged accident, Petitioner was paid a total of $755.08 for the pay period of June 12, 2016 through June 18, 2016. (PX3). There are no details on the check regarding the hours, rate, overtime, or bonus.

Petitioner claims that on June 23, 2016, he was working "near North Avenue and Ashland" in Chicago. (T. 15). He testified he went there directly from home, and did not go to Respondent's shop first. (T. 79). He testified this was a residential job, at a private house. (T. 20). He testified this was the only day he was ever at this particular job site. (T. 79). Petitioner testified the only person he was working with at the time of the accident was named "Samuel Santian." (T. 18-19, 79). Petitioner testified Mr. Santian was not an employee of Respondent, and that he had never seen him before. (T. 80). Petitioner testified he was not sure if the job he was working on at the time of the accident was a private job or a job for Respondent. (T. 20).

Petitioner testified that at the time of the accident he was cutting cement on a sidewalk close to a fence. (T. 9). Petitioner testified the saw in Respondent's Exhibit One is the type of saw he was working with at the time of the accident. (T. 12).

Respondent's Exhibit One is a photo of a gas powered Stihl concrete saw with two handles perpendicular to one another, and the top half of the blade covered with a guard. (RX1).

Petitioner testified "Samuel Santian" brought the concrete saw. (T. 80). Petitioner testified the saw blade he was using was a 10 inch blade. (T. 12). He testified the saw did not have a safety cover on it. (T. 12). He testified the cover was removed because it would fill up with concrete. (T. 28). Petitioner testified he was using the saw to cut cement on his left side. (T. 16). He testified the saw blade was moving straight ahead from his body. (T. 17). He testified his left hand was holding the rear handle, and his right hand was holding the front handle. (T. 17). He testified the accident occurred at 10:30 – 11:00am. (T. 18). He testified the saw blade would be hot enough to burn. (T. 28).

Petitioner testified that while he was using the saw, it struck a metal rod in the cement, causing it to bounce up and cut his face. (T. 9-10). Petitioner testified he reported this to his manager, Olegario Escalante. (T. 10). Petitioner testified he called Mr. Escalante 5 minutes after the accident. (T. 19). Petitioner testified Mr. Escalante told him not to worry, and to take as much time off work as necessary. (T. 20).

On June 23, 2016, Petitioner sought treatment at Franciscan Health in Chicago Heights, located at 1423 Chicago Road, Chicago Heights, Illinois 60411. (PX1). Petitioner testified he drove alone from the job site for part of the drive to the hospital. His wife then met up with him at Lincoln Highway and the exit for the expressway and drove him the rest of the way. (T. 18). It was noted he arrived via car at 11:35 am. (PX1 at 3). He provided a history of falling down five stairs, causing a cut from the center of his chin to the left jaw. (PX1 at 7). Petitioner reported he tripped on the stairs and the left side of his face struck a bannister. (PX1 at 8). An x-ray exam was negative. (PX1 at 10). The laceration was noted to be 8 cm in length and was closed with 13 stitches. (PX1 at 11). He was diagnosed with a chin laceration and was discharged with instructions to return for suture removal in 7 days. (PX1 at 11).

Petitioner testified he reported he had injured himself falling down stairs because his supervisor told him not to report it or the supervisor would get in trouble. (T. 11). Of the work he was performing that day, Petitioner testified: "I thought that the job was not a company job, that it was [the supervisor's] own job." (T. 11).

Petitioner was paid a total of $719.91 for the pay period of June 19, 2016 through June 25, 2016. (PX3). There are no details on the check regarding the hours, rate, overtime, or bonus.

Petitioner next sought medical treatment on June 30, 2016 when he was seen at ACCESS Family Health in Chicago Heights for suture removal. (PX2). He once again reported he injured himself in a fall. (PX2). There was no mention of a work accident. Petitioner testified he did not have to pay for this visit, as his wife works at this facility and carries insurance for him. (T. 21).

Petitioner was paid a total of $709.17 for the pay period of June 26, 2016 through July 2, 2016. (PX3). There are no details on the check regarding the hours, rate, overtime, or bonus.

An October 19, 2016 letter from a collection agency indicates a $1,622.70 balance from St. James Hospital for a June 23, 2016 date of service. (PX1). There are no procedure codes listed.

Petitioner testified his employment with Respondent ended in October 2016. (T. 14). His last check from Seven D was dated October 21, 2016 for a pay period of October 9, 2016 through October 15, 2016. (PX3).

Respondent Exhibit Two are the certified records from Premier Landscape. (RX2). Petitioner completed an Employment Application for Premier Landscape on November 14, 2016. (RX2 at 16). Petitioner indicated that from 1999 to 2010 he worked for Zepeda Construction. (RX2 at 17). It was noted Petitioner was hired as a Snow and Skid Steer Operator to begin at Premier as of December 4, 2016. (RX2 at 22). These records indicate Petitioner was to be rehired for seasonal work as a landscape laborer as of April 3, 2017 earning $14.50 per hour for a 45 day period, with an increase in wages to follow. (RX2 at 11).

Petitioner testified he worked with Premier in the winter of 2016-17 driving a Bobcat to clear snow, and later on making decks and laying bricks. (T. 22, 30).

A February 21, 2017 balance from Franciscan Alliance indicates a $1,234.95 balance for the June 23, 2016 date of accident. (PX1). No CPT codes are listed. (PX1).

An April 12, 2017 $0 balance from ACCESS Community Health Network indicates a $0 balance for a June 30, 2016 date of service. (RX3).

Olegario Escalante testified he is a foreman at Respondent. (T. 38). He was not present for Petitioner's testimony. He has been with the company for 10 years, and in this position for 5 years. (T. 53). He testified he assigns employees work, and makes sure jobs are completed. (T. 38). He is responsible for approximately 20 people on a daily basis. (T. 39). He testified these jobs typically included laying down soil and grass, but mostly planting trees. (T. 39). He testified Respondent's work is done primarily in Chicago. (T. 39). Mr. Escalante explained that work accidents are usually reported to him, and that he then calls the office. (T. 61). He testified they either call an ambulance of send the person to a clinic. (T. 61). Mr. Escalante testified he reports to Mr. Gavilanes, who is the general supervisor. (T. 55). He testified he was Petitioner's supervisor. (T. 40). He was in charge of sending Petitioner out to work on a daily basis. (T. 42). He testified Petitioner would call him if he were running late or had to leave work early. (T. 42). He testified that occasionally Petitioner would ask to leave work early to complete side jobs outside of his employment with Respondent. (T. 52). He testified that employees had to be in the shop by 6 a.m., and that jobs began at 7am. (T. 43). He testified that is why employees cannot work if they come in late. (T. 43).

Mr. Escalante testified Respondent's Exhibit One depicts a saw used to cut cement. (T. 45). He testified he has 15 years of experience using the saw. He testified it weighs approximately 20-25 pounds. (T. 45). He testified 12" or 14" blades are used, and that a 10" blade is never used because it does not fit. (T. 46-7). He testified they never took the blade guard off the saw at Respondent. (T. 47). He testified he has never seen someone use a concrete saw with the blade guard removed. (T. 60). He testified concrete does not get stuck in the blade guard when cutting concrete. (T. 60). He explained that one person applies water to the blade while in operation, and that it rinses off the debris and keeps the blade clean. (T. 64).

Mr. Escalante testified it would be impossible for Petitioner to have injured himself with a saw like that in Respondent's Exhibit One. (T. 51). He testified he believed the saw was too heavy, and that due to the blade guard, the saw would have to flip over to cause the injury alleged. (T. 51). He testified that when one lets go of the trigger, the blade stops rotating. (T. 51).

Mr. Escalante testified that cutting concrete is only done when the City of Chicago wants trees planted in an area where there is now a sidewalk. (T. 40). This occurs approximately once a month. (T. 40). Mr. Escalante testified that a concrete cutting job always involves 3-4 people. (T. 41). He explained that this is because additional people were needed to stop the flow of pedestrian traffic while the saw was in use. (T. 41). He testified that only himself and one other supervisor operate the concrete saw and cut cement. (T. 41). He testified the landscaping division of Respondent owns only one concrete saw. (T. 62).

Mr. Escalante testified Petitioner's job involved digging holes for trees, laying down dirt, and cleaning up. (T. 40). He testified Petitioner did not cut concrete. (T. 40). He testified he never saw Petitioner use a concrete saw during his time with Respondent. (T. 59).

Mr. Escalante testified Petitioner was not working for Respondent on June 23, 2016. (T. 43). He testified Petitioner called on that morning to say he would not be at work because he had to finish another job and the traffic was bad. (T. 43). Petitioner told him he was remodeling a house and putting drywall on the walls. (T. 44). He testified Petitioner called him later that day between 11:00 a.m. and 1:00 p.m. and told him he injured his face. (T. 44). He testified Petitioner did not tell him how he injured his face, or that he was injured at work. (T. 45, 60). He was not aware Petitioner was alleging a work accident until months later, when he found out from Respondent's office. (T. 45). He testified this was after Petitioner had last worked for Respondent. (T. 52).

Mr. Escalante testified Respondent does not do any plumbing work. (T. 59). He testified employees were paid in a weekly check, and that overtime was included in the check. (T. 66).

Mauro Gavilanes testified he is the project manager for the landscape division at Respondent. (T. 69). His job duties include scheduling projects, delegating work, and communicating with the City of Chicago on projects. (T. 69). Work accidents and claims are reported to him. (T. 70). He testified that typically accidents are reported from the employees to Mr. Escalante, who the reports to him. (T. 72). He testified they then decide whether to call an ambulance or take the claimant to a hospital. (T. 72). He testified Respondent typically sends injured employees to the company clinic, MercyWorks, at 55th and Pulaski and 26th and Michigan. (T. 73). He testified he was not notified of Petitioner's alleged work accident until approximately 6 months later. (T. 70). He testified that until that time he was not even aware Petitioner had been injured at all, let alone in a work accident. (T. 71).

At trial, Petitioner testified he is currently employed at a roofing company called Calderon Roofing. (T. 14). He testified he began asserting he injured himself in a work accident only "when [Respondent] told me they were not going to pay that I said, hey, you know, I got to pay my bills." (T. 21). He testified he has received bills since the accident, but he just lets them pile up and does not open them. (T. 23). He testified he would perform plumbing work during the time he worked for Respondent. (T. 26). He testified he worked in construction for 15 years prior to working for Respondent. (T. 26-7).

Petitioner's Exhibit Four is an undated, undescribed photograph of Petitioner lying on his side, with blood on his chin. (PX4). He is bearded, and any scar or laceration is not visible through his beard. (PX4).

Petitioner testified he usually has a beard. (T. 27).

At trial, the arbitrator viewed Petitioner's scar to determine the nature and extent of the injury. He noted Petitioner had to use a pen to show him where his scar was. He had to view scar from various angles "to see what I could see under the petitioner's beard." (T2. 9-10).

CONCLUSIONS OF LAW

The Arbitrator makes the following findings on the issue of **(C) did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?**

A claimant bears the responsibility of proving his claim by a preponderance of the evidence in a workers' compensation hearing. Rambert v. Indus. Comm'n., 133 Ill.App.3d 895, 477 N.E.2d 1364, 1369, 87 Ill.Dec. 836 (Ill.App.2nd. Dist. 1985). The Industrial Commission decides questions of fact, including judging the credibility of witnesses, determining the weight of the evidence, and resolving conflicting questions of medical evidence. See, Dexheimer v. Indus. Comm'n., 202 Ill.App.3d 437, 442, 559 N.E.2d 1034, 1037, 147 Ill.Dec. 694, 697 (1st Dist. 1990). In the instant case, the Arbitrator finds that the preponderance of the credible evidence does not support Petitioner's allegation regarding a June 2016 work accident.

Petitioner testified that on June 23, 2016 he was working at a residential site near North Avenue and Ashland, in Chicago. (T. 20). He testified the job involved cutting cement on a sidewalk close to a fence. (T. 9). He says he went there straight from home that morning. (T. 79). He testified only one other person was working with him that day, and it was someone he had never met before. (T. 80). He states this person did not work for Respondent, but brought the concrete saw that day. (T. 80). Though this person brought the saw, Petitioner was the one using it. Petitioner testified the concrete saw in Respondent's Exhibit One is the type of saw he was working with at the time of the accident. (T. 12). He testified the blade was 10 inches in diameter, and that the blade guard had been removed, because it would fill up with concrete. (T. 12). He testified he was holding the saw with both hands while operating it. (T. 17). He testified the saw hit a metal rod in the cement, causing it to bounce up and cut his face. (T. 9-10). He testified he then drove himself from North and Ashland to Chicago Heights, some 35 miles away. (T. 18). Petitioner told the hospital he had been injured after falling down five stairs, striking the left side of his face on a bannister. (PX1 at 7, 8). He testified he was told to lie. The Arbitrator makes a finding of fact that statement is not credible and not adopted.

First, the evidence suggests Petitioner was not working for Respondent that day. By Petitioner's own account, he went straight from home in Chicago Heights to a location in the city of Chicago to work with a man who did not work for Respondent. This man, and not Respondent, provided the concrete saw Petitioner states he was using at the time of the accident. Petitioner did not testify that Respondent provided him any direction that day regarding how to perform his job or where to go once injured. There is no indication Respondent controlled Petitioner's actions that day. Petitioner provided only vague details about where the accident occurred, and testified he had never been at that location before while working for Respondent. Petitioner himself testified of the work he was performing on June 23, 2016: "I thought that the job was not a company job." (T. 11). During cross-examination, Petitioner again testified he was not sure if the job he was working on at the time of the accident was a private job or a job for Respondent. (T. 20).

The Arbitrator adopts the testimony of Mr. Escalante.Petitioner's supervisor, Mr. Escalante, testified Petitioner was not working for Respondent on June 23, 2016. (T. 43). He testified Petitioner called on that morning to say he would not be at work because he had to finish a side job and the traffic was bad. (T. 43). He testified Petitioner told him he was remodeling a house and putting drywall on the walls. (T. 44). After Mr. Escalante testified, Petitioner was recalled for rebuttal testimony. He did not address any of Mr. Escalante's statements. (T. 77-80).

There is a major discrepancy between the testimony of Petitioner and that of Mr. Escalante. This can be explained: Petitioner's statements are not credible. Mr. Escalante explained Petitioner was lying about working on June 23, 2016, about using a saw, and about reporting a work accident. Though given a chance to return to the witness stand and rebut Mr. Escalante's statements, Petitioner chose not to. Petitioner admitted he lied to his medical providers on multiple occasions about how he was injured. (T. 11). He testified he only changed his story and began asserting he injured himself in a work accident "when [Respondent] told me they were not going to pay that I said, hey, you know, I got to pay my bills." (T. 21). He initially testified he worked only for Respondent at the time of the accident. (T. 8). He later admitted he may have been doing private jobs outside of work for Respondent, and that he actually did plumbing work during the time he worked for Respondent. (T. 11, 20). Petitioner testified that when he receives bills in the mail, he just lets them pile up and does not open them. (T. 23). The evidence indicates Petitioner is not credible. There is no evidence Mr. Escalante is not credible.

Additionally, Petitioner alleges he was injured at North and Ashland, on the north side of Chicago, yet sought treatment following the accident in Chicago Heights 35 miles away through downtown. (PX1). Once at Franciscan St. James that day, Petitioner provided a history of falling down five stairs, causing a cut from the center of his chin to the left jaw. (PX1 at 7). Petitioner again provided a history of injuring himself during a fall when he sought treatment at ACCESS on June 30, 2016. (PX2). There is no mention of a saw, no mention of Respondent, and no mention of work. It is unlikely Petitioner would have foregone emergency treatment close to his alleged accident cite, and that he would have provided a false history to his initial medical providers.

Petitioner has the burden of proving every element of his claim. His first hurdle to clear is that he was working for Respondent on the date of accident. The credible and unrebutted testimony indicates Petitioner was not working for Respondent on the date of the alleged accident. Even if we assume Petitioner is telling the truth, and that Mr. Escalante is lying, Petitioner's claim he was working for Respondent is tenuous at best. Therefore, the Arbitrator finds Petitioner failed to meet his burden of proving he was working for Respondent at the time of the alleged accident.

Second, the evidence indicates Petitioner was not using a concrete saw that day. Petitioner claims he was using a concrete saw with a 10" blade with a blade guard removed to cut a city of Chicago sidewalk with one other person on the date of the alleged accident. However, this story does not stand up to scrutiny. Despite not being allowed in the room for Petitioner's testimony and having no idea what was said, Mr. Escalante credibly rebutted Petitioner's statements regarding the saw.

Mr. Escalante testified he has 15 years of experience using concrete saws. (T. 45). Mr. Escalante testified only 12" or 14" blades are used for the saw in question, and that a 10" blade is never used because it does not fit. (T. 46-7). Mr. Escalante testified they never took the blade guard off the saw at Respondent, and that he has never seen anyone anywhere using a concrete saw with a blade guard removed. (T. 47, 60). He testified concrete does not get stuck in the blade guard, as water is applied while in use, rinsing the blade. (T. 60, 64). He testified Petitioner's job did not include operating the concrete saw, that he never saw Petitioner using the saw, and that only Mr. Escante and one other supervisor were authorized to use the saw. (T. 41, 62). He testified that 3-4 people are required to use the saw: one person to operate the saw, one person to apply water to the blade, and the remaining person or persons stopping the flow of pedestrian traffic while the saw was in use. (T. 64, 41). Again, Petitioner was recalled to testify after he heard Mr. Escalante's testimony. He did not correct any of the statements he made about his use of the saw. (T. 77-80). In addition, cutting a city sidewalk in the public way is the type of activity that would draw some notice, especially in a dense part of the city of Chicago. It is highly unlikely Respondent would risk their city business by sending out Petitioner (someone who does not use a concrete saw) and a non-employee to perform the job with an understaffed team, and an altered and unsafe machine. The evidence indicates it is not likely Petitioner was operating a concrete saw for Respondent on the date of the alleged accident.

Third, it is unlikely Petitioner would have suffered his injury as a result of the accident alleged. Petitioner alleges he was using a concrete saw at the time of the accident, of the same type shown in Respondent's Exhibit One. (T. 12). This is a gas-powered Stihl concrete saw that Petitioner states he was holding with two hands on his left side when it struck a metal rod, causing the saw to bounce up and the disk to strike his face. (T. 16). Mr. Escalante explained it would be impossible for Petitioner to have injured himself with the concrete saw as claimed. (T. 51). He testified he believed the saw was too heavy at 20-25 pounds, and that due to the blade guard, the saw would have to flip over to cause the injury alleged. (T. 51, 45). He testified that when one lets go of the trigger, the blade stops rotating. (T. 51). Mr. Escalante's testimony was unrebutted by Petitioner. (T. 77-80). It is simply unlikely that a 20-25 pound saw being held with two hands by an adult would lose control and flip up and backwards, striking the left side of Petitioner's face with a glancing blow that caused only a perfectly straight minor laceration.

Based on the totality of the evidence above, the Arbitrator finds the preponderance of same the Petitioner did not sustain an accident as alleged in the case at bar.

Thus, no further findings need be determined. The Arbitrator further sayeth naught.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPUAGE)

☐	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

Maryann Walker,

Petitioner,

vs. NO: 15 WC 33987

Oswego C.U.S.D. 308,

20 IWCC0660

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical expenses and nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, with changes as stated herein, said decision being attached hereto and made a part hereof.

The Commission notes in her brief, Petitioner represented the following: "Dr. Goldberg did order an MRI and CT and these were done at Elmhurst Hospital on July 12, 2017. The bill for the procedures totaled $11,033.00 and was included in Petitioner's Exhibit 18. There was a Medicaid adjustment of $10,757.50 leaving a balance of $275.50 which should be deducted from the medical award, reducing it to $231,555.29." (Petitioner Brief, pp.17-18).

Therefore, based on the above, and the record taken as a whole, the Commission finds that Petitioner is entitled to medical expenses in the amount of $231,555.29 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/8/18 is affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $398.04 per week for a period of 79-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner reasonable and necessary medical expenses in the amount of $231,555.29, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $358.24 per week for a period of 212.5 weeks, as provided in §8(d)2 of the Act, for the reason the injuries sustained caused the permanent partial loss of use of 35% person-as-a-whole (cervical spine) and 7.5% person-as-a-whole (left shoulder).

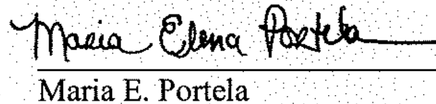
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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

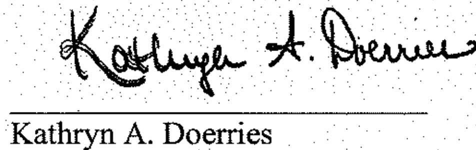
Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 13 2020
o: 9/15/20
TJT: pmo
51

Thomas J. Tyrrell



Maria E. Portela



Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALKER, MARYANN
Employee/Petitioner

Case# **15WC033987**

OSWEGO C.U.S.D. 308
Employer/Respondent

20IWCC0660

On 1/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

0445 RODDY LAW LTD
PAUL SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

20 I W C C 0 6 6 0

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

Maryann Walker
Employee/Petitioner

v.

Oswego C.U.S.D. 308
Employer/Respondent

Case # **15** WC **33987**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On August 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* 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 as explained *infra*.

In the year preceding the injury, Petitioner earned $31,047.12; the average weekly wage was $597.06.

On the date of accident, Petitioner was 48 years of age, *single* with no dependent children.

Petitioner *has* received all reasonable and necessary medical services as explained *infra*.

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

Respondent shall be given a credit of $10,851.27 for TTD, $0 for TPD, $0 for maintenance, and $47,815.33 for other benefits (i.e., Section 8(j) payments), for a total credit of $58,666.60. *See* AX1.

Respondent is entitled to a credit of $47,815.33 under Section 8(j) of the Act. *See* AX1.

ORDER

Causal Connection

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a causal connection between her cervical spine and left shoulder conditions and accident at work on August 10, 2015.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $398.04/week for 79 & 1/7th weeks, commencing August 14, 2015 through August 23, 2015 and from October 15, 2015 through January 31, 2016 and from February 27, 2016 through February 28, 2016 from May 21, 2016 through July 27, 2017 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from August 10, 2015 through November 21, 2017, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall receive a credit of $10,851.27 for temporary total disability benefits paid as agreed by the parties.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits totaling $231,830.79 for medical bills that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $47,815.33 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.

20IWCC0660

Permanent Partial Disability

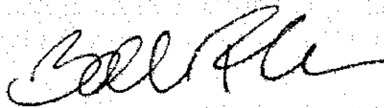
As explained in the Arbitration Decision Addendum, based on the factors delineated in Section 8.1b of the Act, and the record taken as a whole:

Respondent shall pay Petitioner permanent partial disability benefits of $358.24/week for 175 weeks, because the injuries sustained caused the 35% loss of use of the person-as-a-whole (cervical spine), as provided in Section 8(d)2 of the Act.

Respondent shall also pay Petitioner permanent partial disability benefits of $358.24/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of use of the person-as-a-whole (left shoulder), as provided in Section 8(d)2 of the Act.

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

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



Signature of Arbitrator

January 3, 2018
Date

ICArbDec19(b) p. 3

JAN 8 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Maryann Walker
Employee/Petitioner

v.

Oswego C.U.S.D. 308
Employer/Respondent

Case # **15** WC **33987**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include whether a causal connection between Petitioner's current condition of ill-being and such an accident, Respondent's liability for payment of Petitioner's medical bills totaling $231, 830.79 per Sections 8(a) and 8.2 of the Act, Petitioner's entitlement to temporary total disability benefits commencing on August 14, 2015 through August 23, 2015 and from October 15, 2015 through January 31, 2016 and from February 27, 2016 through February 28, 2016 from May 21, 2016 through July 27, 2017, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Maryann Walker (Petitioner) testified that she was employed as a driver for Oswego C.U.S.D. 308 (Respondent), and had been so employed for approximately five years, driving a bus for special needs students.

Petitioner had previously received medical treatment to the cervical spine and left shoulder or left upper extremity. RX1-RX2. In March of 2012, Petitioner was seen by Dr. Welsh at M & M Orthopedics following a motor vehicle accident resulting in a complex regional pain syndrome (CRPS) diagnosis and possibly cervical radiculitis. *Id.* She underwent an MRI that revealed a foraminal disc herniation at C5-6 towards the left as well as a focal disc protrusion at C6-7 on the left. *Id.* As of May 10, 2012, Petitioner complained of pain radiating to the left shoulder and both hands along with upper extremity paresthesia and weakness. *Id.* Dr. Kashow diagnosed Petitioner with cervicalgia. *Id.* Petitioner last received such treatment toward the end of 2012. *Id.*

Accident

On August 10, 2015, Petitioner explained that she was sitting at a red light on Randall Road at the intersection of Big Timber when her bus was struck from behind. Petitioner testified that she hurt her left shoulder and the left side of her neck. The police arrived and Petitioner testified that she drove the remaining child back home and then returned to her own home. Petitioner explained that she felt neck and back pain, so she went to the emergency room and reported the motor vehicle accident. She also testified that she reported left shoulder and neck pain as well as right shoulder pain.

Respondent offered video footage from within Petitioner's bus of the motor vehicle accident. RX3. The footage demonstrates the accident from two different viewpoints within the bus; one view point showing the

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Deposition exhibits are further denominated "(Dep. Ex. _)" with the corresponding number identified by each party.

rear-end of the bus, and the second view point showing the rear-end of the bus toward the front of the bus. *Id.*

Medical Treatment

The medical records reflect that Petitioner presented at the emergency room of Rush Copley Hospital where she reported that she had been involved in a motor vehicle accident. PX4. She complained of neck and left shoulder pain and some pain in the right shoulder. *Id.* Petitioner also underwent x-rays of her neck, shoulder, and thoracic spine, given pain medication, and told to follow up with the occupational health physician. *Id.*

On August 11, 2015, Petitioner testified that she was in a lot of pain on her left side and in her neck. She explained that she could not really move her neck and she contacted her employer at 5:00 a.m. Petitioner testified that her niece had to drive her to work. Respondent then directed Petitioner to additional medical care at Edwards Immediate Care in Oswego.

The medical records reflect that Petitioner presented at Edwards Immediate Care in Oswego reporting the motor vehicle accident. PX5. She reported cervical and thoracic pain along with pain radiating into the left upper extremity. *Id.* She was given valium and ibuprofen, recommendation for warm and cold packs, and restricted her physical activity. *Id.* Petitioner testified that she then began missing time from work beginning on August 14, 2015 through August 23, 2015.

On August 17, 2015, Petitioner returned to Edwards Immediate Care in Oswego reporting improvement to the right shoulder, but complaining of severe pain down her neck and back. PX5. She was given a prescription for Naproxen and Flexeril, continued off work, and recommended for a physical therapy evaluation. *Id.*

On August 24, 2015, Petitioner returned to work light-duty desk work. She explained that Respondent had her sitting at a desk all day doing nothing. Two days later, on August 26, 2015, Petitioner underwent an "Initial Physical Therapy Evaluation Shoulder" at WCS Advanced PT as ordered. PX5. She attended approximately six sessions between August 26, 2015 and September 9, 2015. *Id.* Petitioner testified that her pain was focused in her left arm.

Petitioner then returned to Edward Oswego Immediate Care on August 31, 2015. PX5. It was recommended that she continue with warm and cold packs, remain on modified work and physical restrictions, and told not to drive the bus. *Id.*

As of September 8, 2015, Petitioner "continue[d] to complain of pain in the left side of the neck and back area." PX5. Petitioner also reported difficulty raising her left arm above shoulder-height and "left shoulder pain getting 'stuck'." *Id.* Petitioner was referred for left shoulder x-rays to rule out any dislocation, but they were negative. *Id.* A cervical MRI was ordered and Petitioner remained on work restrictions. *Id.*

The cervical MRI was completed on September 18, 2015 at Premium Healthcare. PX6. The interpreting radiologist noted: (1) moderate degenerative disc disease at C5-6 and C6-7 with asymmetric stenosis along the left neural foramen and due to disc bulging and asymmetric protrusions with superimposed bony spondylotic changes; (2) moderate C3-4 stenosis, asymmetric along the right neural foramen, and due to disc bulging and asymmetric protrusions with superimposed bony spondylotic changes; and (3) no acute compression fracture or destructive process. *Id.*

Petitioner returned to Edward Oswego Immediate Care on September 23, 2015 and was referred to a neurosurgeon/spine surgeon for follow up. PX5. Petitioner remained on work restrictions, and testified that she continued the sedentary desk job for Respondent through October 14, 2015.

On October 14, 2015, Petitioner chose to see Joshua Alpert, M.D. (Dr. Alpert) at Midwest Bone & Joint. PX1. She reported her motor vehicle accident at work and symptoms including left shoulder and neck pain. *Id.* Regarding the left shoulder, Petitioner reported that she could not pick up the left arm, shooting pains, numbness down the arm, weakness, inability to sleep on the left due to pain, and that her shoulder was at 10% of normal. *Id.* Dr. Alpert prescribed a Medrol Dosepak and suggested an MRI arthrogram of the left shoulder. *Id.* He also placed Petitioner off work. *Id.* Petitioner testified that she began missing time from work beginning on October 15, 2015 through January 31, 2016.

Section 12 Examination – Dr. Skaletsky

On October 26, 2015, Petitioner submitted to a medical evaluation with Gary Skaletsky, M.D. (Dr. Skaletsky) at Respondent's request. RX4. Dr. Skaletsky took a history from Petitioner, performed a physical examination, reviewed various treating medical records, and rendered opinions regarding the relatedness, if any, of Petitioner's medical conditions to an accident at work. *Id.* At the time of the evaluation, Dr. Skaletsky noted Petitioner's report of left-sided neck pain that radiated into the left shoulder, arm and hand. *Id.*

Dr. Skaletsky diagnosed Petitioner with symptoms of left cervical radiculopathy and/or left shoulder pathology. RX4. He recommended a left shoulder MRI given the limitations on physical examination due to Petitioner's pain complaints. *Id.*

Continued Medical Treatment

Petitioner underwent the recommended MRI arthrogram on November 10, 2015 at Naperville Imaging Center and returned to Dr. Alpert on November 18, 2015. PX7. The interpreting radiologist noted: (1) mild supraspinatus tendinopathy without evidence of a supraspinatus tendon tear with intact rotator cuff tendons; and (2) a short segment tear in the anterior-superior labrum at the chondrolabral junction with minimal posterior-superior labral fraying; (3) minimal subacromial bursal inflammation; (4) minimal posterior subluxation of the humeral head relative to the glenoid without evidence of a bone contusion, fracture or dislocation; and (5) non-specific mild subcutaneous edema located superficial to the posterolateral deltoid muscle. *Id.*

On November 18, 2015, Dr. Alpert noted his review of Petitioner's left shoulder MRI arthrogram and Petitioner's continued complaints of mainly neck pain as well as left shoulder pain. PX1. He recommended additional physical therapy and he administered a cortisone injection into the left shoulder. *Id*

Petitioner began physical therapy on December 7, 2015 at Atlas Physical Therapy and had approximately 11 visits before discharge on February 9, 2016. PX8. Petitioner testified that after physical therapy she still could not lift her arm, had a stiff neck, and radiating pain down her arm.

Section 12 Addendum Report – Dr. Skaletsky

In the interim, Dr. Skaletsky issued an addendum report dated December 26, 2015. RX5. Therein, Dr. Skaletsky noted his review of Petitioner's left shoulder MRI, Petitioner's February 13, 2014 cervical MRI scan, and some additional treatment records. RX5. Dr. Skaletsky opined that Petitioner sustained an injury to the left

shoulder due to the motor vehicle accident on August 10, 2015 that aggravated her pre-existing degenerative cervical condition. *Id.* However, Dr. Skaletsky noted that the left shoulder condition and associated treatment was outside of his expertise and should be referred to an orthopedic surgeon for further evaluation. *Id.*

Continued Medical Treatment

On January 27, 2016, Petitioner returned to Dr. Alpert reporting that she was "doing terrible right now" and that she could barely move her shoulder without significant pain. PX1. He discussed possible shoulder surgery involving a left shoulder manipulation under anesthesia, arthroscopy, capsular release with biceps tenotomy, and subacromial decompression. *Id.* Dr. Alpert also prescribed a topical pain medication and limited Petitioner to desk work. *Id.*

Respondent offered Petitioner light duty work from February 1, 2016 to February 26, 2016. Petitioner testified that she missed work beginning on February 27 through 28, 2016, and that she returned to light duty work from March 1, 2016 through May 20, 2016. Beginning on May 21, 2016, Petitioner explained that she has been off work.

Utilization Review – CorVel

Respondent offered a utilization review from CorVel dated March 3, 2016. RX8. The topical Compound A3 medication ordered by Dr. Alpert was non-certified. *Id.*

Section 12 Examination – Dr. Bush-Joseph

On June 1, 2016, Petitioner submitted to a medical evaluation with Charles Bush-Joseph, M.D. (Dr. Bush-Joseph) at Respondent's request. RX6 (Dep. Ex. 2). Dr. Bush-Joseph took a history from Petitioner, performed a physical examination, reviewed various treating medical records, and rendered opinions regarding the relatedness, if any, of Petitioner's medical conditions to an accident at work. *Id.* Dr. Bush-Joseph noted the following history in pertinent part:

> As you know, Ms. Walker is a 48-year-old right-hand-dominant female who is a school bus driver for District #308. She states she has worked in that position for approximately five years. Ms. Walker claims no prior injury, treatment or trauma to the left shoulder before suffering a work-related injury which occurred on August 10, 2015.
>
> Ms. Walker described in detail that she was driving her bus and was wearing her seatbelts when she was struck by another vehicle at a high rate of speed which she was stopped. She states she was holding the wheel at the time of the accident. I was able to view video images from the on-board cameras as well as damage photos from the accident. The video file and photos are consistent with a very low-speed rear-end collision.

Id.

Dr. Bush-Joseph diagnosed Petitioner with a chronic cervical strain and trapezial spasm with voluntary shoulder spasm. RX6 (Dep. Ex. 2). He indicated that, after reviewing the video footage and additional information provided, that there was evidence of a mechanical injury to the head and neck region. *Id.* However, he indicated that the injury was consistent with a soft tissue injury. *Id.* Dr. Bush-Joseph further stated that the

"accident was very low velocity with minimal movement by Ms. Walker at the time of impact. Certainly, it is difficult to say the mechanism of injury and the trauma I witnessed was sufficient to produce injury and the findings noted on exam." *Id.*

Ultimately, Dr. Bush-Joseph opined that Petitioner's motor vehicle accident at work did not produce a chondral labral injury and that the significant delay in reporting left shoulder symptoms and motion loss suggested a lack of causation. *Id.* He indicated that Petitioner could perform her sedentary work, but indicated that she should not lift overhead or reach with the left arm. *Id.*

Continued Medical Treatment

On July 6, 2016, Petitioner returned to Dr. Alpert at which time he recommended left shoulder surgery involving a left shoulder manipulation under anesthesia with extensive debridement, biceps tenotomy, and subacromial decompression. PX1. He diagnosed Petitioner with significant adhesive capsulitis in the left shoulder after her motor vehicle accident. *Id.*

Petitioner underwent left shoulder surgery with Dr. Alpert on July 26, 2016 at the Ashton Surgery Center. PX9. Pre- and post-operatively, Dr. Alpert diagnosed Petitioner with adhesive capsulitis in the left shoulder. *Id.* He performed a left shoulder arthroscopic manipulation under anesthesia with extensive debridement, a biceps tenotomy, and subacromial decompression. *Id.* Petitioner had an initial physical therapy evaluation post-surgery at ATI on July 27, 2016. PX10. However, she elected to undergo the physical therapy treatment at AthletiCo. PX1.

On August 3, 2016, Petitioner returned to Dr. Alpert. PX1. She was instructed to discontinue use of the sling, to do more aggressive with physical therapy, and he gave her pain cream. *Id.* She was given work restrictions of no lifting with the left arm. *Id.* As of September 14, 2016, Petitioner reported to Dr. Alpert that she was doing very poorly with significant pain in her neck, down her left arm, and numbness and tingling that she felt was worse since the surgery. *Id.* He recommended a cervical MRI and follow up with his associate, Dr. Stanley. *Id.*

Petitioner underwent the MRI on September 19, 2016. PX7. The interpreting radiologist noted: (1) straightening of the normal cervical lordosis; (2) multilevel cervical spondylosis and disc desiccation; (3) moderate C3-4, mild-to-moderate C5-6 and C6-7, and mild C4-5 spinal canal narrowing due to disc bulge which flattens the ventral cord; (4) moderate-to-severe neural foraminal narrowing on the right at C3-4, on the left at C5-6, C6-7 as well as moderately on the right at C4-5 and C5-6, and mild-to-moderate on the left at C4-5 and mild on the left at C3-4; and (5) incidentally noted 1.1 cm right thyroid cyst or nodule. *Id.*

Petitioner returned to Dr. Stanley on September 29, 2016. PX1. He noted that she had profound weakness in the left upper extremity. *Id.* Dr. Stanley recommended an EMG/NCV test and discussed the possibility of cervical spine surgery in the form of a cervical discectomy and fusion at C4-5, C5-6, and C6-7. *Id.*

On October 6, 2016, Dr. Stanley reviewed Petitioner's October 3, 2016 EMG/NCV results, which confirmed left-sided radiculopathy at C4, C5, C6, and C7. PX1. Dr. Stanley stated that Petitioner's symptoms were consistent with her motor vehicle accident, which was the cause for her need for surgery. *Id.*

Petitioner then sought a second opinion on October 3, 2016 Ryan Hennessy, M.D. (Dr. Hennessy). PX12. He

agreed with Dr. Stanley's recommendation for the multi-level fusion. *Id.* Petitioner testified that Dr. Hennessy was recommended by Blue Cross Blue Shield.

Petitioner returned to see Dr. Alpert on October 10, 2016. PX1. He recommended a home exercise program for her left shoulder and wanted to wait on further care until after her neck surgery. *Id.*

On October 26, 2016, Petitioner underwent surgery with Dr. Stanley. PX13. Pre-and post-operatively, Dr. Stanley diagnosed Petitioner with cervical radiculopathy. *Id.* He performed an anterior cervical discectomy and fusion at C4-5, C5-6, and C6-7 with instrumentation and allograft. *Id.*

Petitioner testified that after her cervical spine surgery, she began experiencing panic attacks and anxiety which delayed her discharge until November 12, 2016.

Deposition Testimony – Dr. Stanley

On November 15, 2016, Petitioner called Dr. Stanley as a witness and he gave testimony at an evidence deposition. PX3. Dr. Stanley testified that he is a board-certified surgeon. PX3 at 4-5; PX3 (Dep. Ex. 1).

Dr. Stanley testified that Petitioner was referred to him by his partner, Dr. Alpert. PX3 at 5-6. He testified that when Petitioner first presented to him, she had been in a motor vehicle accident after which she was diagnosed with a whiplash injury. *Id.*, at 7. Dr. Stanley explained that Petitioner's MRI and EMG confirmed her cervical stenosis and radiculopathy for which he recommended surgery. *Id.*, at 8-10. Ultimately, Dr. Stanley diagnosed Petitioner with cervical radiculopathy and he opined that her condition was causally related to her accident at work. *Id.*, at 13-14. In so concluding, he explained that Petitioner had no pre-existing radiculopathy. *Id.*

On cross-examination, Dr. Stanley acknowledged that he had not reviewed Petitioner's prior medical records. PX3 at 15. He was not aware of a 2012 cervical MRI noting pathology in the neck including disc herniations and protrusions, or of Petitioner's 2012 diagnosis of cervicalgia. *Id.*, at 15-17. Notwithstanding, Dr. Stanley explained that the MRI findings in 2012 were not surprising to him, but it was not the MRI findings that he attributed to the accident at work, rather it was the radiculopathy that he attributed to the accident at work. *Id.*, at 17-18.

Continued Medical Treatment

On November 18, 2016, Petitioner saw Dr. Stanley with complaints of skin breakdown on her chest due to the prescribed neck brace. PX1. He had her discontinue the use of the neck brace and recommended a bone growth stimulator. *Id.* He further suggested beginning a course of physical therapy in four weeks. *Id.*

Petitioner returned to Dr. Stanley on December 27, 2016 and reported that the pinched nerve pain down her arm was gone. PX1. She also reported some neck stiffness and continued difficulty with shoulder motion. *Id.* Dr. Stanley recommended additional physical therapy for the neck and shoulder and an MR arthrogram. *Id.*

On December 30, 2016, Petitioner underwent the MR arthrogram. PX7. The interpreting radiologist noted: (1) low to intermediate grade partial thickness articular surface tear of the distal supraspinatus tendon with no discrete full thickness tear noted; and (2) minimal fraying/irregularity of the superior glenoid labrum, that may be post-operative in nature. *Id.*

Petitioner returned to Dr. Alpert on January 11, 2017. PX1. She had continued complaints of pain and inability to lift her arm. *Id.* He recommended a cortisone injection in the left shoulder, physical therapy, and additional topical pain medication. *Id.*

Deposition Testimony – Dr. Alpert

On January 27, 2017, Petitioner called Dr. Alpert as a witness and he gave testimony at an evidence deposition. PX2. Dr. Alpert testified that he is a board-certified surgeon. PX2 at 4-6; PX2 (Dep. Ex. 1).

Dr. Alpert testified that when he first saw Petitioner she reported left shoulder and neck pain following a motor vehicle accident. PX2 at 6-7. On physical examination, he noted decreased left shoulder range of motion, weakness with rotator cuff strength testing, and pain around her neck as well as paraspinal muscles. *Id.*, at 8. Dr. Alpert diagnosed Petitioner with a rotator cuff or SLAP tear. *Id.* Ultimately, Dr. Alpert recommended and performed the left shoulder surgery. *Id.*, at 12. Intraoperatively, he noted a type 2 superior labral tear, where the biceps pulls the entire labrum off the socket. *Id.*, at 12-13. Dr. Alpert also testified that generally a type 2 SLAP tear is traumatically induced and that an inflamed biceps tendon and the extensive synovitis and bursitis that he noted were usually an acute inflammatory-type condition, and not degenerative in nature.. *Id.*, at 13.

Dr. Alpert was also provided with video footage of the accident from within Petitioner's bus. PX2 at 17. He testified that he believes that there is a causal relationship between the accident and Petitioner's left shoulder condition. *Id.* Specifically, Dr. Alpert opined that Petitioner had no pre-existing complaints of left shoulder pain or stiffness before the accident and the mechanism of injury involved her hand on the steering wheel when she was rear-ended. *Id.*, at 17-18. He went on to note that Petitioner complained of symptoms within a reasonable amount of time after the accident and that the development of pain and stiffness and a labral tear is common to develop given the mechanism of Petitioner's injury. *Id.*

On cross-examination, Dr. Alpert acknowledged that he was not aware of Petitioner having any left arm issues before her accident at work, or involvement in a prior motor vehicle accident in 2012. PX2 at 20. He also acknowledged that he did not review the emergency room records from after the accident. *Id.*, at 21.

Regarding the video footage of the accident from within the bus, Dr. Alpert testified that she saw Petitioner's hands on the steering wheel and her neck and arm "move in a whiplash maneuver, but it certainly wasn't a massive movement." PX2 at 23-24. Dr. Alpert also testified that adhesive capsulitis can be traumatically induced or it can just occur. *Id.*, at 24. He testified that if Petitioner had left shoulder stiffness for four years after her 2012 motor vehicle accident or a CRPS or RSD diagnosis, the adhesive capsulitis could have developed therefrom. *Id.*, at 24-25. Dr. Alpert also testified that four weeks is "on the cusp of late[]" in terms of reporting her left shoulder symptoms. *Id.*, at 25.

Ultimately, Dr. Alpert maintained that Petitioner's left shoulder surgery was necessary as a result of her motor vehicle accident at work. PX2 at 28-29.

Continued Medical Treatment

Petitioner began physical therapy at Total Rehab on February 23, 2017 for approximately 10 visits until April 6, 2017. *Id.*

Petitioner returned to Dr. Alpert on March 29, 2017 with continued pain complaints. PX1. Dr. Alpert indicated that Petitioner could either live with the symptoms or attempt a repeat left shoulder manipulation under anesthesia followed by more physical therapy. *Id.*

On May 5, 2017, Petitioner returned to Dr. Stanley who kept her off work. PX1. As of May 23, 2017, Dr. Stanley referred Petitioner back to Dr. Alpert. *Id.* During this time, Petitioner was attending physical therapy, but she testified that she felt as if it was not really helping her. Dr. Stanley told Petitioner she should either do another shoulder surgery or get a functional capacity evaluation. *Id.*

Petitioner told Dr. Stanley she wanted to get a second opinion, and obtained one from Dr. Goldberg on June 7, 2017. She testified that he recommended another MRI and nerve test with follow up care from Dr. Stanley. Petitioner underwent the recommended CT scan and cervical MRI on July 12, 2017 as well as an EMG on July 19, 2017. PX1. She then returned to Dr. Stanley on July 27, 2017 and he reviewed the testing. *Id.* Dr. Stanley placed Petitioner at maximum medical improvement and sent her for a functional capacity evaluation. *Id.*

On August 1, 2017, Petitioner sought a third opinion from an orthopedic surgeon, Joanne Labriola, M.D. (Dr. Labriola) at Elmhurst Clinic regarding further operative care. PX17. Dr. Labriola diagnosed Petitioner with left shoulder adhesive capsulitis and left cervical radiculitis. *Id.* She did not recommend further surgery indicating that it could further worsen her symptoms. *Id.*

Petitioner then underwent the recommended functional capacity evaluation on August 26, 2017. PX11. The evaluating physical therapist determined that the results were valid and that Petitioner could work at the sedentary physical demand level. *Id.*

Deposition Testimony – Dr. Bush-Joseph

On May 17, 2017, Respondent called Dr. Bush-Joseph as a witness and he gave testimony at an evidence deposition. RX6. Dr. Bush-Joseph testified that he is a board-certified surgeon focusing in knee, shoulder, hip and ankle. RX6 at 4-6; RX6 (Dep. Ex. 1).

Dr. Bush-Joseph maintained the opinions articulated in his Section 12 report. RX 6 at 15-16. Namely, Dr. Bush-Joseph testified that Petitioner suffered from a chronic cervical strain with voluntary shoulder muscle spasm. *Id.* He also maintained that Petitioner's motor vehicle accident, which was low-velocity based on the documentation, photos and video footage that he reviewed, did not correlated with an intra-articular or intrinsic shoulder injury. *Id.*, at 16-17. Dr. Bush-Joseph conceded that Petitioner sustained an injury at work, but he did not believe that it was an intrinsic shoulder injury or that her cervical spine condition and spasms were causally related to the accident. *Id.*, at 17-18.

On cross-examination, Dr. Bush-Joseph testified that it was possible for a patient to have an acute inflammatory reaction (i.e., inflamed biceps tendon, extensive synovitis, and bursitis) because of a traumatic event. RX6 at 19. He acknowledged that Petitioner had no prior left shoulder complaints of pain or stiffness, that her left hand was on the steering wheel at the time of the accident, and that it was possible to sustain a labral tear when involved in rear-end accident while holding the steering wheel. *Id.*, at 19-20.

Dr. Bush-Joseph testified that he did not have the opportunity to review Petitioner's operative report from the

left shoulder surgery, or Petitioner's left shoulder x-ray from September 8, 2015. RX6 at 20, 23. He also acknowledged that Petitioner's only pre-existing condition in the left shoulder was of a prior clavicle fracture. *Id.*, at 21. Dr. Bush-Joseph admitted that, if Petitioner had complained about left shoulder symptoms less than a month after the motor vehicle accident causing a physician to order a left shoulder x-ray, he would no longer characterize Petitioner's report of left shoulder symptoms to have been significantly delayed. *Id.*, at 24.

Vocational Rehabilitation Assessment – Mr. Blumenthal

Petitioner offered a vocational rehabilitation assessment report from Steven M. Blumenthal (Mr. Blumenthal) dated October 4, 2017. PX16. Mr. Blumenthal determined that Petitioner would require additional computer skills training, job readiness training, and job placement assistance to re-enter the job market. *Id.* He indicated that Petitioner had clear transferrable skills and intellectual ability, but required the foregoing additional assistance given Petitioner's age, physical limitations, and lack of recent office experience. *Id.* Among other prior work experience and skills noted, Petitioner had worked as a paralegal from 1995 to 1999, with American Express from 1999 through 2003, and as a mortgage closer at American Title 2003 to 2009. *Id.* Mr. Blumenthal estimated that such training would take 8-10 months and cost approximately $18,000-$25,000. *Id.*

Vocational Assessment & Transferrable Skills Analysis – Ms. Dytrych

Respondent offered a labor market survey from Kathleen M. Dytrych of EVR, Inc. dated October 31, 2017. RX7. Respondent also offered a vocational assessment report and transferrable skills analysis from Ms. Dytrych dated October 16, 2017. *Id.* Ms. Dytrych concluded that Petitioner could work at the sedentary physical demand level within the restrictions outlined in her functional capacity evaluation. *Id.* She further opined that Petitioner would likely experience a slight wage loss with an earning capacity within the range of $10.00 to $13.00 per hour. *Id.* Respondent also offered a labor market survey from Ms. Dytrych of EVR, Inc. dated October 31, 2017. *Id.*

Additional Information

Regarding her current condition, Petitioner testified that she drops things (i.e., cups, spoons) and continues to experience tingling and a feeling her in right hand as though it were "going to sleep." She also has a hard time doing a lot of things she cannot function the way she used to function. Petitioner testified that she cannot do simple things like go shopping by herself.

Petitioner eats with paper plates because regular plates are too heavy. She sometimes needs help getting dressed and cannot lift her arm. Petitioner also testified that she now has anxiety attacks, which she did not have before her injury. She is afraid that someone will hit her when in crowded places and driving is hard because she does not have movement of her neck. Petitioner testified that she obtained different opinions to be sure that surgery was the best option for her. She explained that she is trying to live with one arm, and it is very hard. Petitioner testified that she did not have any of these issues before her accident.

Petitioner does have an "angel wing" condition meaning that her shoulders are shaped like an angel wing and they slope down. She explained that she was always able to function and she had no restrictions because of this condition. Petitioner testified that she has her CDL license, but not the endorsements required to drive a bus.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Based on the totality of the evidence, the Arbitrator finds that Petitioner's claimed current conditions of ill-being in the cervical spine and left shoulder are causally related to the injury sustained at work on August 10, 2015. In so finding, the Arbitrator relies on the opinions of Petitioner's treating physicians, Dr. Alpert and Dr. Stanley, as well as Petitioner's testimony.

A claimant need only establish a causal connection between her work-related injury and claimed current condition of ill-being by showing that her injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). In this case, the record reflects that Petitioner had prior medical treatment to the cervical spine and left shoulder. Petitioner acknowledged that she was involved in a motor vehicle accident in 2012. In March of 2012, Petitioner was diagnosed with complex regional pain syndrome (CRPS) and possibly cervical radiculitis. As of May 10, 2012, Petitioner complained of pain radiating to the left shoulder and both hands along with upper extremity paresthesia and weakness. Dr. Kashow diagnosed Petitioner with cervicalgia. There is no evidence of further cervical spine or left shoulder symptoms requiring medical treatment or preventing Petitioner from performing full duty work for years until after her motor vehicle accident at work on August 10, 2015.

Respondent's Section 12 examiner, Dr. Skaletsky opined that Petitioner sustained an injury to the left shoulder due to the motor vehicle accident on August 10, 2015 that aggravated her pre-existing degenerative cervical condition, but he noted that left shoulder treatment was outside of his expertise and should be referred to an orthopedic surgeon for further evaluation. Respondent then sent Petitioner to Dr. Bush-Joseph for a Section 12 evaluation focused on the left shoulder.

Dr. Bush-Joseph opined that there was no causal connection between Petitioner's accident and left shoulder condition. In so concluding, Dr. Bush-Joseph noted a significant delay in Petitioner's report of any left shoulder symptoms. However, on cross-examination Dr. Bush-Joseph conceded that if Petitioner had reported left shoulder symptoms less than a month after her accident he would no longer characterize her report as significantly delayed. The medical records reflect that Petitioner did report left shoulder symptoms within one month of her accident. On September 8, 2015, 29 days after her accident at work, Petitioner's medical records reflect her report of continued "complain[t] of pain in the left side of the neck and back area[,]" difficulty raising her left arm above shoulder-height, and "left shoulder pain getting 'stuck'." PX5. Dr. Bush-Joseph also conceded that he did not review Petitioner's left shoulder operative report. This is significant because Dr. Stanley noted intra-operative findings suggesting an acute process. When questioned on cross-examination whether it was possible for a patient to have an acute inflammatory reaction (i.e., inflamed biceps tendon, extensive synovitis, and bursitis as reflected in the operative report), Dr. Bush-Joseph conceded that this could occur because of a traumatic event. Based on the foregoing, the opinions of Dr. Bush-Joseph are not persuasive

given the totality of the record.

Considering the cervical spine condition, it is notable that Respondent's Section 12 examiner, Dr. Skaletsky, diagnosed Petitioner with symptoms of left cervical radiculopathy and opined that the condition was aggravated by the motor vehicle accident at work. However, the record also contains the opinions of Petitioner's treating physicians, Dr. Alpert and Dr. Stanley, who specifically related Petitioner's left shoulder and cervical spine conditions to the accident at work.

The medical records reflect Petitioner's immediate report of symptoms in the neck, upper back, and left shoulder symptoms within one month of the accident. Dr. Stanley noted that Petitioner had no cervical radiculopathy symptoms or treatment for years, and that she could drive her bus without impediment until after August 10, 2015. Dr. Alpert noted that Petitioner had no complaints of left shoulder pain or stiffness for years before the accident, and he highlighted the mechanism of injury as competent to cause Petitioner's left shoulder condition. Specifically, Dr. Alpert noted that Petitioner had her left hand on the steering wheel when she was rear-ended. Dr. Alpert and Dr. Bush-Joseph disagree as to the force involved in the rear-end collision, but they agree—and the video footage confirms—Petitioner holding the steering wheel with her left hand when she was jolted because of the vehicle colliding with her bus.

Given the totality of the record, including the mechanism of injury and medical records reflecting Petitioner's immediate reports of cervical and upper back complaints coupled with her specific complaints of left shoulder pain and weakness one month after the accident, the Arbitrator finds the opinions of Petitioner's treating physicians, Dr. Alpert and Dr. Stanley, to be persuasive and adopts those opinions herein. Thus, the Arbitrator finds that Petitioner has established a continued causal connection between her cervical spine and left shoulder conditions of ill-being and accident at work on August 10, 2015.

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

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after her accident at work. In consideration of the treatment records and medical bills, the Arbitrator finds that the treatment rendered to Petitioner is reflective of reasonable and necessary medical treatment to alleviate her of the effects of her accident at work. Therefore, the Arbitrator awards payment of the medical bills submitted in Petitioner's Exhibits totaling $231,830.79 as those are reasonable, necessary, and related to medical treatment necessitated after Petitioner's accident at work. Respondent shall be given a credit of $47,815.33 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 support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

Considering the causal connection analysis explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits from August 14, 2015 through August 23, 2015 and from October 15, 2015 through January 31, 2016 and from February 27, 2016 through February 28, 2016 from May 21, 2016 through July 27, 2017.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n,* 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n,* 2014 IL App (3d) 130028WC at *28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n,* 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine,* 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n,* 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

Petitioner's testimony and the medical records reflect that Petitioner underwent medical treatment and was incapacitated because of the effects of her accident such that she was either placed off work or on light duty restrictions that Respondent could not accommodate. Thus, based on the record the Arbitrator finds that Petitioner was temporarily totally disabled from August 14, 2015 through August 23, 2015 and from October 15, 2015 through January 31, 2016 and from February 27, 2016 through February 28, 2016 from May 21, 2016 through July 27, 2017 as claimed. Respondent shall receive a credit for temporary total disability benefit payments made as agreed by the parties totaling $10,851.27.

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

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:
>
> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and

(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a bus driver the time of her accident. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. This fact is stipulated by the parties. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there is no evidence of diminishment[2] in Petitioner's future earnings capacity as a result of her accident. Petitioner presented the report of Mr. Blumenthal, who indicated that she would require additional training to update her transferrable skills, but thereafter she could re-enter the labor market without diminished wages. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained cervical injury requiring a three-level fusion and a left shoulder injury requiring surgery. Specifically, Dr. Alpert diagnosed Petitioner with adhesive capsulitis in the left shoulder and performed a left shoulder arthroscopic manipulation under anesthesia with extensive debridement, a biceps tenotomy, and subacromial decompression. Dr. Stanley diagnosed Petitioner with cervical radiculopathy and performed a three-level anterior cervical discectomy and fusion C4-5, C5-6, and C6-7 with instrumentation and allograft. Petitioner testified that she continues to have residual symptomatology. Thus, the Arbitrator assigns significant weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 35% loss of use of the person as a whole for the cervical spine injury and permanent partial disability to the extent of 7.5% loss of use of the person as a whole for the left shoulder injury pursuant to Section 8(d)2 of the Act.

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[2] Petitioner waived her right to a wage differential award at the hearing, which is stipulated by the parties.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Mitchell,
Petitioner,

vs. No: 16 WC 22130

20 I W CC0661

Mach Mining, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

Petition for Review having been timely filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of exposure, disease, causal connection, and nature and extent under the Occupational Disease Act, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

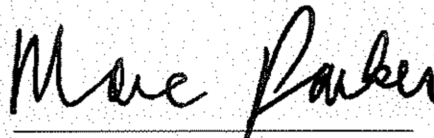
IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 4, 2020, is hereby affirmed and adopted.

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

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

No bond is set in this case, as the Commission made no award. 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: NOV 13 2020



Marc Parker

mp/dk
0-11/5/20
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Barbara N. Flores

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MITCHELL, MICHAEL
Employee/Petitioner

Case# **16WC022130**

MACH MINE LLC [MACH MINING LLC]
Employer/Respondent

20IWCC0661

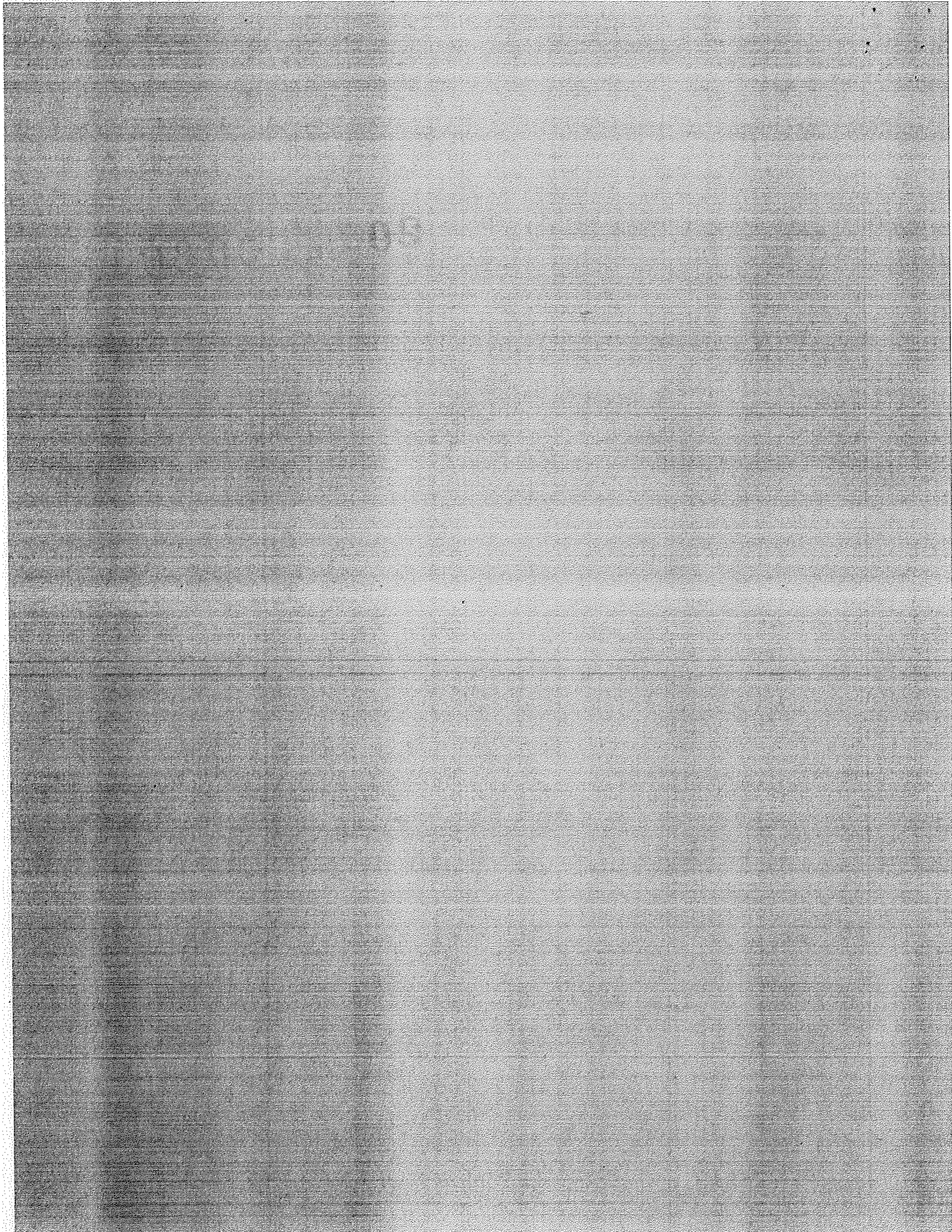
On 3/4/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5236 CULLEY FEIST KUPPART & TAYLOR
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

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



STATE OF ILLINOIS)
)SS.
COUNTY OF 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

Michael Mitchell
Employee/Petitioner

Case # 16 WC 22130

v.

Consolidated cases: ______

Mach Mine LLC [Mach Mining, LLC]
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on January 16, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On May 22, 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 $n/a; the average weekly wage was $1,557.22.

On the date of accident, Petitioner was 62 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's 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

March 1, 2020
Date

MAR 4 - 2020

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 May 22, 2016, 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 40 years (Arbitrator's Exhibit 2).

At the time of trial, Petitioner was 65 years of age. Petitioner worked in the coal mines for almost 41 years, from 1975 until he retired in May 2016. While working in the coal mine, he was regularly exposed to coal and rock dust, diesel fumes and smoke in the shop from the kerosene heaters. Petitioner last worked in the coal mine on May 22, 2016, for Respondent at its Pittsburg, Illinois location. Petitioner was 62 years of age on his last day of employment. His job classification was dozer operator. On this last day Petitioner was exposed to and breathed coal dust. Petitioner testified that he retired on that date. One reason for his retirement at that time was he had cancer. In 2012 he had colon cancer and they removed part of his colon. His cancer metastasized to his liver in 2014. Petitioner testified that he was working 12 ½ hours per day, six days on and then three days off. He testified that those hours were too hard on him. Petitioner testified that at the end of his career it was harder for him to do his job than when he began. In part it was harder because of the 12 ½ hour days and the rotating schedule. He testified that there was just one dozer on the gob pile, and he did not have time to stop. He testified that it was a physically demanding job. Petitioner's working conditions played a role in why he retired. Petitioner testified that when he had to run in third gear there was more dust stirred up in the cab. Petitioner has not been employed since retiring from Respondent.

Petitioner graduated from high school in 1972. Petitioner then completed one year of junior college at Southeastern Illinois College where he studied agricultural mechanics and auto mechanics. Petitioner went to work at Tom Johns' Ford as a mechanic and then as a service manager and parts manager. After about a year and a half he went to Denny Trucking where he was a mechanic and drove a truck for about a year. Petitioner then went to work at D & S Coal in Madisonville, Kentucky, from 1975 to 1978. In 1978 he went to work for Peabody Coal at its Will Scarlett Mine. He worked there until 1987 when he went to work for Sahara Coal. He worked there until December, 1988. He drove a truck for Celebrity Freight for about six months. In the summer of 1988, he went to work for Eagle Valley Coal until 1990. From 1990 to 2001, Petitioner worked at Arclair Coal at the Big Ridge Mine. When Big Ridge shut down in 2001, Petitioner went to Willow Lake. From January 2007 until May 2016, he worked for Respondent. Petitioner's classifications in the coal mine included coal truck driver, dozer operator, pumper, end loader operator, scraper operator, drill helper, gob truck driver, repairman in the plant, and other equipment operator.

While working for Respondent, he was a dozer operator on the raw coal pile as well as the clean coal pile loading trains with coal. He also repaired one day a week. Petitioner testified that as dozer operator at Respondent the exertional requirements of the job were heavy. It was also

stressful mentally. Petitioner testified that there was only one dozer on the beltline and he would have to push 1,200 to 1,500 tons of coal per hour with a 20 yard blade. He had to make a cycle every minute. Petitioner testified that in the beginning of his career the dozer he ran did not have a cab. He testified that the dozer he worked on at Respondent did have a cab but when he had to run that fast it would shake the door so badly that it did not keep the dust out. When working in the plant worked on all floors doing repairs. He testified there were at least half a dozen floors and there were 20 to 30 feet between the floors. He would have to climb stairs between those floors. Replacing screens in the shakers would stir up a lot of dust. He testified that changing rollers would also stir up dust. He testified that the rollers weighed at least 50 pounds. They were six foot rollers. It would take two people to move them. He would have to carry up to forty pounds of tools and small parts in a five gallon bucket when going up and down the stairs. Petitioner testified that when the plant was not running it was dry and everything he did would kick up dust.

Petitioner testified that he runs out of air quickly. He testified that he cannot walk very far or do much without having to stop to get his breath. When he was working on the gob pile, Petitioner not only pushed the gob away but also had to build the slopes and impoundment for the slurry. If he had to get off the dozer and go check a grade stake or move one, then he would have to climb back up the slope. He noticed that he would have to stop before he could get back up to the dozer. Petitioner would climb from the rock coal up to the top of the plant. He testified that he would have to climb 500 feet to the top of the plant.

Petitioner testified that it is about 200 feet from his driveway down to the road. He testified that he can make it down to the road, but he cannot make it back from the road without having to stop. He testified that at the plant it was probably 30 feet to the first floor. If he was going up to the control room on the second floor where they kept the tools, he would have to stop at the top of the first flight of stairs. Petitioner testified that from the onset of his breathing problems until trial, they had gotten worse.

Petitioner testified that he had never been prescribed any breathing medications. Petitioner testified that he used to be able to mow his yard with a push mower and weed eat, but he cannot do that anymore. He just mows what he can with a mower and does no trimming with push mower or weed eater. Petitioner testified that he cannot chase his grandchildren. Petitioner testified that his treating physician is Dr. James Alexander. He testified that he has never seen Dr. Alexander for breathing problems because he didn't think there was anything he could do. Petitioner testified that he has never smoked.

In addition to breathing limitations, Petitioner has had colon cancer twice. He has high blood pressure. Petitioner testified that while working at Respondent, he was able to complete his job but it was harder at the end than it was in the beginning because it was more strenuous both physically and mentally. Petitioner testified that as of trial, he could not do his last job in the coal mine as a dozer operator.

Petitioner testified that at the various mines where he worked, he was basically an equipment operator and mechanic. He testified that he always worked on the surface. His entire employment at Respondent was as a dozer operator. Petitioner testified that other than trying to keep up with his grandkids, he does very little. He testified that he rides a scooter. Petitioner testified that he owns about four acres with a house and pole barn. Most of the acreage is wooded.

Dr. Suhail Istanbouly examined Petitioner on October 18, 2016, at the request of Petitioner's counsel. Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. Dr. Istanbouly testified that roughly 30% of his patient census deals with the care and treatment of coal miners. He has performed black lung examinations for the U.S. Department of Labor. He has been the medical director of the pulmonary department at Herrin Hospital since 2005. Dr. Istanbouly performs five to seven examinations such as that performed on Petitioner every month. Those exams are always at the request of a claimant's attorney (Petitioner's Exhibit 1, pp 4-6, 18).

Dr. Istanbouly noted that Petitioner was a coal miner for over 40 years with his last month of coal mine employment being May, 2016. Petitioner never smoked. He mentioned that he had mild exertional dyspnea as he was able to walk for a quarter of a mile at a slow pace. Petitioner reported being treated for colon cancer in 2012 and 2014 (Petitioner's Exhibit 1, pp 7- 8).

Physical examination of Petitioner's chest was within normal limits. Petitioner's pulmonary function studies were within normal limits. Dr. Istanbouly testified that having pulmonary function studies within the range of normal does not mean that the lungs have not been damaged. He testified that there can be damage, but the damage is not significant enough to be revealed on pulmonary function testing. Dr. Istanbouly reviewed a chest x-ray dated June 22, 2016, taken at Ferrell Hospital. He testified that the chest x-ray he reviewed was of diagnostic quality. Dr. Istanbouly testified that the chest x-ray revealed mild bilateral interstitial changes suggestive of simple coal workers' pneumoconiosis of a profusion 1/0 per B-reader Dr. Henry Smith. Dr. Istanbouly diagnosed Petitioner with coal workers' pneumoconiosis which was caused by Petitioner's long term coal dust inhalation (Petitioner's Exhibit 1, pp 8-13).

Dr. Istanbouly described coal workers' pneumoconiosis as fine particles being inhaled into the deep parts of the airways ending in the alveoli creating a local irritation or inflammation that ends up with tiny scars which are seen as small, round opacities on the x-ray. The tiny scars replace the normal lung tissue and affect the gas exchange to the vascular parenchymal barrier. The scarring and fibrosis of coal workers' pneumoconiosis are permanent. By definition, if one has coal workers' pneumoconiosis, he has permanent impairment in the function of his lungs at least at the site of the scar or fibrosis (Petitioner's Exhibit 1, pp 13-15).

Dr. Istanbouly testified that Petitioner had clinically significant pulmonary impairment based on his exertional dyspnea. Due to his coal workers' pneumoconiosis, Petitioner cannot have additional exposure to coal dust without endangering his health. Dr. Istanbouly testified that coal workers' pneumoconiosis makes an individual more susceptible to respiratory infections and

pneumonias. He testified that it makes recovery from those respiratory infections and pneumonias more difficult (Petitioner's Exhibit 1, pp 16-17).

Petitioner denied chronic daily cough. He could not identify any triggers for his cough when he did have cough. He had no significant sputum production with his cough. Dr. Istanbouly testified that dyspnea on exertion can be caused by conditions other than pulmonary disease. Deconditioning is something that can be associated with same. Petitioner was not taking any breathing medications when he saw Dr. Istanbouly and did not provide the doctor with a history of ever having taken breathing medications in the past. Dr. Istanbouly did not review any treatment records regarding Petitioner. Petitioner's spirometry was normal. There was no indication of restriction or evidence of obstruction in Petitioner. Petitioner did not tell Dr. Istanbouly that he left work at the mine at the time he did due to respiratory symptoms or disease. He did not report to Dr. Istanbouly that he had a difficult time in performing his last job duties in the mine because of respiratory problems (Petitioner's Exhibit 1, pp 18, 20-23).

Dr. Istanbouly was provided with Dr. Smith's interpretation of the June 22, 2016, chest x-ray. He was not provided any other interpretation of chest images for Petitioner. Dr. Istanbouly testified that he does not use the standard ILO films when interpreting a chest x-ray for black lung. Dr. Istanbouly is neither an A-reader or a B-reader of films. Dr. Istanbouly does not provide profusion ratings for the films he interprets for black lung. When he reviews a film for black lung, he determines whether the film is positive or negative, and if he finds that it is positive he classifies the film as revealing early, moderate or severe disease. In Petitioner's case, he interpreted the film as early disease. He could not say whether the film he reviewed had a profusion of 1/0 or 0/1. Petitioner did not have complicated pneumoconiosis. Dr. Istanbouly's sole diagnosis was simple coal workers' pneumoconiosis (Petitioner's Exhibit 1, pp 23-24).

Dr. Henry K. Smith is a diagnostic radiologist (Petitioner's Exhibit 2, p 4). Dr. Smith has been board certified in radiology since 1973. He first took the B-reader exam in 1987 and has been continually certified as a B-reader since that time (Petitioner's Exhibit 2, p 11). Dr. Smith testified that he failed the B-reading recertification exam twice somewhere around 1999. He testified that he failed because of overreading the films. He was finding more disease than was present on the standard film (Petitioner's Exhibit 2, p 47). Dr. Smith received his Doctor of Osteopathic Medicine in 1968 from Kirksville College of Osteopathic Medicine (Petitioner's Exhibit 2, p 7; Deposition Exhibit No. 1). Dr. Smith did a rotating general internship at Carson City Hospital in Carson City, Michigan, and a radiology residency at Memorial Osteopathic Hospital in York, Pennsylvania. Dr. Smith operated his own private radiology practice from 1988 to 2016. Since closing his practice he has been doing consulting work in the field of radiology including a lot of B-readings (Petitioner's Exhibit 2, pp 8, 10).

Dr. Smith testified that in performing a B-reading, he starts with determining the quality of the film. The next step is to determine if there are any small opacities present. If opacities are present, he determines if there are enough to be called pneumoconiosis. If so, then he determines whether they are round or linear opacities and categorizes them by size. Dr. Smith testified that

with coal workers' pneumoconiosis, the preponderance of the small opacities are round. He testified that with other kinds of pneumoconiosis, such as asbestos related, they are linear or irregular opacities. In coal workers' pneumoconiosis opacities occur primarily in the upper to mid lung zones. With asbestosis, it predominantly incurs in the mid to lower lung zones. The next thing the B-reader considers is the profusion which is the concentration or density of the findings in the lungs. Dr. Smith testified that the profusion tells the reader what degree of involvement is present. Dr. Smith testified that the last thing included in completing the B-reading form is the obligatory findings which are things that need to be recorded other than the findings of black lung. Dr. Smith described an opacity as a small, abnormal density that one would not see on a normal chest x-ray. It is often seen with people that have occupational lung disease or pneumoconiosis (Petitioner's Exhibit 2, pp 19-23, 25, 28-29).

Dr. Smith reviewed a chest x-ray of Petitioner dated June 22, 2016, at the request of Petitioner's counsel. Dr. Smith testified that the film was of diagnostic quality. He testified that he did not note any poor contrast on the film. If he had seen poor contrast, he would have recorded it in his report. Dr. Smith testified that he found small opacities of the middle and lower lung zones bilaterally of a profusion 1/0. He testified that there were no large opacities or other findings. There was a soft tissue density of the lateral lower lung region which Dr. Smith attributed to a prominent nipple shadow. Dr. Smith testified that Petitioner had coal workers' pneumoconiosis. Dr. Smith testified that Petitioner had damage to his lungs as a result of his coal workers' pneumoconiosis (Petitioner's Exhibit 2, pp 35-37).

From 1988 to 2016, Smith Radiology was a freestanding diagnostic, walk-in medical facility. Dr. Smith testified that Smith Radiology was netting 1.25 million in annual income after expenses. He testified that of that income maybe 5% was from medical legal exams or interpretations. Dr. Smith testified that he interpreted chest x-rays for black lung for over 20 law firms. He testified that 80% of those firms represented claimants. Dr. Smith testified that presently he is reviewing films for black lung for five firms that represent claimants. Dr. Smith testified that one of those firms is Petitioner's counsel. He has also reviewed films for Culley & Wissore. He testified that he has read more than 345 films for Culley & Wissore or Petitioner's counsel. Dr. Smith testified that when he received films from Culley & Wissore, he would get two or three films at a time on a frequency of twice a month. He might receive a tiny bit more than that from Petitioner's counsel. Dr. Smith testified that at his peak he was interpreting 2,000 films a year for law firms. Presently he is interpreting about 1,500 films a year (Petitioner's Exhibit 2, pp 50-56, 58).

Dr. Smith has never sat on any committee with NIOSH. Dr. Smith has not held any office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. Dr. Smith testified that the syllabus he uses to study for the B-reading exam he pretty much takes as gospel. He testified that the panel that puts that together are the peers that he aspires to be. He testified that the leaders in the field have been chosen to put that syllabus together. Dr. Smith testified that a new syllabus has been authored for NIOSH and that Dr. Cris Meyer was one of the authors of that syllabus. Dr. Smith testified that he agrees with the current B-reading syllabus that small opacities associated with exposure to silica and coal dust are usually rounded. Dr. Smith

agreed with the B-reading syllabus that the small rounded opacities usually involve the upper lung zones first and as the dust exposure continues, all the lung zones may become involved. He testified that has been his experience (Petitioner's Exhibit 2, pp 60-62, 64-65).

Dr. Smith testified that simple pneumoconiosis is unlikely to progress once the exposure ceases. Dr. Smith testified that pulmonary impairment is determined by appropriate valid pulmonary function testing and not by a chest x-ray. Dr. Smith testified that Petitioner does not suffer from complicated pneumoconiosis. He testified that the presence of a large opacity on chest x-ray is required for that diagnosis. There is no lower profusion rating than the 1/0 that Dr. Smith could have assigned to this film and it remain positive for pneumoconiosis. Dr. Smith saw only the smallest of the small, round opacities in the imaging that he reviewed. He testified that those were the P opacities and were seen only in the bilateral mid and lower lung zones (Petitioner's Exhibit 2, p 65, 67-68).

Dr. Smith did not know whether the monitors he uses for interpreting chest x-rays meet the guidelines that are set forth in the Code of Federal Regulations. He did not know whether the equipment complied with the DICOM standard that is set forth in the Code of Federal Regulations (Petitioner's Exhibit 2, p 67).

Dr. Cristopher Meyer reviewed a chest x-ray of Petitioner from Ferrell Hospital dated June 22, 2016. He testified that the film was quality 1. Dr. Meyer testified that there were no small or large opacities on the film. His impression was that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Meyer testified that the distinction between simple pneumoconiosis and complicated pneumoconiosis is the presence of conglomerate fibrosis, which manifests itself on chest radiograph or chest CT scan as an opacity exceeding 1 cm in dimension or similarly at pathology. He testified that it is not a diagnosis that is made based upon a patient's symptoms such as cough, sputum or shortness of breath. He testified that it is purely a change in the architecture of the parenchyma. Dr. Meyer found no opacities consistent with pneumoconiosis either small or large on Petitioner's chest x-ray. Dr. Meyer had the opportunity to review an interpretation of the same film by Dr. Henry K. Smith. Dr. Meyer disagreed with Dr. Smith's findings of P opacities of profusion 1/0. Dr. Meyer testified that Dr. Smith did not find the presence of complicated pneumoconiosis. Dr. Meyer agreed with that finding (Respondent's Exhibit 1, pp 40-43).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p 7). Dr. Meyer has been a B-reader since 1999. Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the teaching course which is called the B-reader program (Respondent's Exhibit 1, pp 19-21). Dr. Meyer testified that the American College of Radiology runs the B-reading course. He has participated in the course previously in studying for the examination and was asked to have an active academic role in helping with the course of the future. As a member of the ACR Pneumoconiosis Task Force, he helped complete a new syllabus for the course as well as a test that was delivered to NIOSH in 2017. He testified that the B-reading course is about a day and a half in which there are a series of

lectures describing the B-reading classification system. He testified that there are a series of practice examples that are done with mentors overseeing the practice examples. Finally, there is an exam at the end of the weekend. Dr. Meyer testified that the faculty for the B-reading course is typically experienced senior level B-readers. 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 the distinction between a 0/1 profusion and 1/0 profusion film. Dr. Meyer testified that the certifying exam is six hours long with 120 chest x-rays to be characterized. The pass rate of the examination runs roughly 60% (Respondent's Exhibit 1, pp 31-34).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or linear opacities and based on the size and appearance of those small opacities they are given a letter score. 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. 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. 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 22-23, 28, 30).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and chest x-ray regarding Petitioner. Dr. Castle is a pulmonologist and is board certified in internal medicine and in the subspecialty of pulmonary disease. Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease which encompassed critical care medicine. Dr. Castle's practice included treating patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis. Dr. Castle was continuously certified as a B-reader from 1985 through June 30, 2017 (Respondent's Exhibit 2, pp 3, 6-7, 12, 18).

Dr. Castle reviewed a chest x-ray of Petitioner taken at Ferrell Hospital on June 22, 2016. Dr. Castle found the film to be quality 2 because of poor contrast. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. There was evidence of atherosclerosis and calcified granulomas. The film was otherwise entirely normal. Dr. Castle testified that for a proper B-reading, one needs to compare the subject film to the standard ILO classification films. He testified that first thing that goes on the form is the name of the patient and the quality of the film. He then looks at the film to see if there are any parenchymal abnormalities consistent with pneumoconiosis. If there are some, then he compares the subject film to the ILO classification films to determine the profusion. At the same time he also determines the size of the abnormality. He also notes in which of the six lung regions the

abnormalities occur. Next he determines the amount of the abnormality that is present in any affected area of the lung. He testified that this is the profusion. He determines the profusion by comparing the subject film to the ILO classification film. He then looks at the film to see if there are any large opacities. Dr. Castle testified that a large opacity is a lesion greater than 1 cm. If there are any present, they are categorized as A, B or C depending upon their size. Dr. Castle testified that it is important to see if there are any large opacities on the film because that is a more severe form of the disease. He testified that if an individual has developed a lesion that is greater than 1 cm in size, then it has a greater chance of progressing. He testified that complicated disease more frequently leads to complications. Dr. Castle testified that a physician does not have to use the ILO system to diagnose someone with pneumoconiosis, but it is a more accurate way of making a determination (Respondent's Exhibit 2, pp 26-30, 41).

Dr. Castle testified that the important distinction between the profusion of 1/0 and 0/1 is that the 1/0 is the most minimally positive film for pneumoconiosis. The 0/1 profusion is technically negative for the disease. Dr. Castle testified that one cannot diagnose simple or complicated pneumoconiosis based on symptoms. Dr. Castle testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. He 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 dust exposure levels at the mine until he reaches retirement age (Respondent's Exhibit 2, p 31-32).

Dr. Castle testified that there is no clinical significance to subradiographic pneumoconiosis. He testified that Petitioner's diffusion capacity was 115% of predicted which was normal. He testified that same indicated Petitioner had normal interstitium of the lung where the blood gas is exchanged. Dr. Castle testified that it was very unlikely that Petitioner would have any changes of the interstium particularly given a diffusing capacity as normal as his. Dr. Castle testified that based upon the spirometry performed on Petitioner, he does not suffer from an obstruction. Based upon his forced vital capacity as measured in the testing by Dr. Istanbouly there was not any indication of restriction. Based upon his diffusion capacity, Petitioner had no evidence of impairment in gas exchange. Dr. Castle testified that based upon the results from his pulmonary function testing, Petitioner was capable of heavy manual labor from a respiratory standpoint. Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that if he applied the results obtained from pulmonary function testing on Petitioner to Table 5-4 of the *Guides*, Petitioner would fall in Class 0 impairment. Dr. Castle testified that based on a thorough review of all the data, Petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure. He testified that Petitioner worked in or around the underground mining industry for a sufficient enough time to have possibly developed coal workers' pneumoconiosis if he were a susceptible host. He had significant dust exposure according to the historical information (Respondent's Exhibit 2, p 32-35).

Dr. Castle testified that Dr. Alexander indicated in 2016 that Petitioner had complicated coal workers' pneumoconiosis. Dr. Alexander did not indicate how he justified the diagnosis of

complicated coal workers' pneumoconiosis (Respondent's Exhibit 2, p 36). Dr. Castle testified that from his review of the medical, there was no basis for the diagnosis of complicated pneumoconiosis by Dr. Alexander (Respondent's Exhibit 2, p 30). Dr. Castle testified that there was nothing in the office note of July 13, 2016, that would allow a physician to make that diagnosis. Dr. Alexander did not describe a chest x-ray or describe anyone else's interpretation of an x-ray (Respondent's Exhibit 2, pp 59-60). Dr. Castle testified that there was not an interpretation of any of Petitioner's chest imaging which revealed large opacities. Dr. Smith who interpreted the film on behalf of Petitioner did not find any large opacities (Respondent's Exhibit 2, p 64). Dr. Castle noted that Dr. Alexander described pneumoconiosis as well as complicated coal workers' pneumoconiosis. Dr. Castle testified that there are specific criteria for both those diagnoses and Dr. Alexander did not describe any of those specific criteria and none of them were met in Petitioner's case (Respondent's Exhibit 2, p 43).

Dr. Castle described coal workers' pneumoconiosis as a chronic dust disease brought about by the inhalation of coal mine dust over a period of working in or around the coal mines. He testified that it is manifested by the presence of an abnormal chest x-ray with small, round regular-type opacities primarily in the upper lung zones but depending upon the severity may involve the middle and occasionally the lower lung zones. The disease may or may not be symptomatic. Coal workers' pneumoconiosis is a type of interstitial lung disease. Along with that disease process there is scarring and fibrosis that can occur in the lungs. Dr. Castle testified that the scar tissue cannot carry on the function of normal healthy lung tissue. Dr. Castle testified that the scarring and fibrosis that occurs with pneumoconiosis are permanent and irreversible (Respondent's Exhibit 2, pp 46-48).

Medical records of HMC Clinic were admitted into evidence. Petitioner underwent a chest x-ray on December 7, 1995, which was interpreted as revealing possible left lower lobe pneumonia (Respondent's Exhibit 4, p 99). On the same date Petitioner was seen in the office complaining of chest discomfort. Physical examination of the chest revealed the lungs to be clear (Respondent's Exhibit 4, p 94). Petitioner was seen on December 21, 2006, for a pre-employment physical (Respondent's Exhibit 4, p 93). Spirometry performed on that date was interpreted as normal (Respondent's Exhibit 4, p 91). A chest x-ray of December 21, 2006, showed no active pulmonary disease (Respondent's Exhibit 4, p 90).

Petitioner was seen on November 5, 2013, for a rash and pain under his right arm and into his back. He denied shortness of breath. Social history noted that he was a former smoker and full time miner. Review of systems pulmonary revealed no dyspnea or cough. Physical examination of the chest revealed the lungs to be normal (Respondent's Exhibit 4, pp 84-86). On January 22, 2014, Petitioner underwent a chest x-ray. The reason for same was malignant large intestine. The film was interpreted as revealing stable chest and no active cardiopulmonary disease (Respondent's Exhibit 4, p 83).

Petitioner was seen on September 29, 2015, with history of an ATV accident occurring on September 25, 2015. He had no pulmonary symptoms on that date and his review of symptoms

pulmonary revealed no dyspnea, cough or wheezing (Respondent's Exhibit 4, pp 74-77). Petitioner was seen on October 1, 2015. His review of systems pulmonary revealed no dyspnea, cough or wheeze. Physical examination of the chest revealed no adventitious sounds (Respondent's Exhibit 4, pp 68-71).

Petitioner was seen on July 13, 2016, for blood pressure check. It was noted that Petitioner had been placed on Lisinopril and developed a dry cough after a few days of taking same. He discontinued the Lisinopril and the cough went away. Petitioner related dyspnea with exertion but no chronic cough and no wheezing. Dr. Alexander noted that Petitioner was working full time as a miner and charted that he was unable to perform the usual physical activities for his age because of severe difficulty breathing. His review of systems pulmonary revealed no dyspnea or cough. Physical examination of the chest revealed rales and crackles. The assessment included coal workers' pneumoconiosis (complicated) (Respondent's Exhibit 4, pp 63-67). Petitioner was seen on August 26, 2016, for blood pressure recheck. No shortness of breath or shortness of breath with exertion was charted. There was no chronic cough (Respondent's Exhibit 4, pp 54-58). Review of systems pulmonary revealed no dyspnea and no cough. In an office note on December 19, 2016, Petitioner's active problems included pneumoconiosis (complicated). History obtained was positive for dyspnea and cough but no shortness of breath. There was concern that his cough may be related to an ACE inhibitor that he was taking for hypertension. It was recorded that he was working full time as a coal miner. Review of systems pulmonary was positive for dyspnea and cough. Physical examination of the chest revealed rales/crackles (Respondent's Exhibit 4, pp 48-52).

Petitioner was seen on February 27, 2017, for follow up on lab work. He reported that he had a cold lately and had a deep non-productive cough. He was noted to be a full time coal miner. His review of systems pulmonary revealed no dyspnea or cough. Physical examination the chest revealed rales/crackles. The assessment included acute sinusitis (Respondent's Exhibit 4, pp 42-47). Petitioner was seen on July 3, 2017, for follow up on lab work. He was still noted to be working full time as a coal miner. His review of systems pulmonary was negative for dyspnea or cough. Physical examination of the chest revealed rales/crackles (Respondent's Exhibit 4, pp 38-42).

Petitioner was seen on January 10, 2018, for lab follow up. Review of systems pulmonary was negative for dyspnea or cough. Physical examination of the chest revealed rales/crackles. The assessment was hypertension, chronic kidney disease stage III, hyperlipidemia and adenocarcinoma of the sigmoid colon. It was noted that Petitioner's lungs were in good shape (Respondent's Exhibit 4, pp 29-34). Petitioner was seen on July 11, 2018, for lab follow up. According to the office note there was no evidence of recurrence of Petitioner's cancer. He did not appear to have any dyspnea. Review of systems pulmonary showed no dyspnea or cough. Physical examination of the chest revealed crackles and rales. Assessment included benign essential hypertension, complicated coal workers' pneumoconiosis, hyperlipidemia and adenocarcinoma of the sigmoid colon (Respondent's Exhibit 4, pp 13-19). Petitioner was seen on January 16, 2019. He had no chest pain or dyspnea. Review of systems pulmonary was negative

for any dyspnea or cough. Physical examination of the chest continued to show rales/crackles (Respondent's Exhibit 4, pp 3-8).

Conclusion 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 with Respondent.

In support of this conclusion the Arbitrator notes the following:

The spirometry performed as part of Dr. Istanbouly's examination was within normal limits. Dr. Castle and Dr. Istanbouly testified that there was not any evidence of obstruction or restriction in Petitioner based on his spirometry. Dr. Castle opined that Petitioner did not suffer from any pulmonary disease or impairment that had occurred as a result of his occupational exposure to coal mine dust. Dr. Castle testified that based on Petitioner's objective testing from a pulmonary perspective, he was capable of heavy manual labor.

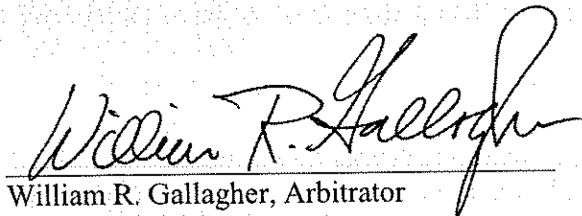
Dr. Henry K. Smith a B-reader and board certified radiologist, interpreted Petitioner's chest x-ray of June 22, 2016, as positive for coal workers' pneumoconiosis. Dr. Istanbouly, who also interpreted this film, is not an A-reader or B-reader. Dr. Istanbouly does not have the special training for interpreting chest x-rays for occupational lung disease that was described by Dr. Meyer. Dr. Meyer and Dr. Castle, B-readers, reviewed Petitioner's chest x-ray dated June 22, 2016. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. Dr. Castle testified as to what is required for a proper reading of the chest x-ray for pneumoconiosis. Dr. Istanbouly did not follow that protocol. Dr. Castle also testified to the importance of identifying the profusion when interpreting a chest x-ray for pneumoconiosis. He testified that the profusion is what determines whether or not the x-ray is positive or negative. Dr. Istanbouly does not provide profusion ratings on the films that he reviews for black lung.

All of the experts in this case, except Dr. Alexander, agreed that Petitioner did not have complicated coal workers' pneumoconiosis. Dr. Smith testified that the presence of a large opacity on the chest x-ray is required for a diagnosis of complicated pneumoconiosis. Dr. Smith saw no large opacities on the chest x-ray he reviewed. Dr. Castle noted that Dr. Alexander first included the diagnosis of complicated pneumoconiosis in his office note of July 13, 2016. Dr. Castle testified that there was nothing in that office note or any of Dr. Alexander's records that would justify the diagnosis of complicated coal workers' pneumoconiosis. Dr. Alexander did not describe a chest x-ray showing complicated pneumoconiosis nor did his records contain an interpretation by anyone else of a chest x-ray showing complicated pneumoconiosis.

The Arbitrator finds the opinions of Dr. Castle and Dr. Meyer to be more persuasive than those of Dr. Istanbouly, Dr. Smith and Dr. Alexander.

Petitioner testified that when he was working on the gob pile he also had to build slopes and impoundment for the slurry. If he had to get off the dozer and checked a grade stake or moved one, he would have to climb back up the slope. He noticed that he would have to stop before he would get back up to the dozer. He testified that he could not walk very far or do much without having to stop to get his breath. Petitioner also testified that when climbing to upper floors in the plant, he would have to stop at the top of the first flight of stairs to rest. Dr. Alexander's medical records contain intermittent complaints of shortness of breath. Although Dr. Alexander included complicated coal workers' pneumoconiosis as an active problem for Petitioner, there was no basis in Dr. Alexander's records to justify his diagnosis of complicated pneumoconiosis. Petitioner was 62 years of age on his last day of employment. Petitioner retired on that date. One of the reasons for his retirement at that time was that he had cancer. He was working 12½ hours per day on a rotating schedule. He testified that those hours were too hard on him and that he could not keep up with the physically demanding job of operating the dozer on the gob pile. Dr. Castle testified that Petitioner was capable of heavy manual labor from a respiratory standpoint. No physician ever restricted Petitioner from work as a result of an occupational lung disease.

In regard to disputed issues (L) and (O) the Arbitrator makes no conclusion 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)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
COUNTY OF MADISON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nicolette Wilson,
Petitioner,

vs. No: 17 WC 26914

20 IWCC0662

Fed Ex,
Respondent.

DECISION AND OPINION ON REVIEW

Petition for Review having been timely filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical benefits, temporary total disability, nature and extent, and penalties and fees, and being advised of the facts and law, affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 28, 2020, 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.

20IWCC0662

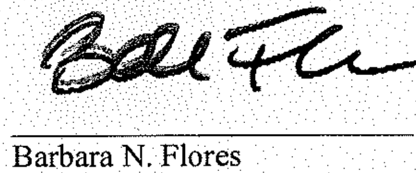
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

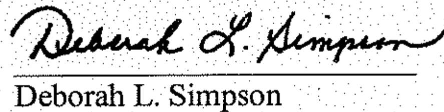
IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for the cost of living adjustments, paid by the Rate Adjustment Fund, as provided in §8(g) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 13 2020

Marc Parker


Barbara N. Flores


Deborah L. Simpson

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSON, NICOLETTE
Employee/Petitioner

Case# **17WC026914**

FED EX
Employer/Respondent

20 IWCC0662

On 2/28/2020, 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 1.44% 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:

1775 JOHN H HUSTAVA PC
101 ST LOUIS RD
COLLINSVILLE, IL 62234

1685 KOPKA PINKUS DOLIN PC
MATTHEW G GORSKI
200 W ADAMS ST SUITE 1200
CHICAGO, IL 60606

20 IWCC0662

STATE OF ILLINOIS)
)SS.
COUNTY OF **MADISON**)

- [ ] 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

NICOLETTE WILSON
Employee/Petitioner
v.
FED EX
Employer/Respondent

Case # **17 WC 26914**

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 **Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **12/17/19**. 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. [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. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **8/25/17**, 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $37,945.96 the average weekly wage was $729.73.

On the date of accident, Petitioner was **43** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**43,248.55** for TTD, $**0.00** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**43,248.55**.

Respondent is entitled to a credit of $**24,105.51** under Section 8(j) of the Act.

ORDER

See attached Decision

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

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

[signature]
Signature of Arbitrator

2/20/20
Date

FEB 28 2020

NICOLETTE WILSON vs. FED EX
17-WC-26914

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS

Petitioner worked for Respondent as Operation Manager in the loading docks. Her duties included, inter alia, over-seeing package handlers in the proper and efficient handling of packages (Tr.p.10).

Petitioner has never filed a workers compensation claim prior to this one. Petitioner never injured her left arm or left hand prior to this injury.

Petitioner testified that on 8/25/17 she was taking packages from the conveyor belt and loading them into a truck (Tr.p.10). She loaded approximately 360 packages per hour (Tr.p.11). On this day, she was attempting to load a package that she estimated weighed between 75-85lbs. While lifting it up onto a shelf which was about chest high, her left hand was scratched on a package that was already on the shelf (Tr.p.12,39). She noticed that after she scratched her hand and cut it, that it was bleeding. She ran out of the truck to get a paper towel which was located at the supervisor station. She also yelled to a co-worker, Cassandra Campbell, to pull her packages off the belt because she was not in the truck (Tr.p.14).

Petitioner testified that there are multiple video cameras in the loading dock area. She said that in the control room there are 8 monitors that control the cameras, monitoring the loading procedures. She testified that these were basically to look for individuals stealing (Tr.p.13). There are cameras pointed inside the truck but none located inside the truck. After obtaining a wet paper towel, Petitioner returned to the loading area and finished her shift. She described the scratch as being on her left hand in the web spacing between the thumb and the index finger which went around the top of her hand ending at the far side of her wrist (Tr.p.42) She testified that she reported this injury to her supervisor, Toni Wilke, before the end of her shift (Tr.p.43). Toni Wilke never asked to look at her hand (Tr.p.23) when she reported her injury, possibly because it was reported as only a scratch. At the end of her shift, Petitioner went into the office and completed her paperwork for the day. She again discussed with Toni Wilke her scratch on her hand (Tr.p.31). Petitioner was scheduled to work the next day but did not, reporting off work due to her sick child and her hand (Tr.p.46).

Toni Wilke did not testify at arbitration.

Later that Friday evening, as Petitioner was sleeping, she was awoken with a burning sensation in her hand. She noticed blisters, swelling, and a bright redness to her hand.

On 8/27/17 Petitioner was seen at St. Anthony's Medical Center complaining of worsening blisters, redness, swelling of the left hand since Friday working at Fed Ex. In the triage history, she stated that she noticed a tingling, burning, and itching sensation in her left hand since throwing boxes around at work on Friday. She told the Dr. Furukawa while hospitalized that she sustained an abrasion to her hand while working with boxes at Fed Ex. She also reported to nurse practitioner Linville of an abrasion to the left hand while working with boxes at Fed Ex and complained of a rash, pain, and blisters to her left hand. Nurse Coleman also recorded a history of an abrasion to the left hand while working at Fed Ex. An MRI showed cellulitis. Discharge diagnosis was left arm/hand cellulitis. She was cautioned to monitor her condition closely for any necrotizing fasciitis and compartmental syndrome (P.Ex.1). Pictures of Petitioner's left hand are contained in Petitioner's Exhibit 19 with the first photo taken on 8/27/17 and the last on 9/7/17 (Tr.p.16).

Petitioner testified that she received a text message from Dylan Rogers, the assistant senior manager at Respondent's (Tr.p.24). She also received telephone calls from Mr. Rogers. Copies of the texts from Mr. Rogers to Petitioner dated 8/30/17 indicate that Mr. Rogers was completing Petitioner's accident report and was inquiring as to where on her body did the package scratch her. Petitioner responded that it was "on the top my left hand and arm". She again told him that she was loading a heavy package when her hand hit, rubbed up against another package. She asked if they needed a picture. Mr. Rogers told her they did not. (P.Ex.21) In a phone conversation, Petitioner testified that Mr. Rogers told her that Respondent knew she got hurt as they had seen it on the videos (Tr.p.25).

Petitioner started treating with her family physician, Dr. Adams, on 9/6/17. She gave a consistent accident history of her left hand being scratched at work while loading a truck for Respondent. His diagnosis was left hand cellulitis, phlebitis and he continued to authorize her off work. A blood culture came back positive for staph infection. On 9/13/17, his notes indicated a large hyperemic area approximately 12cm wide that looks like a 2nd burn. He also erroneously indicated that he was seeing her for her right arm as opposed to her left. His diagnosis was left hand pain and abrasion to the left hand sequela. Dr. Adams referred Petitioner to Dr. Sherrod, a neurologist. Petitioner initially saw Dr. Sherrod on 9/19/17 (P.Ex.3). She gave a history of left hand pain after sustaining a hand abrasion while lifting a package at work. His diagnosis was causalgia with a history of cellulitis. He recommended an infectious disease consultant.

Petitioner saw Dr. Boedefeld, a pain management specialist, on 9/27/17 upon referral of Dr. Adams. Again, she gave a consistent accident history that she cut her left wrist and hand at work on a package. His diagnosis was complex regional pain syndrome (P.Ex.7). A repeat MRI of the left wrist revealed no specific findings compatible with complex regional pain syndrome. Even though the MRI was negative for regional pain syndrome, Dr. Boedefeld continued with that diagnosis. He recommended stellate ganglion blocks and continued to authorize Petitioner off work.

Petitioner saw Dr. Yong upon Dr. Adams' referral on 10/4/17 (P.Ex.5). Petitioner gave a history of a left hand abrasion almost 2 months ago. His diagnosis was reflex sympathetic dystrophy/complex regional pain syndrome.

Petitioner started treating with Dr. Padda, a pain management specialist on 10/30/17. She testified that Dr. Padda's office was much closer to her home and was easier for her to seek treatment there.

Dr. Padda testified via deposition on 9/17/19 and 11/5/19. Dr. Padda is board- certified in anesthesiology, interventional pain, and addiction medicine. He testified that Petitioner gave a history of sustaining a relatively minor abrasive injury to the dorsal aspect of her left hand at work at Fed Ex on 8/25/17 (P.Ex.18p.6). He related that she ended up being treated for a staph infection and had intravenous antibiotics. Her condition got worse and she was eventually diagnosed with a neuropathic injury. She reported some improvement with a stellate block. Dr. Padda opined that she had a complex regional pain syndrome stage 2 or stage 3 with stage 1 being fresh and acute and stage 2 and 3 as it progressed. He noted that Petitioner had vasomotor instability with swelling. He testified that complex regional pain syndrome, formerly known as Reflux Sympathetic Dystrophy (RSD), is an abnormality in the sympathetic nervous system that controls blood supply, blood flow, electrical impedance, the entire sympathetic and parasympathetic system for an area and controls the pain pathways causing excruciating, lancinating, burning, dysesthetic complex pain in that area. He stated that this would progress to a point where they cannot use the extremity affected. They start to loose muscle mass and guard the arm. He indicated that the extremity will eventually end up auto amputating (P.Ex.18p.9). He discussed the evaporative skin test wherein a drop of alcohol is placed on a very tiny gauze and put on the patient's affected area to evoke a response. He indicated a positive response was screaming from the pain (P.Ex.18p.11). Dr. Padda testified that based upon a reasonable degree of medical certainty that the complex regional pain syndrome was related to her work injury (P.Ex.18p.13). He further opined that Petitioner

is unemployable due to her left hand injury. Dr. Padda testified that Petitioner also had a C6 radiculopathy which was not related to the work accident. He initiated physical therapy, medication, and stellate blocks (P.Ex.18p.16). A TENS unit was prescribed. She was prescribed Neurontin for the nerves and Hydrocodone or Norco for pain, and Baclofen which is a muscle relaxant. A trial dorsal column stimulator was attempted by Dr. Williams, a neurosurgeon at DePaul Hospital, which gave some relief but it was discontinued due to her neck problem (P.Ex.18 p.23). They could not properly implant the stimulator due to her C6 disc. At her physical therapy initial evaluation on 11/30/17, it was noted that Petitioner had skin changes, temperature changes, severe hypersensivity to light touch. They recorded the diagnosis of complex regional pain syndrome with a history of her left hand being scraped on a box. It was noted that Petitioner's symptoms were severely limiting her life. (Pt.Ex.11). Dr. Padda referred Petitioner to Dr. Rafati, a psychiatrist, on 11/13/18. Dr. Rafati diagnosed anxiety, depression and pain from the CRPS. Various medications were prescribed. Dr. Rafati also authorized Petitioner off work. (Pt.Ex.15). Petitioner continued to receive injections from Dr. Padda.

Dr. Padda opined on 4/3/19 Petitioner was at maximum medical improvement and that she was not going to get any better. He testified that her prognosis is poor and that she will never become employable (P.Ex.18p.28). Dr. Padda indicated that the cost for treatment of the complex regional pain syndrome on the low end is $55,000-$60,000 a year to a high of $100,000 a year for the patient's life.

Dr. Padda testified about the 2 independent medical examinations performed on behalf of Respondent by Dr. Hagan and a Dr. Lantsberger (P.Ex.18p.29). The doctor testified that he reviewed those exams and relied upon while treating Petitioner. Dr. Padda stated that he would be stupid not to rely upon reports from other doctors concerning care and treatment of his patient (P.Ex.18p.30). Dr. Hagan indicated that Petitioner suffered from a type 1 RSD. Dr. Padda stated that he agreed she had complex regional pain syndrome which used to be called RSD (P.Ex.18p.30). Dr. Padda also noted Dr. Hagan's opinion that Petitioner may be a candidate for a spinal cord stimulator. Dr. Padda also reviewed and relied upon the report of Dr. Lantsberger, another IME performed upon Respondent's behalf. Dr. Padda agreed with Dr. Lantsberger's opinion that Petitioner underlying psychiatric condition was aggravated by her work injury and resulted complex regional pain syndrome (P.Ex.18p.31). Dr. Padda testified that his bill for services up through 9/5/19 was $61,279.94 and was reasonable and necessary (P.Ex.18p.32).

Upon cross examination, Dr. Padda testified that he devotes probably 1% of his practice to treating workers compensation injuries. The vast majority of his patients are either failed back surgery patients or cancer patients. Dr. Padda testified that he also owns an aesthetic and laser medicine practice but has not stepped foot on that location for over 3 years as others run it. He also owns 5 restaurants in the St. Louis area for which he has full time managers (P.Ex.18p.36-37). Dr. Padda testified that his board certification is in interventional pain involves treatment for behavioral therapy and pain management.

Dr. Padda testified that it is "not clinically likely" that Petitioner could fake symptoms of RSD/Complex Regional Pain Syndrome (CRPS). At this time, the deposition was terminated due to time constraints and was rescheduled for 11/5/2019. Dr. Padda testified that heat temperature, air flow, light, water, and alcohol can affect CRPS. Dr. Padda testified that Petitioner had a progression of her symptoms and signs into the right upper extremity which wax and wane (P.Ex.18p.57). Dr. Padda indicated that Petitioner could drive with one arm, can push, pull or lift with her right hand but not her left (P.Ex.18p.67-68). He felt that she was not somebody who was going to have a meaningful job function (P.Ex.18p.69).

Since the earlier deposition, Dr. Padda has seen the patient 4 times with a new bill totaling $62,851.00.

Respondent did not produce any medical evidence via depositions.

Petitioner testified that she was aware that she was being surveilled as she lives in a small neighborhood and unfamiliar vehicles were noticed. On one of the set of pictures/video, Petition is seen holding paper in her right hand. When asked about that, she testified that she was holding her mail in her right hand and was trying to open her mail with her teeth (Tr.p.27).

Petitioner testified that she has difficulties performing basic daily mildly functioning tasks. She testified that either her daughter or her boyfriend has to wash her hair and brush her hair (Tr.p.32). She stated she cannot cut up her food while eating and that it needs and if it needs to be done, someone else has to do it. If no one is around, she picks the food up with her right hand and chews on it. She testified she cannot take a shower because of the water, air, excessive movement makes her arm worse. She does take sponge baths given by her daughter. Petitioner testified that her pain never goes away. She has to keep her arm covered because of the cold and the wind. She was on medication but testified that it did not interfere with her testifying. She was asked to take her coat off to show the Arbitrator her arm. There are pictures to document this (P.Ex.21). The Arbitrator viewed Petitioner taking off her coat which resulted in excruciating pain to her arm and resulted in tears. The Arbitrator noted atrophy to the arm and swelling of the hand.

Upon cross examination, Petitioner denied re-injuring her left hand after 8/25/17. Petitioner denied ever treating with any mental health care provider before Dr. Singh. However, she did receive some antidepressants from her family doctor, Dr. Adams, on a temporary (trial) basis prior to the date of accident (Tr.p.64). She testified that she never has attempted to return to work as Dr. Padda has told her she is disabled.

Next to testify was Cassandra Campbell. She is a former Fed Ex employee who testified she was working with Petitioner on 8/25/17 when she hurt her left hand. She testified that she appeared pursuant to a subpoena from Petitioner's attorney. She testified that on the day of the injury Petitioner was lifting a heavy package off the belt and took it into the truck. When she tried to load it she was scratched her left hand (Tr.p.69). Ms. Campbell noticed the scratch bleeding. She testified that Petitioner asked her to take care of her packages, to finish loading them, and then Petitioner left the truck. Ms. Campbell guessed that Petitioner left to go wash the blood off or go see a manager but did not know because she stayed in the truck. She testified that no one from Respondent has talked to her about the accident. She did say that there were multiple cameras in the control room and cameras outside the truck which should have shown Petitioner getting out of the truck holding her bleeding hand (Tr.p.71).

Dylan Rogers testified on behalf of the Respondent. He has been employed by Fed Ex since 2002. In 2017, he was an assistant senior manager. Part of his duties was to investigate workers compensation claims (Tr.p.77). Mr. Rogers testified that he had an independent recollection of 8/25/17 (Tr.p.81). He testified that he did not receive any request for first aid by Petitioner on 8/25/17. He stated that Petitioner did not report a work related injury to him on that date however, he did say he received an e-mail on 8/28/17 from Toni Wilke concerning Petitioner's injury (Tr.p.86). He testified that Petitioner told him that she scratched the top of her left hand on the bottom of a shelf (Tr.p.93). On cross-examination, Mr. Rogers testified that he was volunteering his time at arbitration for Respondent. He stated that he did not recall having a conversation with Petitioner on 10/3/17. However, when confronted with Ms. Wilson's phone records and his phone number, he said it did not surprise him, but he could not recall the conversation. Even though Mr. Rogers stated that he conducted an investigation he has claimed he did not produce a report. He stated that he did not have a report since he was no longer employed by Fed Ex Ground. Petitioner's counsel asked him about the videos that Petitioner testified to indicating that Mr. Roger's said he saw Petitioner get hurt on the videos. He did admit to looking at the videos.

He stated that he did not have the videos either as he is not employed by Fed Ex Ground. Mr. Rogers, although no longer employed by Fed Ex Ground is employed by Fed Ex Express and he is now a senior manager at that facility. He did not recall telling her that he saw her get hurt on the videos or that she should not worry about her claim as Fed Ex was not disputing it. He did not recall telling her that Sedgwick was not going to dispute it (Tr.p.101). However, he did not deny making these statements.

Zachary Zalewski, a field investigator for Digistream, testified for Respondent. He was hired to perform surveillance on Petitioner on 7/3/19 and 7/4/19. This he did and submitted a report. On cross examination, when asked if he ever observed Petitioner use her left arm he stated he would have to review his written reports (R.Ex.2). His report indicates that Petitioner was observed walking, standing, smoking cigarettes, conversing, carrying a large bag over her right shoulder, entering, exiting, and driving a vehicle. There is no mention of her doing anything with her left arm or moving her left arm.

Michael Crenshaw, a field investigator for Advantage, testified for Respondent. He was hired to perform surveillance on Petitioner. This he did and submitted a report. His report indicates that Petitioner was observed walking, standing, smoking cigarettes, and driving a vehicle. There is no mention of her doing anything with her left arm or moving her left arm.

Ian Redimaind, a field investigator for Advantage, testified for Respondent. He was hired to perform surveillance on Petitioner. This he did and submitted a report. His report indicates that Petitioner was observed walking and pushing a cart inside of Wal-Mart. His video shows Petitioner pushing around the cart with only her right arm. There is no mention of her doing anything with her left arm or moving her left arm.

A review of the extensive surveillance videos and still photographs show that Petitioner never used her left hand or arm in any manner and that her left arm hung limp at her side on all videos and still photographs which further legitimizes and affirms the full nature and extent of her injury.

Respondent terminated TTD benefits. Petitioner stated that she never received any notice from the Respondent as to why they discontinued paying her benefits. She stated that Respondent's attorney was the 4th law firm involved in handling her claim (Tr.p.34).

CONCLUSIONS OF LAW;

The Arbitrator finds after reviewing the testimony and evidence submitted:

I. ACCIDENT

(A) Petitioner sustained accidental injuries which arose out of and in the course of her employment with Respondent on 8/25/17. There is no evidence to the contrary.

Petitioner credibly testified to the details of her injury. Her testimony supported by the testimony of the subpoenaed witness, Cassandra Campbell, who testified she saw Petitioner bleeding from the hand immediately after the incident. She saw Petitioner leave the truck to rinse the blood off her hand. Respondent's personnel, Toni Wilke, knew of the incident shortly after it happened. Dylan Rogers, Respondent's assistant senior manager, also knew of the incident soon after. Mr. Rogers' duties included investigating work comp. claims.

Petitioner testified that Mr. Rogers told her by phone that Respondent knew she got hurt because they saw it on the video. At trial, Rogers conveniently could not remember this phone conversation but did not deny it. He completed Petitioner's injury report and details elicited from Petitioner. Respondent has paid over $43,000 in TTD benefits and over $24,000 in medical expenses. It was not until after Respondent retained its 4th different legal counsel that benefits were terminated.

All medical evidence reflects that Petitioner gave a consistent accident history to the volume of treating and examining physicians involved. There is no medical evidence to the contrary.

Lastly, Respondent has video of Petitioner washing off the blood on her hand. This was confirmed by Cassandra Campbell and Respondent's assistant senior manager, Dylan Rogers. Respondent did not produce Mr. Roger's investigation report. Most importantly, Respondent did not produce the video showing Petitioner's injury. There is a presumption in law that if a party fails to produce retained evidence which is beneficial to its opponent and detrimental to the position that said evidence must be deemed detrimental to its position. Respondent did produce hours of surveillance videos which do not show Petitioner using her left arm.

II. CAUSATION

The Arbitrator finds that the Petitioner's present condition of ill-being is casually related to her work injury of 8/25/17. Again, there is no evidence to the contrary.

All of the treating physicians attributed her condition to the work injury. Even Respondent's Section 12 examiner, Dr. Hagan, causally related it. Petitioner's main treating physician, Dr. Padda (who is board certified in 3 disciplines; anesthesiology, interventional pain and addiction medicine) testified that Petitioner sustained the abrasion injury at work, then a staph infection set in leading to the progression of reflux sympathetic dystrophy (RSD) or now commonly known as regional complex pain syndrome (RCPS). Petitioner's Exhibit 21 shows pictures of the progression of the infection. The record is void of any medical opinion or evidence to the contrary.

III. NATURE AND EXTENT

The Arbitrator finds that after a careful review of the testimony and evidence, that Petitioner is permanently and totally disabled from gainful employment as of 4/3/19.

Dr. Padda testified that Petitioner is unemployable due to her CRPS. There is no medical evidence or opinion to the contrary.

The Arbitrator observed Petitioner at Arbitration. Petitioner held her left arm at her side and would not move it. She broke down in tears when she attempted to remove her coat, even with assistance. He noted left arm atrophy and swelling of the left hand.

Petitioner testified that she has no use of her left arm. It hangs by her side at all times. She cannot use it to eat, open mail, wash and brush her hair, or any other bodily maintenance tasks. She is on strong narcotic medications (hydrocodone, neurotin, baclofen, clonidine and carbamazepine). Dr. Padda testified that these medications will cause other medical complications such as hormone suppression and impediment of bone formation. Petitioner testified that she has to sleep in a recliner. The arm is super

sensitive to touch, wind, temperature change, and movement. When doing any activity, such as depicted in Respondent's surveillance videos, she does it with her other arm. This includes driving and pushing shopping carts. Dr. Padda testified that Petitioner's CRPS causes a "lifetime of suffering" with symptoms of hyperesthesia, allodynia, muscle wasting, and vasomotor instability. Dr. Padda stated that Petitioner is now developing symptoms in her opposite arm which is a common progression.

Petitioner is not a candidate for a permanent spinal cord stimulator as her C6 disc prevents safe implantation.

IV. MEDICAL EXPENSES

The Arbitrator finds that after reviewing the above, that Respondent shall pay $104,769.20 in related and necessary medical expenses subject to the medical fee schedule. Respondent shall pay for Petitioner's related medical expenses in the future, as described by Dr. Padda. Respondent shall receive credit for $24,105.51 previously paid.

V. PERMANENT TOTAL DISABILITY BENEFITS

The Arbitrator finds that because the injury cause the permanent and total disability of the Petitioner, starting from the date 4/3/19, the Respondent shall pay the Petitioner the sum of $486.49/week for life as provided in Section 8(f) of the Act.

Unless this award is appealed, beginning on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the Respondent; Rate Adjustment Fund as provided in Section 8(g) of the Act.

VI. PENALTIES- Section 19(k) & ATTORNEY'S FEES- Section 16(a)

The Arbitrator finds that after Respondent's conduct in terminating medical benefits was unreasonable, frivolous and vexatious meant solely to cause Petitioner great financial hardships. Respondent had no legal justification for terminating benefits as there is no real controversy in denying the benefits. It manufactured issues of accident and causation when none existed. It withheld evidence of the accident. It disregarded the opinions of two separate Section 12 examiners who opined that Petitioner's condition was casually related to the work accident. It terminated TTD and medical benefits without explanation to Petitioner and without any evidence to support its actions.

Respondent shall pay to Petitioner for the sum of $40,331.81 (50% of due $80,663.61) from non-payment of medical expenses.

Section 19(k) penalties for TTD benefits are denied as Plaintiff's treating physician, placed her at MMI on 4/3/19.

Respondent shall pay Petitioner attorney's fees of $16,132.72 ($80,663.61x20%) for its unreasonable and vexatious non-payment of medical expenses. Their non-payment was not based on fact and was frivolous meant solely to place Petitioner in dire financial straits especially since Respondent's IME doctors agreed that Petitioner suffered a work related injury.

VII. TTD BENEFITS

The Arbitrator finds that Respondent shall pay Petitioner TTD benefits of $486.89 from 8/27/17-4/3/19

(date of MMI per Dr. Padda) which is a period of 83 3/7 weeks. Respondent is entitled to credit for $43,248.55.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRONK, KEVIN SON OF CRONK, RICHARD DECEASED,
Petitioner,

vs. NO: 09 WC 49653

KIMBALL HILL HOMES,

Respondent.

20 I W CC0663

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, permanent disability, entitlement to benefits under §7(a), and evidentiary rulings, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

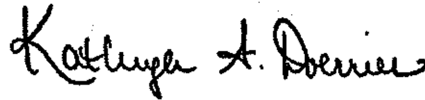
IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 12, 2019, is hereby affirmed and adopted.

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.

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2) (West 2013).* Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 13 2020
KAD/bsd
O0915020
42



Kathryn A. Doerries

Maria E. Portela

DISSENT

I respectively dissent. I believe that Petitioner proved by a preponderance of the credible evidence that the Decedent sustained accidental injuries that arose out of and in the course of employment on 12/6/06, resulting in his death, and that said injuries were causally related to his employment. Furthermore, I believe that a literal reading of the statute supports a finding that Petitioner was a dependent under §7(a) of the Act and is therefore entitled to benefits following his father's untimely employment-related death.

The Decedent, Richard Cronk, was working as a construction manager for Respondent on 12/6/06. The evidence shows that on that date he was shoveling snow from a walkway of a home prior to the arrival of buyers when he experienced chest pain and difficulty breathing. An ambulance was called and while providing this information to paramedics he went into full cardiac arrest. He was transported to St. Joseph Hospital in Joliet where he was subsequently pronounced dead. An autopsy conducted by the Will County Coroner's Office noted the immediate cause of death as Hypertensive Cardiovascular Disease with Coronary Atherosclerosis being a significant contributing cause.

It is axiomatic that employers take their employees as they find them. *Sisbro, Inc. v. Industrial Commission*, 278 Ill.Dec. 70, 77, 797 N.E.2d 665, 672 (Ill. 2003); citing *Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2002). "When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment." *Sisbro*, 797 N.E.2d at 672; citing, *General Electric Co. v. Industrial Commission*, 89 Ill2d 432, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro*, at 672-673; citing *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36; *Williams v. Industrial Comm'n*, 85 Ill. 2d 117, 122, 51 Ill. Dec. 685, 421 N.E.2d 193 (1981); *County of Cook v. Industrial Comm'n*, 69 Ill. 2d 10, 18, 12 Ill. Dec. 716, 370 N.E.2d 520 (1977); *Town of Cicero v. Industrial Comm'n*, 404 Ill. 487, 89 N.E.2d 354 (1949) (It is a well-settled rule that where an employee, in the performance of his duties and as a result thereof, is suddenly disabled, an accidental injury is sustained even though the result would not have obtained had the employee been in normal health). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was a causative factor in the resulting

condition of ill-being. *Sisbro*, at 673; citing *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967).

In the present case, Decedent was clearly engaged in an employment-related activity -- one that his employer would have reasonably expected him to perform in fulfilling his assigned job duties – when he was clearing snow from a walkway in preparation for the arrival of potential home buyers. As a result, Decedent was exposed to a risk of injury distinctly associated with his job, and as such the Arbitrator erred in finding that Petitioner failed to prove that Decedent suffered accidental injuries arising out of and in the course of his employment on 12/6/06, particularly in light of the recent Illinois Supreme Court case of *McAllister v. Illinois Workers' Compensation Commission*, 2020 IL 124848 (filed 9/24/20).

Furthermore, while the evidence shows that Decedent suffered from an unknown, underlying heart condition, per the autopsy, the fact remains that his employment-related activity of shoveling snow on the date of the accident was ***a*** contributing factor in his subsequent fatal heart attack, per the opinion of Dr. Tamlyn. Indeed, even Respondent's expert, Dr. Carroll, conceded that "… given the temporal relationship between [Decedent's] shoveling activities and his development of chest pain, it would make sense that the two were related." As such, and in light of the dictates of *Sisbro*, supra, I believe the Arbitrator erred in finding that Petitioner failed to prove that Decedent's death was causally related to his employment with Respondent.

Finally, I believe the Arbitrator erred in finding that Petitioner was not a dependent of Decedent at the time of death pursuant to §7(a) of the Act. §7(a) provides that benefits are payable to any surviving child 1) under 18 years of age, 2) under 25 years of age who is a full-time student at any accredited educational institution, or 3) is physically or mentally handicapped. The evidence shows that Petitioner, Kevin Cronk, had turned 18 years of age on 5/1/06, or approximately seven months prior to his father's passing and was not enrolled in an accredited educational institution at that time. However, he subsequently did enroll as a full-time student on 8/20/07 and eventually obtained an undergraduate degree and ultimately a law degree. A plain reading of §7(a) reveals no requirement that the surviving child be enrolled on the date of death. Indeed, the court in *Drives, Inc. v. Industrial Commission*, 124 Ill. App. 3d 1014 (4th Dist. 1984) specifically refused to fix the claimant's status on the date of the father's death, noting that "[t]he statute makes no exceptions to the 25-year-age rule and does not expressly terminate benefits in the event of a break in the educational continuum." *Drives, Inc.*, p.1017.

Thus, I believe the spirit of the law, not to mention a literal reading of the statute, would allow for the finding that Petitioner was a dependent child under the Act, and as such was entitled to benefits following the fatal injuries his father sustained as a result of his employment on 12/6/06.

Therefore, I respectively dissent from the majority's opinion affirming and adopting the Arbitrator's denial of benefits.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

CRONK, KEVIN SON OF COOK, RICHARD DECEASED Case# **09WC049653**
Employee/Petitioner

KIMBALL HILL HOMES
Employer/Respondent

20IWCC0663

On 4/12/2019, 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 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT E HARRINGTON JR
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

Kevin Cronk, son of Richard Cronk, Deceased Case # **09** WC **49653**
Employee/Petitioner

v.

Kimball Hill Homes **20 IWCC0663**
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **New Lenox**, on **March 13, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [x] Did an accident occur that arose out of and in the course of Decedent's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

F. [x] Is Decedent's current condition of ill-being causally related to the injury?

G. [ ] What were Decedent's earnings?

H. [ ] What was Decedent's age at the time of the accident?

I. [ ] What was Decedent's marital status at the time of the accident?

J. [x] Who was dependent on Decedent at the time of death?

K. [ ] Were the medical services that were provided to Decedent reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

L. [ ] What compensation for permanent disability, if any, is due?

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident alleged, **December 6, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Decedent's death *is not* causally related to the accident.

In the year preceding the injury, Decedent earned $**67,378.14**; the average weekly wage was $**1,294.77**.

On the date of accident, Decedent was **50** years of age, *married* with **1** dependent child (Miranda Mullner, a minor).

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 $**0** under Section 8(j) of the Act.

The Arbitrator finds that Decedent died on **December 6, 2006**, leaving **2** survivor(s), as provided in Section 7(a) of the Act, including **1** ***surviving spouse*** **, Barbara Cronk (widow), and Miranda Mullner, a minor**.

ORDER

Petitioner failed to establish that decedent, Richard G. Cronk sustained an accident that arose out of and in the course of his employment with Respondent.

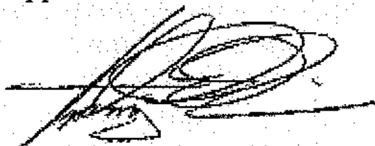
Petitioner failed to establish that decedent's condition of ill-being was causally related to his employment with Respondent.

Petitioner failed to establish that he is entitled to any survivor benefits under Section 7(a) of the Illinois Workers' Compensation Act.

No benefits are awarded herein.

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

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



Arbitrator Anthony C. Erbacci

April 9, 2019
Date

APR 12 2019

FACTS:

The Petitioner, Kevin Cronk, testified he is the son of Richard Cronk, deceased. Petitioner offered into evidence of copy of a Judgment for Dissolution of Marriage of Barbara Cronk and Richard G. Cronk. (PX 4). The Arbitrator notes that this exhibit indicates that Barbara Cronk and Richard Cronk were married on October 11, 1986 in Chicago, Illinois and that only one child, Kevin G. Cronk, was born to that marriage. The exhibit indicates that Kevin G. Cronk's date of birth was May 1, 1988. The Arbitrator notes that Petitioner Kevin Cronk, was approximately one and a half years old at the time of his parent's divorce.

Nine years later, Richard Cronk married Barbara Annette Mullner on November 7, 1998. A Certificate of Marriage recorded November 10, 1998 was offered into evidence as Respondent's Exhibit Number 1.

Richard G. Cronk passed away on December 6, 2006. Respondent offered a copy of the Medical Examiner's Coroner's Certificate of Death as Respondent's Exhibit Number 2. This exhibit states that Petitioner's cause of death was Hypertensive Cardiovascular Disease. This exhibit also indicates the decedent was married and listed the name of the surviving spouse as Barbara Rowe Cronk. Respondent also offered into evidence a copy of the autopsy and toxicology reports regarding Richard G. Cronk (RX 3). Petitioner offered a copy of the subpoenaed records from Will County Coroner (PX 2). Both of these exhibits contain statements from coroner's physician Bryan R. Mitchell, M.D. who concluded, "In my opinion, the cause of death was as follows: Immediate cause (a) Hypertensive Cardiovascular Disease and other significant conditions contributing to death but not related to the terminal conditions: Coronary Atherosclerosis." (RX 3). PX 2 also contained history that decedent smoked approximately one pack of cigarettes daily for several years.

The Arbitrator notes that given Petitioner's May 1, 1988 date of birth, Petitioner Kevin Cronk was approximately 18 years and 7 months old on the date of his father's death. Petitioner testified he never resided with decedent, Richard Cronk, or Barbara Rowe Cronk at any time during their marriage. He testified he was not enrolled as a full time student at any school at the time of his father's death. He testified he took a gap year following his graduation from high school in May of 2006 and did not enroll in Joliet Junior College until the fall of 2007. He testified he was not physically or mentally incapacitated at any time.

On March 23, 2007 Barbara Rowe Cronk caused to be filed an Application for Adjustment of Claim 07 WC 12760 (PX 5) relative to decedent's February 6, 2006 alleged work-related accident. Respondent offered a record review report from Dr. Richard J. Carroll dated March 4, 2007 (RX 5) and also an addendum report from Dr. Carroll dated April 8, 2007 (RX 6) following the doctor's review of the autopsy report and records. In his first report, Dr. Carroll found decedent's coronary artery disease was most likely due to genetic factors, low good cholesterol, and his cigarette smoking. The doctor asked to review the autopsy report and records. (RX 5). After reviewing the autopsy report and records, Dr. Carroll issued a final addendum report on April 8, 2007 opining that decedent was found to have multi-vessel coronary artery disease with 50% narrowing noted in the left anterior descending coronary artery, the circumflex coronary artery and the right coronary artery. The doctor noted that however, there was no evidence of acute occlusion or thrombosis, confirming that the decedent did not have an acute heart attack. The doctor opined that the decedent did, however have an enlarged, thickened heart (cardiomegaly); hence the anatomic diagnosis of hypertensive heart disease. Dr. Carroll went on to state that in his opinion, the immediate cause of death was most likely a fatal cardiac arrhythmia, a result of his abnormal heart muscle. He also stood by his previous opinions that this was unrelated to physical activity stating that the amount of activity performed and

the degree of narrowings noted on the autopsy would not have been significant enough, either alone or together, to precipitate either an acute heart attack or fatal arrhythmia. Dr. Carroll stated that "we note that in patients with cardiomegaly such arrhythmias often occur spontaneously, separate and distinct from any physical activity, because of the abnormal architecture of the heart muscle." He stated he believed this was the case here. (RX 6).

The Petitioner's attorney in case 07 WC 12760 thereafter obtained a record review report from Thomas M. Tamlyn, M.D. Dr. Tamlyn opined that Richard Cronk died of cardiac arrhythmic arrest most likely resultant to cardiac ischemia and unstable angina or transient coronary occlusion. He found he also had cardiac hypertrophy. Dr. Tamlyn opined that the event was brought on or aggravated by physical exertion because he developed symptoms consistent with cardiac ischemia while shoveling snow (PX 1).

On April 27, 2009 this Honorable Commission approved a settlement contract in Case Number 07 WC 12760. A copy of that settlement contract was offered into evidence by Respondent as Respondent's Exhibit 4. This exhibit shows that Respondent denied that the Petitioner sustained accidental injuries arising out of and in the course of his employment and denied a causal relationship between decedent's condition of ill-being and any injury arising out of decedent's employment. That case settled on a compromised adjustment for total sum of $225,000.00 in order "to purchase peace and avoid further litigation." (RX 4).

On December 4, 2009, Petitioner Kevin Cronk caused to be filed the pending Application for Adjustment of Claim concerning the same alleged accident that was the subject of settled Case Number 09 WC 49653.

According to Arbitrator's Exhibit 1, the Respondent continues to dispute the issue of accident and causal connection and further disputes that any survivor benefits are due to Petitioner Kevin Cronk.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

Petitioner failed to establish by a preponderance of credible evidence that decedent, Richard Cronk, sustained a December 6, 2006 accident that arose out of and in the course of his employment with Respondent.

A claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident, which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008). Burden of proof consists of producing sufficient evidence to establish a prima facie case for entitlement to benefits consisting of "evidence on all the necessary elements to establish the underlying cause of action." City of Chicago v. Illinois Workers' Compensation Commission, 373 Ill. App.3d 1080, 1090-1091 (Ill. App. Ct. 1st Dist. 2007). An injury is sustained "in the course" of employment when it occurs during employment, at a place where the worker may reasonably perform employment duties or engage in some incidental employment duties. Baggett v. Industrial Commission, 201 Ill.2d 187, 194, 775 N.E.2d 908, 912-913, 266 Ill. Dec. 836 (2002). An injury "arises out of" one's employment if it

originates from a risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. I.d. at 194, 775 N.E.2d at 912. Both elements must be present at the time of the claimant's injury in order to justify compensation. Illinois Bell Telephone Company v. Industrial Commission, 131 Ill.2d 478, 483 (1989).

In support of this finding, the Arbitrator takes into consideration that Petitioner, Kevin Cronk, presented no testimony or witness testimony pertaining to the disputed December 6, 2006 accident. The only documentation of alleged mechanism of injury was the very limited statements contained in the subpoenaed records from Will County Coroner. These only state "shoveling snow at worksite and complained of difficulty in breathing." This exhibit also contains a history "Richard was not shoveling a driveway or any extensive amount of shoveling, just a sidewalk leading up to the front of the house" (PX 2). There is no indication of the amount of snow or weight of snow contained in the record. Due to the lack of evidence submitted by Petitioner, the Arbitrator finds Petitioner failed to meet his burden of establishing accident by a preponderance of credible evidence.

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

"In a workers' compensation case, the claimant has the burden of proving by a preponderance of the evidence, some causal relation between her employment and her injury." Mansfield v. Ill. Workers' Comp Comm'n, 2013 IL App (2d) 120909WC, p. 27, 376 Ill. Dec 657, 999 NE 2d 832.

In order to obtain compensation under the Act, a claimant must prove, by a preponderance of the evidence, that he suffered an injury which arose out of and in the course of employment. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203, (2003). For a finding that an injury "arose out of" employment, the injury must have "had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." Id. at 203.

For an employee's workplace injury to be compensable under the Workers' Compensation Act, he must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. Hansel & Gretel Day Care Center v. Industrial Comm'n, 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. Board of Trustees of the University of Illinois v. Industrial Comm'n, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969).

It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. O'Dette v. Industrial Comm'n, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. Hosteny v. Workers' Compensation Comm'n, 397 Ill. App. 3d 665, 674 (2009).

In comparing the opinions of both physicians, it is paramount to recognize that "[l]iability cannot be premised upon imagination, speculation or conjecture but must arise from facts established by a preponderance of the evidence." Illinois Bell Tel. Co. v. Industrial Comm'n, 265 Ill. App. 3d 681, 685 (1st Dist. 1994). "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, *16-17,960 N.E.2d 587, 594 (4th Dist. 2011).

The Arbitrator finds that notwithstanding the prior finding on issue of accident, Petitioner also failed to establish by a preponderance of credible evidence that decedent, Richard Cronk's death was causally related to his employment with Respondent.

In support of this finding, the Arbitrator relies upon the medical opinion of Richard Carroll, M.D. which he finds to be most credible and reliable. Dr. Carroll opined that decedent's death was unrelated to physical activity and that the amount of activity performed and the degrees of narrowing noted on the autopsy would not have been significant enough, either alone or together, to precipitate either an acute heart attack or fatal arrhythmia consistent with autopsy report and death certificate (RX 5, RX 6).

The Arbitrator finds that Dr. Carroll's opinions are consistent with and supported by the cause of death listed on the decedent's death certificate (RX 2) and the coroner's autopsy and toxicology reports (RX 3).

In Support of the Arbitrator's Decision relating to (J.), Who was dependent on Decedent at the time of death, the Arbitrator finds and concludes as follows:

Notwithstanding the foregoing findings on accident and causal connection, the Arbitrator further finds Petitioner failed to establish a preponderance of credible evidence that he was a dependent of decedent at time of death pursuant to Section 7(a) of the Act.

On the date of decedent's death, December 6, 2006, decedent was married to and left surviving widow Barbara Rowe Cronk. Therefore, Barbara Rowe Cronk would be a survivor entitled to benefits under Section 7(a) of the Act.

On the date of decedent's death, Petitioner, Kevin Cronk, was over eighteen (18) years of age, and not enrolled as a full-time student in an accredited educational institution. Petitioner testified that he turned 18 on May 1, 2006 and graduated high school in either May or June 2006. He testified he was not enrolled in any school on the date of decedent's death. He testified that he did not apply to school until August 2007. Because Petitioner was over eighteen (18) at the time of decedent's death and not enrolled in school, he is not entitled to survivor benefits under Section 7(a) of the Act.

Petitioner cites in his opening statement at trial, Drives, Inc. v. The Industrial Commission, 124 Ill. App. 3d 1014 (1984) as supporting his claim as a survivor entitled to benefits under Section 7(a) of the Act. The Arbitrator finds that Drives is inapposite to this case, and does not support Petitioner's claim for benefits under Section 7(a).

In Drives, at the time of the decedent's death the Petitioner was 21 years old and enrolled as a full-time student at an accredited education institution. The Claimant completed her undergraduate degree, and left school to teach. Subsequently, Claimant had married and returned to school to obtain her Master's degree. The Court was tasked with addressing whether the Claimant's marriage and break in education terminated her benefits. The first proposition of Drives was that a legal obligation to support is not a definitive requirement for benefits under Section 7(a) and that the child could receive benefits subsequent to marriage if they were still enrolled full-time. The second proposition was that a break in the education continuum would not wholly terminate benefits and that the Claimant would be entitled to benefits during the periods that she was enrolled.

However, the Drives Court focused on the child's status on the date of death. ("At the time of her father's death, Janice was 21 years of age and enrolled as an undergraduate in her senior year in college; she was totally dependent upon her father for support.") Drives, at 1015.

Petitioner testified that he never lived with the decedent and Barbara Rowe Cronk, and was not mentally or physically incapacitated at any time. He also was not enrolled full-time in any school at the time of the death, and did not testify to having any dependency upon the decedent at the time of the decedent's death.

The Arbitrator notes that Section 7(a) evinces an intent of determining survivorship status on the date of death. The use of "shall continue" indicates that the child would have been receiving benefits, or eligible thereto, at the time of death, and that such benefits would necessarily continue from that date.

Although there are no Appellate decisions that are directly on point, a review of Commission decisions shows survivorship status, particularly for adult children, is determined at the date of death. In Pawel Dabrowski v. Masonry Restoration Group, Inc., 12 IWCC 395, decedent left one child under 18 years old and one child who was 18 years old at the time of death. Only benefits to the child under 18 were awarded and there was no discussion otherwise with regard to the child who was over 18. Similarly, in Lisa Tucker v. Goodyear Tire & Rubber, 4 IIC 753, at the time of the decedent's death, of decedent's four children, two were under 18 and thus awarded benefits, and the other two were over 18 and under 25, but "not in school at the time of death" and therefore, compensation for those adult children was denied. In Todd Gottschall v. Illinois Veterans Home, 17 IWC 675, the decedent left surviving two children who were over 18 and not enrolled in school at the time of death, and therefore, only the widower was deemed an eligible survivor under Section 7(a).

Public policy favors certainty in determining eligible beneficiaries, as well as facilitating timely and efficient payment of benefits. Interpreting Section 7(a) under Petitioner's arguments would prevent any finality or closure of benefits when there remains a child over 18 at the time of death, requiring parties to wait until that child reaches the age of 25.

The public policy of Illinois favors an expeditious and efficient system for resolution of workers' compensation disputes. It also favors finality. See, e.g., Michael v. Fansteel, Inc., 235 Ill. App. 3d 961, 602 N.E.2d 494 (2nd Dist. 1992); Sankey Bros., Inc. v. Guilliams, 152 Ill. App. 3d 393, 504 N.E.2d 534 (3rd Dist. 1987). The Petitioner's theory of contingent and intervening entitlements would seemingly offend those policy preferences.

Addressing Petitioner's claims that the marital settlement agreement established a legal obligation of support, the Arbitrator notes that the agreement provided that Petitioner would become emancipated on the later of him turning 18 or graduating high school. Although the marital agreement also provided the decedent would need to pay college tuition and related expenses, the Arbitrator notes that Petitioner was not enrolled in any school at the time of accident, and therefore, there was no legal obligation to support at the time of death.

For all of the above reasons, the Arbitrator finds Petitioner is not entitled to any benefits.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RHETT MCCRADY,

Petitioner,

vs. NO: 19 WC 01650

LANGHEIM CONCRETE SERVICE, INC,

Respondent.

20IWCC0664

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, and medical expenses, and being advised of the facts and law, reverses, in part, 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).

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

Petitioner was employed as a laborer for Respondent. He performed general construction activities on several rental properties as well as concrete work which required setting up forms and pouring concrete. (T. 10) Petitioner's job duties included shoveling and "crumbing" out holes. (T. 11)

On December 28, 2018, Petitioner was working at Springfield Plastics in Auburn where they were cutting out a concrete floor. (T. 12) While his co-workers were busting out the concrete, he was spraying the area with a hose to keep the dust down so the workers were not

breathing the dust and the dust would not get into the machinery. (T. 13) After the concrete was removed with the excavator, Petitioner got down into the hole to crumb out the leftover rock, mud and concrete. (T. 13) Petitioner testified that as he was shoveling the mud, concrete and debris out of the hole, after about his fourth of fifth scoop, he heard a snap and felt instant pain in his shoulder. (T. 14) Petitioner put the shovel down and exited the hole. Petitioner testified it was very noisy in the hole. He stated that they could not communicate, and he used hand signals, grabbing his shoulder, showing that he was hurt, and he was leaving. (T.15) Petitioner departed the work site using a work truck. Petitioner's wife then drove Petitioner to the emergency room. (T.15)

Petitioner sought medical attention at Memorial Medical Center on the date of the accident. The ***History of Present Illness*** indicates, "Patient was doing well until he tried to (sic) shoveling concrete today. Patient stating that he fel (sic) sudden onset of snap and following by crackling sound to the left shoulder…" (PX1) Petitioner underwent an x-ray examination of the left shoulder on that date and provided a history of severe left shoulder pain after shoveling concrete this afternoon. (PX1)

Petitioner sought medical attention from Dr. Mark Greatting on January 3, 2018. Petitioner testified this appointment was already scheduled before he went to the emergency room on December 28, 2018. (T. 36) Petitioner reported that on December 28 he was shoveling mud which was very heavy and required a lot of force and lifting and he had an immediate onset of severe increased pain in his shoulder. (PX7)

Mr. Reese Langheim, owner of Langheim Concrete Service, Inc., testified he was present at the work site on the date of accident. Mr. Langheim testified that on that date, Petitioner did not report an accident to him. (T. 42) Mr. Langheim testified that after the truck was loaded up, Petitioner departed in his [Mr. Langheim's] truck and did not return to pick him up. (T. 43) Another co-worker contacted Petitioner's wife who advised she was trying to make a doctor's appointment for Petitioner. (T. 43)

Based on the foregoing, the Commission finds Petitioner has proven by a preponderance of evidence that he sustained an accident arising out of and in the course of his employment with Respondent on December 28, 2018. Petitioner's testimony that he sustained an injury to his left shoulder while shoveling is supported by the initial treating records at Memorial Medical Center and the history provided to Dr. Greatting. Petitioner's testimony is further supported by the testimony of Mr. Langheim who corroborated that Petitioner left work early on December 28, 2018, and his wife was seeking medical attention for him on that day. The Commission finds the contemporaneous medical records and consistent testimony show Petitioner sustained his burden of proof with respect to accident.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator finding Petitioner failed to prove he sustained an accident arising out of and in the course of his employment, is hereby reversed and vacated.

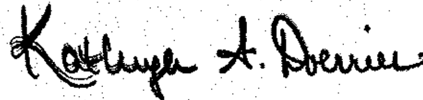
IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator finding Petitioner failed to prove a causal connection between his current condition of ill-being and the accident occurring at work on December 28, 2018, is hereby affirmed and adopted and benefits are denied.

IT IS FURTHER ORDERED that, as Petitioner failed to prove a causal relationship between the current condition of ill-being and work-related accident, all other issues are rendered moot.

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

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

DATED: NOV 13 2020
o-10/6/20
KAD/jsf



Kathryn A. Doerries

Maria E. Portela

Thomas J. Tyrrell

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

McCRADY, RHETT
Employee/Petitioner

Case# **19WC001650**

LANGHEIM CONCRETE SERVICE INC
Employer/Respondent

20IWCC0664

On 4/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

4494 SGRO HANRAHAN DURR RABIN
ALEX B RABIN
1119 S 6TH ST
SPRINGFIELD, IL 62703

0358 QUINN JOHNSTON HENDERSON ET AL
JOHN F KAMIN
227 N E JEFFERSON ST
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF **SANGAMON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RHETT MCCRADY
Employee/Petitioner

Case # **19** WC **1650**

v.

Consolidated cases: _____

LANGHEIM CONCRETE SERVICE, INC.
Employer/Respondent

20 I W CC0664

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **February 21, 2020**. 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, **12/28/18**, 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 year preceding the injury, Petitioner earned **$22,825.25**; the average weekly wage was **$417.10**.

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

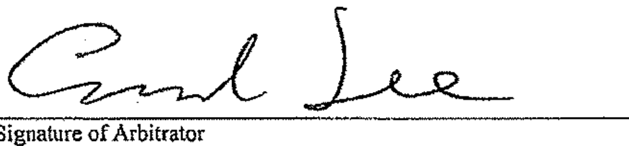
Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

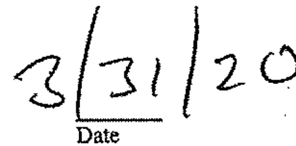
Petitioner's claim for compensation is denied as Petitioner failed to prove that his current condition of ill-being is related to accidental injury occurring at work on December 28, 2018.

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

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



Signature of Arbitrator



Date

4834-4242-0406 v. 1

APR 3 - 2020

20IWCC0664

ILLINOIS WORKERS' COMPENSATION COMMISSION

RHETT MCCRADY, Petitioner, v. LANGHEIM CONCRETE SERVICE, INC., Respondent.	)	CASE NO. 19 WC 1650

20IWCC0664

ADDENDUM TO MEMORANDUM OF DECISION OF ARBITRATOR

In support of the Arbitrator's decision with regard to:

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

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

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?**

L. **What temporary benefits are in dispute? TTD**

The Arbitrator finds the following facts:

Petitioner testified that he was employed at Langheim Concrete Service on December 28, 2018 with his general job duties being that of a laborer. He stated that he worked for them for less than three years and considered himself a full-time employee. He noted that his work involved general construction activities as well as doing some concrete work, setting up forms and pouring concrete. He said that some of his work involved the use of a shovel and that he would use a shovel to remove dirt that would be in his way or to level ground and also performed crumbing out holes. On December 28, 2018, he was working on a project where they were removing a

concrete floor from a business with an excavator. His work initially involved spraying a hose to keep dust down from the work. He said that after the concrete pieces were removed with an excavator, they had to go down into the hole and use a shovel to crumb out the small pieces of leftover rock and mud that were left in the hole. Petitioner testified that during the process of scooping rock and mud from the hole into the excavator bucket, that at about the fourth or fifth scoop he heard a snap in his shoulder and felt instant pain. He stated that it was very noisy there and he got out of the hole. He grabbed onto his shoulder and left the job site. He said his wife then took him to the emergency room. He said he was in excruciating pain and could not move his arm. He said that he visited Memorial Medical Center and they immobilized his shoulder, ordered x-rays and referred him to a specialist. He then went to see Dr. Greatting who subsequently performed two surgeries on his shoulder. He also consulted with his primary care physician, Dr. Martinek, and is still restricted from work noting his understanding of a five-pound lifting restriction. Petitioner noted that he had a prior injury to his shoulder and believed he had his last surgery to his shoulder in 2009. He stated the only problems he had with his shoulder prior to December 28, 2018 was when he would overdo it at work. He said if he did, he would miss a few days of work and then once he was feeling well enough he would come back and try to do his job. He has been referred for pain treatment and believed he had an MRI set on February 26. Petitioner described metal hardware and a large L-bracket that was in his shoulder before his work injury and has since been replaced.

On cross-examination, Petitioner admitted that he had prior injury to his shoulder back in 2008 and had actually undergone 10 prior shoulder surgeries. Dr. Paletta in St. Louis performed a shoulder fusion. He also noted that after that shoulder fusion he was released with a permanent 20-pound lifting and no overhead lifting restriction some time in 2012 or 2013. He then settled

that workers' compensation claim for approximately $85,000 with an additional $65,000 being paid for anticipated future medical care for his shoulder. He noted that he had tried to get onto the employer's group health insurance and was on it for a month or so but then dropped the coverage because of an extra charge that was related to the insurance.

He stated that when he went to the emergency room, he told the doctor that he was doing well until the injury he described that day. However, on June 26, 2018, he had gone to Dr. Martinek for an exam. Initially, he testified that he told the doctor in June 2018 he was overdoing it. He then conceded he told the physician's assistant that his shoulder had been really bothering him the last couple of months and that he was not sure why it was bothering him and did not recall a recent injury. When asked if he recalled returning to Dr. Martinek's office on September 26, 2018 complaining of chronic shoulder pain for years, he again stated that he would only go there to make complaints about his concrete work. He admitted that as of that visit he had reported decreased range of motion in his shoulder and was using Norco for pain.

He returned to the doctor's office on December 3, 2018, again complaining of left shoulder pain with multiple shoulder surgeries with a fusion, a lot of pain, rated 8/10 in severity with significant weakness, and limited range of motion. At that point he stated that he had obtained insurance and was interested in seeing a specialist. He also recalled on December 20, 2018 being asked by Sarah Langheim, one of the insured's owners, to move some bedroom furniture and box spring and stated that he could not do so because it was above his head and that his arm was fused. He admitted at that time that he told her that he could not do the lifting and that Ms. Langheim had moved the furniture.

Petitioner was also asked about the December 28, 2018 emergency room records which documented that he had an appointment already scheduled with a specialist at the Orthopedic

Center of St. Louis on January 14, 2019. Petitioner testified that record was erroneous and that he did not have an appointment already scheduled in St. Louis on January 14, 2019. However, he subsequently confirmed that the appointment was not in St. Louis but with Dr. Greatting in Springfield. Petitioner confirmed that he had actually had an appointment scheduled with Dr. Greatting to evaluate his shoulder before he even visited the emergency room.

Petitioner also stated that at the time he was hired by Langheim Concrete, he did not tell them he had permanent restrictions imposed on him by Dr. Paletta noting he had no opportunity to do so as he did not fill out an application. However, he then stated he did eventually let them know he had shoulder problems and that he was initially hired to do lawn care and house maintenance.

Respondent called Reese Langheim to testify. He confirmed he was the owner of Langheim Concrete Services and that Rhett McCrady was working for him on December 28, 2018. Mr. Langheim confirmed that the Petitioner was hosing, crumbing, sweeping and cleaning up at the end of the workday. He indicated that that involved placing materials onto the scoop of the excavator. He noted that at no point during the work did Petitioner report to him that he injured himself performing that activity on December 28, 2018. He noted that he had called in Petitioner and the other guys and asked if they wanted to take off early because it was Christmas time and a Friday. He had told the crew that if they got the job cleaned up that they could take off early. He noted that Petitioner was crumbing, sweeping, cleaning and using a garden hose washing off some concrete. After doing so, the Petitioner loaded the excavator onto the trailer and strapped it down. He said that the Petitioner had left, and he thought he was coming back to get him because he had taken his truck. However, he said that he never did return and that one of the coworkers, Beau, actually got in touch with Petitioner's wife and his wife was trying to make a doctor's appointment

or trying to go to the doctor or something. As a result, Mr. Langheim had to get a ride back to the shop to get his truck and grab the equipment and pick it up. It was not unusual for Petitioner to drive Langheim's truck.

MEMORIAL MEDICAL CENTER RECORDS

Petitioner offered the records from Memorial Medical Center for Petitioner's emergency room visit on December 28, 2018 and the follow-up care. (See PX 1). At that time, the physician recorded Petitioner's triage complaint of shoulder pain. The history indicates that Petitioner had had 10 surgeries to his left shoulder secondary to a fracture of the humerus many years ago. He said that the last surgery was with Dr. Paletta in St. Louis. Petitioner reported he was doing well until he tried shoveling concrete that day and stated that he felt a sudden onset of snap, followed by a crackling in his shoulder and stated that a screw was loosening in his shoulder. He noted that he had an appointment set with the Orthopedic Center of St. Louis on January 14 of the following year. The x-rays were taken and compared to a 2015 study. The radiologist noted that the hardware positioning was stable.

DR. GREATTING'S TESTIMONY

The Petitioner was referred to Dr. Mark Greatting. Dr. Greatting was deposed. (See PX 7). Dr. Greatting testified that he had treated the Petitioner in the past but that his most recent episode of care started on January 3, 2019. (PX 7, p. 5). He noted the Petitioner had previously been to Memorial Medical Center and had x-rays. Dr. Greatting noted that Petitioner had multiple surgeries on his shoulder in the past by himself, Dr. Brent Wolters and Dr. George Paletta in St. Louis. In fact, he had had his shoulder fused by Dr. Paletta in 2009. Following same, he had healed, and he had had mild pain, but he seemed to function relatively well. Petitioner gave a history that on December 28th he was shoveling mud which was very heavy and required a lot of

force and lifting and he had an immediate onset of severe increased pain in his shoulder. He examined the Petitioner and found marked tenderness with some painful motion in the shoulder joint. He noted that it appeared he had a chronic nonunion of his left shoulder arthrodesis, or fusion, and that he had loosening or failure of his hardware. He ordered labs and discussed with Petitioner that he would need to have his hardware removed and his shoulder re-fused. He performed surgery to remove the hardware on April 23, 2019. He noted that the labs showed a possible indication of chronic inflammation or infection. Dr. Greatting performed a bone biopsy of the shoulder joint when he removed the hardware on April 23, 2019. The cultures from the surgery showed that he had staph epidermidis and he was referred to an infectious disease physician and was started on intravenous antibiotics to treat the infection in his shoulder. He eventually performed a repeat arthrodesis of the left shoulder on July 14, 2019.

Dr. Greatting stated that based upon his history, if it is correct, that Petitioner was doing okay until December 28, 2018 and whatever happened to him that day caused some increased motion, instability or issues with his shoulder.

On cross-examination, Dr. Greatting was asked what caused the infection of Petitioner's shoulder. He stated that he did not know, and that the Petitioner could have had a chronic infection as he has had multiple procedures over many years. He noted the bacteria that he had was a pretty indolent organism so he potentially could have had a chronic infection in his shoulder for years so that is most likely the cause was the multiple surgeries. (PX. 7, p. 16-17). Dr. Greatting confirmed that Petitioner had previously had multiple procedures involving multiple stabilization procedures of the left shoulder, treatment for labral pathology, other internal derangement, all which eventually culminated in a fusion being performed by Dr. Paletta in 2008 or 2009. Dr. Paletta had placed permanent lifting restrictions against overhead lifting and no lifting greater than 20 pounds

which Dr. Greatting thought would be a very reasonable restriction considering the prior shoulder fusion.

Dr. Greatting confirmed that the labs that he performed showed evidence of infection and in his intraoperative findings he confirmed that there was osteomyelitis which is infection of the bone. (PX 7, p. 18). Dr. Greatting testified that the chronic infection certainly can prevent healing of the procedure, such as a fusion, or it can also cause loosening of the hardware and failure of the procedure over time. He also confirmed that if there was osteomyelitis, you do not necessarily need to have some acute trauma to cause loosening of the hardware. Dr. Greatting noted that his causation opinion was based upon the Petitioner's history that his symptoms developed as a result of the work that he was doing on December 28, 2018 and he confirmed that his opinion was pretty much entirely based upon the history of saying he had mild pain and was doing relatively okay and then had severe increase in pain after the activities.

Dr. Greatting was asked to assume that 8 days prior to Petitioner's alleged work injury, he had been asked to move some furniture and indicated that he could not move the furniture because he was having significant problems with his shoulder and that he was trying to find some free insurance or other insurance to pay for medical treatment. Dr. Greatting was also asked to assume that Petitioner did not report to the employer at the time that he was doing his activity at work on December 28, 2018 that he suffered an injury until sometime after leaving the job site. Presented with the information, Dr. Greatting stated that the hypothetical history or question indicates a difference in what the patient told him and that it could potentially change his opinion. Dr. Greatting confirmed that if the initial history changes and was incorrect, then it would change his opinion. (PX 7, p. 22-23).

DR. MARTINEK RECORDS

Respondent offered medical records from Springfield Clinic for Petitioner's visits on June 26, 2018, September 26, 2018 and December 3, 2018. On June 26, 2018, the Petitioner was seen by Dr. Martinek's physician assistant, Jennifer Hendricks, for a general physical exam. At that time, Ms. Hendricks recorded a history that Petitioner was having a lot of left shoulder pain. He had had a history of about 10 surgeries on his left shoulder which ultimately ended in a fusion of his shoulder. Petitioner stated that his shoulder had really been bothering him for the last couple of months. He stated he was not sure why it was bothering him. He denied any recent injury and tried not to use it as much as possible. He stated that he was really miserable with pain and that he had no insurance right now and could not afford to see a specialist or have further treatment. (See RX 3). He returned on September 26, 2018. At this time, Dr. Martinek recorded a history that Petitioner was a 45-year-old male with left shoulder pain, and a cough and congestion. The history was that Petitioner had left shoulder pain for years now and has had multiple surgeries on his left shoulder. He reported that over the last month he has had decreasing range of motion in his shoulder and having an increase in pain. Petitioner reported that he was using Norco for pain relief. In addition, Petitioner stated that he had had to miss work secondary to his pain and a change in range of motion. He reported that it has been a problem doing his concrete work.

Petitioner then returned for a third appointment on December 3, 2018 and again saw Ms. Hendricks. She recorded a history that Petitioner had come in with complaints of ongoing left shoulder pain. He had had multiple left shoulder surgeries with fusion. He was having a lot of pain and rated it an 8 out of 10 on a severity scale right now. He had significant weakness and limited range of motion of his left arm. He reported that he had recently got insurance and was interested in seeing a specialist.

Respondent also offered the settlement contracts for Petitioner's prior left shoulder injury for case 08 WC 8314. The contract indicates Petitioner received TTD for 4 ½ years after that injury and did not return to his regular job. The contract also confirms Petitioner received a settlement for $151,671.17 with an estimate of the additional future medical care required for his left shoulder to total $66,671.17.

DR. LI'S TESTIMONY

The Respondent retained Dr. Lawrence Li to review Petitioner's medical chart. (See RX 1). Dr. Li was deposed. He confirmed that he was a board-certified orthopedic surgeon focusing on the shoulders, hands and knees. He reviewed the medical records involving Petitioner and prepared a report that was offered as an exhibit to his deposition. He confirmed that osteomyelitis was an infection in the bone that can be a post-surgical complication. Based upon his review of the records, the Petitioner had a very severe shoulder problem that led to 10 surgeries and ultimately wound up with a fusion of his shoulder which is what the physicians call salvage operation. He noted the surgery is very disabling and only done to make a really bad situation less bad and by no means to make a bad situation remotely close to normal. He noted that it was important to him that as early as June 2018 and through December 3, 2018, Petitioner was having significant shoulder pain. As of December 3, 2018, he was rating his pain as high as an 8 out of 10 and had significant weakness and limitation of motion. He noted that the Petitioner subsequently was diagnosed with osteomyelitis. Dr. Li explained this is an infection in the bone that can be a surgical complication. He noted that Petitioner's shoulder fusion is a long surgery in terms of operative time and that an open wound for that amount of time could be one source or infection. He also noted the source of the infection may come from skin ulcers or the like or use of IV drugs.

He noted that Petitioner had osteomyelitis which was a chronic infection that slowly eats away at the bone. He stated that Petitioner had a lot of pain before and apparently worked through it and at some point, his infection had gotten bad enough that he simply could no longer work. He also noted that the diagnosis of osteomyelitis was made through biopsy and that there was no reference that Dr. Pineda had performed any type of biopsy at the time of the emergency room visit.

Dr. Li had absolutely no doubt in his mind Petitioner had osteomyelitis in his shoulder long before December 28, 2018. He noted that while Dr. Pineda did not find evidence of fever, redness or puss to show infection, Petitioner's prior complaints of shoulder pain, limited range of motion and loss of strength as described in the medical records from December 3, 2018 were signs of infection. Dr. Li did not relate the hardware failure to any work activity on December 28, 2018.

Based upon the foregoing, the Arbitrator concludes the Petitioner failed to sustain his burden to prove his condition of ill-being as causally related to an accidental injury that occurred in the course of employment on December 28, 2018. The Arbitrator relies on both the conclusions of Dr. Li, the contents of the medical records that show Petitioner was in active treatment for his shoulder condition prior to December 28, 2018 and the testimony of Dr. Greatting. Dr. Greatting's initial causal relationship opinion was based upon a false premise that Petitioner was doing relatively well prior to December 28, 2018. In fact, Petitioner had visited his family physician regarding severe left shoulder pain, loss of range of motion, loss of function and need for treatment. Based upon the testimony, Petitioner's infection and chronic osteomyelitis and shoulder condition predated his alleged work injury.

With regard to earnings, the Petitioner alleged an average weekly wage of $585 and stated that he was working full time. Petitioner did not offer any other testimony concerning his earnings,

his hourly rate of pay or establish the basis for any time that he may have missed from work. Respondent offered the wage statement of the Petitioner. Petitioner's wage records confirm that he was employed earning $13 per hour. Even assuming a 40-hour work week, the Petitioner would have earned $520 per week. He did not work 40 hours most weeks but did work overtime 13 of the 52 weeks he was employed. Petitioner did not testify that his overtime was mandatory. Based upon the itemized regular earnings on the wage statement, Petitioner's average weekly wage is $417.10.

4833-1396-7030, v. 1

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sarah Wooley,

Petitioner,

vs. NO: 18 WC 15232

20 IWCC0665

State of Illinois/Menard Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 7, 2020, is hereby affirmed and adopted.

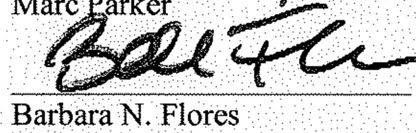
IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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.

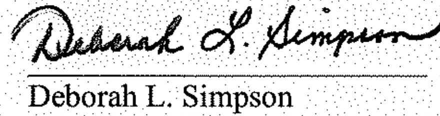
Pursuant to section 19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: NOV 1 3 2020
MP:yl
o 11/5/20
68

Marc Parker



Barbara N. Flores



Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOOLEY, SARAH Case# **18WC015232**
Employee/Petitioner

20IWCC0665

STATE OF IL/MENARD CC
Employer/Respondent

On 5/7/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY & CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

0558 ASSISTANT ATTORNEY GENERAL
AARON 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
802 S 7TH ST
SPRINGFIELD, IL 62794-9208

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

MAY -7 2020

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

SARAH WOOLEY
Employee/Petitioner

v.

STATE OF IL/ MENARD C.C.
Employer/Respondent

Case # **18** WC **15232**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **December 18, 2019**. By stipulation, the parties agree:

On the date of accident, **1/24/2018**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**66,483.76**, and the average weekly wage was $**1,278.53**.

At the time of injury, Petitioner was **41** years of age, ***married*** with **3** dependent children.

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

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

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 **$767.12**/week for a further period of **41.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **25% loss of the left foot**.

Respondent shall pay Petitioner compensation that has accrued from **August 22, 2019** through **December 18, 2019**, 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.

Carolyn M. Doherty

Signature of Arbitrator

5/6/20

Date

MAY 7 - 2020

FINDINGS OF FACT

This matter was tried before Arbitrator Nowak on December 18, 2019. By agreement of the parties, the Decision is authored by Arbitrator Doherty based on the evidence and testimony rendered at trial and contained in the record.

Petitioner has been employed at Respondent's Menard Correctional Center as a correctional officer for 19 years. The parties stipulated she sustained accidental injuries on January 24, 2018 when, while running to an emergency with inmates fighting against staff, she stepped off concrete and injured her left ankle. T. 9-10. PX 7. At trial, Petitioner testified that she had no prior problem or treatment to the left ankle. T. 10. Petitioner continued to experience symptoms of soreness in her left foot and ankle which worsened over the few days following the accident. PX 7.

Petitioner initially presented to the SIH Center for Medical Arts on January 27, 2018 and saw a physician's assistant who took the history of the injury, dispensed medication, placed Petitioner in an air cast for the left ankle and made a recommendation for an MRI. PX 3. Follow up notes included that of January 30, 2018 show that the MRI had still not been scheduled. X-rays taken at the first visit however showed no acute fractures. Petitioner was prescribed physical therapy as of January 30, 2018. PX 5. A course of physical therapy at Rehab Unlimited in Carbondale did not improve Petitioners condition. On March 6, 2018 Petitioner underwent an MRI of the left leg and left ankle. The MRI of the left leg was normal. The MRI of the left ankle showed sprain of posterior talo-fibular ligament, hyperintensity along the tibialis posterior tendon, suggestive of tendonitis, minimal synovial effusion in ankle, intertarsal, and tarsometatarsal joints, mild changes of osteoarthritis in the ankle, intertarsal, and tarsometatarsal joints, and mild subcutaneous edema around the ankle joint. PX 6.

Following the MRI, Petitioner was referred by her primary care physician to the Orthopaedic Institute of Southern Illinois where she saw the P.A. of Dr. Robert Golz. The first visit was March 30, 2018. He took a consistent history of the injury, reviewed the MRI of the left ankle, and diagnosed an ankle sprain. PX 7. He placed her in a fracture boot along with stirrup splinting at night. He advised to her to continue anti-inflammatories and ice. Dr. Golz discontinued PT and told Petitioner to follow up in 4 weeks. PX 7. When Dr. Golz saw her again on April 27, 2018, he found mildly diminished petal pulses in the left compared to the right, mild swelling in the ankle, and good range of motion, slight weakness and decreased sensation of the great toe, second tow and third tow. PX 7. Dr. Golz' assessment was now left ankle sprain with early complex regional pain syndrome. She was given a steroid dose pack, a neuropathic anti-inflammatory cream and was placed back in physical therapy for a range of motion strengthening and desensitizing modalities. He also recommended non-invasive vascular studies to rule out vascular compromise. PX 7.

Petitioner then decided to seek a second opinion with Dr. Matthew Bradley, a board certified orthopedist. On May 10, 2018, Dr. Bradley took the history of the injury and noted that there was a positive Tinel's sign over the tarsal tunnel reproducing the radiating and burning pain Petitioner was experiencing. He noted the mechanism of injury and physical examination were consistent with an acute tarsal tunnel type syndrome. PX 8. He recommended an EMG and Nerve Conduction Study for confirmation of tarsal tunnel syndrome. PX8. This study was performed on June 11, 2018 by Dr. Patricia Hurford. The study was normal. PX 9, PX 10. Dr. Bradley recommended a left tarsal tunnel release. PX 8.

Following the EMG and Nerve Conduction Study, Respondent sent Petitioner for a Section 12 exam performed by Dr. Gary Schmidt, a board certified orthopedic foot specialist. RX 2. He saw Petitioner on July 5, 2018, took the history of the injury and his exam also showed decreased sensation along the medial branch of the posterior

tibial nerve from the arch down to the plantar aspect of her hallux with some numbness circumferentially in Petitioner's great toe. He noted there was quite obvious nerve irritation of her posterior tibial nerve with a markedly positive Tinel's sign at the tarsal tunnel. Petitioner had a mildly antalgic gait and the rest of her examination was normal. He reviewed the MRI and agreed with the interpretation of the radiologist that was normal. Based on the mechanism of injury and the positive physical exam, Dr. Schmidt agreed with Dr. Bradley that Petitioner suffered from traumatic tarsal tunnel syndrome of the left lower extremity and that she would benefit from a tarsal tunnel release. RX 2.

Respondent subsequently forwarded Dr. Schmidt the normal EMG and Nerve Conduction study done by Dr. Hurford and it did not change Dr. Schmidt or Dr. Bradley's opinion that Petitioner was a surgical candidate based on the clinical exam with was "overwhelmingly indicative of tarsal tunnel syndrome". RX 3.

Surgery was done on August 21, 2018 in the form of a left tarsal tunnel release. PX 8. Petitioner testified that prior to surgery her symptoms included pain, tingling, numbness and loss of feeling. Petitioner testified that the surgery improved her symptoms and her improvement was documented by Dr. Bradley through her last visit on August 22, 2019. T. 12. PX 8. Following surgery, Petitioner performed home exercises and took prescribed medication. T. 12-13. PX 8. On her final visit with Dr. Bradley on August 22, 2019, Petitioner reported doing well with no issues at work and very occasional arch pain resolved with OTC medications. PX 8.

Petitioner initially returned to work light duty on November 1, 2018, which lasted until January 4, 2019 when she went back to work full duty. T.13. PX 8. Petitioner testified that she has worked full duty since her release. T. 13.

Despite the improvement resulting from surgery, home exercises and medication, Petitioner testified that she has lasting symptoms. At trial, Petitioner testified that after working an 8 hour shift, she has pain from the interior part of her left ankle to the rear of her left knee which she described as a sharp, burning, stabbing sensation. T.14. This sensation is also prominent when she walks up declines or inclines. She again experiences a pulling, burning, and stabbing sensation. T. 14-15. She has lost some range of motion, specifically, the ability to complete a full squat. T.14-15. Petitioner takes Ibuprofen 2-3 times a week, except for when the pain is heavier, then she takes Tramadol and Diazepam at night so she can sleep. T.15. The medication is prescribed by Dr. Bradley. T. 15. Petitioner was released at MMI by Dr. Bradley on August 22, 2019, and has no scheduled visits. PX 8, T. 15-16. Her hobby of gardening has been adversely affected because of her inability to squat, as has her ability to exercise to her previous level, which has resulted in some weight gain. T. 16. Petitioner further testified that her daily activities of living, including shopping, cleaning or standing for more than one hour, cause pain in her left foot. T. 19.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following 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).

With regard to Subsection (i) of §8.1b(b), the Arbitrator notes that no permanent impairment rating 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, Petitioner continues to serve as a correctional officer for Respondent. T.17-18. Petitioner testified that she has a pain from the interior part of her left ankle to the rear of her left knee after an 8 hour shift, describing it as a sharp, burning, stabbing sensation. Petitioner described this same sensation while walking up declines or inclines. T. 14. The Arbitrator places some weight on this factor.

With regard to Subsection (iii) of §8.1b(b), Petitioner was 41 years old at the time of her injury. Because of the fact that the Petitioner has a significant amount of her working career still ahead of her, the Arbitrator gives greater weight to this factor.

With regard to Subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there has been no diminution in same for Petitioner and therefore gives no weight to this factor.

With regard to Subsection (v) of §8.1b(b), evidence corroborated by the treating medical records, the Arbitrator notes that Petitioner's testimony is wholly corroborated by her treating medical records and the Arbitrator, therefore, gives greater weight to this factor. Petitioner notices pain from the interior part of her left ankle to the rear of her left knee after an 8 hour shift, describing it as a sharp, burning, stabbing sensation. Petitioner described this same sensation while walking up declines or inclines. T. 14. Petitioner further testified to the inability to squat which resulted in the inability to return to her prior level of gardening and exercise activities. Lastly, Petitioner testified that her daily activities of living, including shopping, cleaning or standing for more than one hour, cause pain in her left foot. T. 19. Petitioner takes Ibuprofen 2-3 times a week, except for when the pain is heavier, and then she takes Tramadol and Diazepam at night so she can sleep. T.15. The medication is prescribed by Dr. Bradley. T. 15. Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the left foot pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BOBBIE OVERTURF,

Petitioner,

vs. NO: 16 WC 18663

CONTINENTAL TIRE NORTH AMERICA,

Respondent.

20IWCC0666

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, temporary total disability benefits, 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 30, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $568.72 per week for a period of 12 and 1/7 weeks, representing September 14, 2016 through December 7, 2016, that being the period of temporary total incapacity pursuant to §8(b) of the Act. Respondent shall be given a credit for benefits previously paid in the amount of $4,391.28.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable, necessary, and causally related medical expenses pertaining to the treatment of Petitioner's neck, right shoulder, and right arm as set forth in Petitioner's Exhibit 1, as provided in §§ 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for medical benefit that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $511.85 per week for a period of 62.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 12.5% loss of use of the person as a whole.

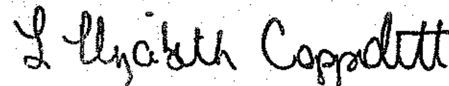
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $511.85 per week for a period of 37.95 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right arm.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000. 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: NOV 13 2020



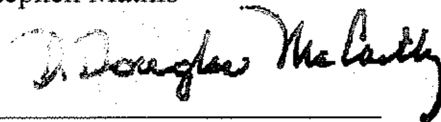
L. Elizabeth Coppoletti

LEC/cak

D: 9/15/2020

Stephen Mathis

43



D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OVERTURF, BOBBIE
Employee/Petitioner

Case# **16WC018663**

16WC018664
17WC006622
17WC030324

CONTINENTAL TIRE NORTH AMERICA
Employer/Respondent

20IWCC0666

On 9/30/2019, 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 1.86% 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:

5623 BEMENT & STUBBFIELD LLC
GARY BEMENT
510 N ILLINOIS ST
FAIRVIEW HTS, IL 62208

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bobbie Overturf
Employee/Petitioner
v.

Case # **16** WC **18663**

Consolidated cases: **16 WC 18664**
17 WC 0622
17 WC 30324

Continental Tire North America
Employer/Respondent

20IWCC0666

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **8/7/19**. 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. ☒ 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 **5/28/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,996.69**; the average weekly wage was $**853.08**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**4,391.28** for other benefits, for a total credit of $**4,391.28**.

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

ORDER

Respondent shall pay reasonable and necessary medical services related to treatment of Petitioner's neck, right shoulder and right arm, as set forth in Petitioner's exhibit 1, 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 $568.72/week for 12 weeks, commencing 9/14/16 through 12/7/16, as provided in Section 8(b) of the Act.

Respondent shall be given a credit 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, the Respondent shall pay Petitioner permanent partial disability benefits of $511.85/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act. Respondent shall further pay Petitioner permanent partial disability benefits of $511.85/week for 37.95 weeks, because the injuries sustained caused the 15% loss of the right arm, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

9/25/19
Date

SEP 30 2019

BACKGROUND

Petitioner alleges four work accidents while employed by Respondent. Three accidents allege injuries to the right shoulder and right elbow (16 WC 18663, 16 WC 18664, 17 WC 6622). Respondent disputes accident and causation. The fourth claim alleges a right knee injury (17 WC 30324). Respondent disputes causation and the reasonableness and necessity of the knee surgery.

FINDINGS OF FACT

The Petitioner is employed as a tire builder with the Respondent. In September of 2014 she worked on an EST machine. She described this machine as one that builds the whole tire. She would have to load the treads, beads, and all the stock, which includes the tire's inner liner, treads, pads, breaker, which are all on large cassettes that are on rollers. Petitioner is required to push these cassettes around her work area. She further described that multiple tires may be built on the machines, which would have different types of tread. She would pull the tread off of a tread tray, which was on a tread book, hit a button to cycle the tread and then put another part of the tire, called bead, on the tire. She would build approximately 300 tires on an eight-hour shift. The tread comes out of something called a book, which has leaves below her shoulders to overhead. She would have to pull the tread off, put it on the machine, hit a button, twist to get a bead, which is a round part that goes on the tire, pull it off, put it on the machine and allow the tire to continue to cycle. She testified that the tread, made of rubber, would be sticky, and sometimes took some force to pull off. It also would include a breaker, which are rubber wires that make the inside of the tire. She would have to push the cassette into the machine, which would weigh several hundred pounds. She would also have to use a walkie to move the tread books in and out as necessary. More particularly, she testified that she had to use her hands and arms a lot throughout the process. She sometimes had difficulty lifting the tread out of the tread book. Sometimes it was overhead. She also had to pick up beads when they were on the bead rack. She testified that they were above her head and all the way down. When she had to push the pad cassettes in, which were also heavy items, they were also above her head to below her shoulders.

On March 21, 2014, Petitioner reported to Respondent she injured her right shoulder and neck pulling ply. (Rx. 2). Petitioner testified she did not file a work comp claim for the accident. Petitioner began treating with Chiropractor Kathalynas June 30, 2014. She reported a one year history of cervical and upper thoracic pain. The chiropractor diagnosed cervicalgia and migraine headaches. Treatment went through July 21, 2014. (Rx. 4). Petitioner worked full duty throughout this course of treatment.

On September 7, 2014, she was pulling a tread out of the tread book. The tread that day was 17 pounds and when she pulled it out, she felt a pain from her neck into her shoulder. She testified that the tread on that day that she was pulling was above her head. She pointed to her pain which was an area from her neck down to her right shoulder. She immediately filled out an accident report, although she continued to work with pain that day. She testified that every time she lifted something, she had extreme pain in her shoulder. She came under the care of Dr. Jones, an orthopedic surgeon in Herrin, Illinois. She believed she had sustained a neck injury. After some diagnostic testing, the Petitioner testified that Dr. Jones felt that it was more shoulder related and referred her to Dr. Brown, also an orthopedic surgeon in Herrin at the same clinic, the Orthopaedic Institute of Southern Illinois.

Dr. Brown treated her with injections and therapy. She continued to work her regular job while undergoing treatment. She continued to develop pain in her shoulder and by May of 2015 had developed pain

and numbness in her right hand and elbow. On May 28, 2015 she reported these repetitive trauma conditions. On September 12, 2016, she received surgery from Dr. Brown which included an arthroscopic rotator cuff debridement, debridement of the superior labrum, subacromial decompression, distal clavicle excision and an open ulnar nerve transposition.

After her post-surgical recovery time, she was able to return to work as a tire builder at Continental Tire. She did return to a different machine which is a finish machine, which she described was a little easier than the EST machine. On the finish machine, she has to build a carpus machine, which builds the inside of the tire and she finishes the outside. This job did not require as much stock prep or moving the cassettes as she had to on the EST machine. She did return to work full duty on the different machine.

In January of 2017, she felt a pop in her shoulder when she had to hit a lock on the breaker in the back of her machine when she felt another pop in her shoulder. She lost no time or received no additional treatment for that incident.

The Petitioner testified that she still has continuous pain in her right shoulder. Using a weed-eater causes increased pain. She is unable to throw a ball with her son. Any time that she has to hold her arm above her head causes additional pain. She does have pain while working, although she takes Ibuprofen daily to help control it. She often times has to ice her shoulder after work. While she describes that her shoulder is better now than it was before the surgery, she continues to have pain. Before surgery she developed headaches, which have now resolved. Raising her arm hurts, although she is able to lay on her right side and can wash and style her own hair. Pulling treads overhead does still cause her to have difficulty and she has to use her other arm more to help.

Her right elbow is better, although she has some numbness at the incision site, and sometimes the numbness shoots down her arm. The pain is better. She does sometimes have numbness that radiates through the whole hand. She does not feel that she has gained full strength back in either her shoulder or her elbow.

The Petitioner was seen beginning in September 2014 at Midwest Occupational Medicine, which is located at the Respondent's facility and was treated with an ice pack and Bio freeze and returned to full duty. The following day she was seen by Dr. Myler through Midwest Occupational Medicine and complained of neck pain and upper trapezius pain. He recommended the Petitioner do a course of physical therapy through the Work-Fit, which is also located at the Respondent's facility. He placed the Petitioner on a 10-pound work restriction. Meanwhile, her primary care physician recommended a CT scan of her neck and epidural injections by October 2014.

In May 2015, the Petitioner was again seen by Nurse Brian at the plant facility complaining of right shoulder, elbow and wrist pain. She reported this was due to the repetitive movements of her normal job. She reported that her hands would go numb intermittently and feel tingly almost constantly. She had pain in her right upper extremity that had been bothering her for several months. She was seen by the PA at Midwest Occupational Medicine on June 3, 2015 with complaints of numbness and tingling into her 4th and 5th digits of the right hand.

She had been referred to Dr. Jones, at the Orthopaedic Institute of Southern Illinois. An MRI in September 2015 showed disc osteophyte complexes at the lower cervical levels resulting in mild canal stenosis with indentation at the thecal sac. There was evidence of foraminal stenosis bilaterally at C4-5, C5-6, and C6-7.

There was no evidence of lateralizing disc herniation. The most significant foraminal narrowing was moderate to severe at the C4-5 level on the left with more moderate narrowing at C4-5 on the right. Dr. Jones ultimately felt that her problems in her neck and shoulder were more related to her shoulder than her neck, so he referred the Petitioner to Dr. Treg Brown, also at the Orthopaedic Institute of Southern Illinois. Dr. Brown testified that he started seeing her in May 2016 for Petitioner's shoulder complaints. She reported that she had pain that started in 2014. She described activities of pushing and pulling heavy cassettes and had two work-related injuries over the course of time.

He further stated that on physical examination, he found that she had pain with cross arm abduction and mild AC joint point. She had some findings consistent with biceps tendonitis and impingement signs consistent with rotator cuff tendonitis. The MRI was reviewed and showed some fraying of the rotator cuff, which is consistent with impingement type process and consistent with possible partial thickness rotator cuff tear. She had inflammation of her biceps and some only mild arthritic changes of her AC joint. At that point he felt that she had some rotator cuff tendonitis and impingement syndrome. He did feel that this could be due to the repetitive over-use she described from her work at Continental Tire. Since she had already had some physical therapy and anti-inflammatories, he recommended a steroid injection which was performed on the first visit.

On follow-up the Petitioner reported that the injection helped her neck pain but not her right shoulder. She still had complaints of pain throughout the day and night. She also had some numbness and tingling in the upper extremity. At that time, she continued to have light weakness of her rotator cuff but still had a 3 out of 3 impingement signs. His working diagnosis continued to be that her primary problems were rotator cuff impingement and cervical radiculopathy due to the complaints of numbness and tingling. He recommended nerve conduction studies. The EMGs showed mild carpal tunnel syndrome bilaterally at the wrist and mild cubital tunnel syndrome as well. He recommended that she have an ulnar nerve transposition and because of her lack of improvement of her prolonged period of time, he recommended an arthroscopic subacromial decompression, distal clavicle excision, rotator cuff debridement, and possible biceps tenodesis. He thought that she should not have a carpal tunnel release at this time, as three surgeries would cause excessive edema in her hand and possibly have a reverse effect on her carpal tunnel release.

During the surgery, Dr. Brown found a very small incomplete rotator cuff tear that was debrided. Her biceps tendon was normal and did not require any type of treatment. She had a small tear of the labrum which was debrided. He proceeded with the distal clavicle excision and subacromial decompression to adjust the impingement on her rotator cuff and once that shoulder procedure was completed, he performed an ulnar nerve transposition at the elbow.

Dr. Brown further testified that based on Petitioner's history of injury at work, and that she had not had any injury outside of work and that symptoms did not develop outside of work, he felt the symptoms were more likely attributed to her repetitive work.

Post-operatively Petitioner underwent a routine physical therapy protocol with modified duty restrictions. When he saw her on November 29, 2016, she felt that her shoulder was getting better, but she was still having some headaches. She completed her physical therapy at that time. He recommended that she see Dr. Alam to determine if her headaches could be related to the previous cervical issues. He felt that she could return to full-duty work on December 8, 2016 and did not need further treatment.

During exam on December 13, 2016 she had normal rotator cuff strength and had normal motion. She did have some tenderness of the superior aspect of the shoulder, which was to be expected following a distal clavicle excision. She continued to have some paraspinal and cervical tenderness. He then saw her again in January and gave a history that she had an aggravation again at work. She testified that she struck a bar on her arm which caused severe shoulder pain. He thought that she may have a strain of the biceps tendon and right rotator cuff capsule. He gave her medrol dose pack and sent her to physical therapy and believed that her condition would resolve. He saw her on February 14, 2017 when she was still complaining of shoulder pain. She felt that she had some popping that bothered her at night. At that time, she was seen by the PA who felt that she had some slight weakness in her rotator cuff and mild impingement findings and ordered an MRI. The MRI was essentially normal, and he felt that she could resume her normal duties and if her symptoms did not fully resolve, she could return to see him, and he released her from care.

Dr. Paletta testified on behalf of the Respondent. Dr. Paletta saw the Petitioner on multiple occasions. Once for her neck and shoulder on January 6, 2016, a second time for her neck and shoulder on January 16, 2017 and for her knee. Each time Dr. Paletta has reported that Petitioner's injury was unrelated to any activities at work. In particular, he testified that on January 6, 2016 he saw her for complaints of neck and shoulder pain. She told him that she was in a standing position working with a machine and that she does this with her hands sort of at the level between her waist and her chest, and that she has to push and pull on some rubber ply. She states that on that particular day when she was pushing and pulling on the ply, she was trying to unstick it and she noticed a stabbing pain in her shoulder because she thought she had pulled the ply either too forcefully or in the wrong way. She reported it the following day due to continuing shoulder pain and neck pain. Her primary symptoms on that date were that she had complaints of pain, particularly neck pain. She stated it went down her shoulders, into her arms, and all the way down to the hands on both sides. She complained of more pain in the right than the left but had numbness in both hands and she complained of pain particularly under the right shoulder blade. She was also complaining of headaches and that those headaches depended on how much she pushed and pulled at work. It was mostly neck pain, shoulder blade pain, pain down both arms, with some intermittent numbness and tingling. She also stated that she would get some occasional swelling at the front of the neck but that was intermittent. He did not feel that pain in her arm was typical of a shoulder injury. On examination, he found that there were no objective findings, although she did have some subjective complaints with mild weakness but that seemed to be due to pain. After examination, his diagnosis was that of cervicalgia with associated degenerative changes at the neck. He saw no evidence to support a diagnosis of primary injury or abnormality at the shoulder and thought everything was coming from the neck. He felt that the neck issues were long-standing and not related to her work activities and did not see any evidence of acute injury or disc herniation that he could relate to her job duties or any job injury.

He saw her for a second exam on November 6, 2017. At that time she reported that she continued to have complaints of ongoing pain in her neck and shoulder pain, and that she had gone on for further evaluation of the shoulder that included an MRI of the right shoulder that was completed at Herrin Hospital, along with an EMG and nerve conduction studies. It was his understanding that the nerve condition studies showed some mild carpal tunnel syndrome and cubital tunnel syndrome but no evidence of nerve issues originating from the neck and that the MRI of the shoulder showed some wear of the rotator cuff but no evidence of a complete tear but did show some biceps tendonitis. She reported to him that Dr. Brown had performed surgery on her shoulder including arthroscopy with debridement and clean-up of the labrum, distal clavicle excision and a subacromial decompression. She also reported that in the midst of recovering from that surgery that she had a

re-injury of the right shoulder in January 2017. At that time, she was pushing a bar and tried to turn off a switch and couldn't get the bar to turn off and felt pain in her shoulder. She returned to Dr. Brown.

Dr. Paletta felt that neither the incidents of 2014 or 2015 contributed in any way to the right shoulder surgery performed by Dr. Brown and felt that impingement syndrome occurs in patients who do repetitive overhead activities. He felt that the Petitioner did not describe that. She described that she was using her arms below shoulder level she described it as waist and chest and was pushing and pulling, which would not be a mechanism causing impingement syndrome. Furthermore, she didn't describe doing any repetitive reaching crossbody which could contribute the AC joint or acromioclavicular joint pathology and on additional examination she had no evidence of either impingement findings or AC joint pain.

When asked about the ulnar nerve and cubital tunnel syndrome issue, Dr. Paletta testified that the job activities as described could have contributed to the development of cubital tunnel syndrome.

Dr. Paletta did not dispute the diagnosis that Dr. Brown made, nor did he dispute the reasonableness and necessity of treatments. He was unaware, however, if she did have to do any overhead work and did agree that in his own review of the job activities, that as part of the job it did require the large books and cassettes to be pushed in and out and that often times those would be at shoulder height or above. He was unaware that she had even made a claim of repetitive trauma.

CONCLUSIONS

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

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

The Petitioner testified regarding a job that appears highly upper extremity intensive. Her job involves building tires on a machine. She is required to move large "cassettes" and "books" in and out of the machine throughout the day. She described having to pull rubber treads off of a "book". The book has shelves that go from the floor to above her hand. The rubber gets tacky and requires some force to pull the treads which weigh between 11 and 17 pounds each. She then twists to put the tread onto the machine at which time she kicks a pedal to cycle it. She then reaches for a "bead" which is a large ring. The beads are stored on racks that start above her knee and end above her shoulder. Taking the bead from the rack she twists to put it on the machine and again kicks the pedal to cycle the drum. She repeats this tire building process over 300 times per shift.

Petitioner first started having problems when on September 7, 2014 she was pulling a tread from above shoulder height. She had to jerk on it and felt a sharp pain in her neck into her shoulder. She received treatment from various providers including Dr. Jones. She was seen by Dr. Paletta pursuant to Section 12. It was felt that she had sustained a neck and shoulder strain, with the neck aggravating some pre-existing degenerative changes. She continued to work. Petitioner had no further significant treatment for her neck or shoulder until May 28, 2015.

On May 28, 2015 she reported that she was having increasing pain in her right shoulder, now into her elbow and hands. She reported that the repetitive nature of the work was making these problems of pain and numbness worse. She went back to the Orthopaedic Institute of Southern Illinois where she was referred to Dr. Young and Dr. Brown. Nerve studies confirmed that Petitioner had carpal tunnel and cubital tunnel. MRI

showed fraying of the rotator cuff which was consistent with impingement syndrome and some inflammation of the biceps with changes at the AC joint. Dr. Brown felt that all three conditions were caused by the repetitive nature of her work.

He operated, finding a small tear of the rotator cuff, a small labral tear, both of which were repaired and did a distal clavicle excision and subacromial decompression. He also performed an ulnar nerve transposition at the elbow.

Dr. Brown opined that Petitioner's shoulder condition and cubital tunnel which required surgery were causally related to her upper extremity intensive job duties.

The Petitioner did as expected post-operatively. She returned to work full duty, albeit on a different, easier machine where she had to load less stock. She did have an aggravation in January 2017 when she had an increase of pain when hitting a bar, but she returned to the baseline and was released from care. Dr. Brown felt the most recent injury was a temporary aggravation with no new pathology.

Dr. Paletta felt that the Petitioner's shoulder issues were not caused by her employment because it did not include overhead or reaching across her body. This opinion is contrary to the facts, however, as Petitioner testified that her job does include pulling above her shoulder and pulling tread across her body. Dr. Paletta did, however, concede that the Petitioner's repetitive job could have caused her cubital tunnel syndrome.

The Arbitrator finds the testimony and opinions of Dr. Brown more persuasive than those of Dr. Paletta. The Arbitrator further finds that the Petitioner's job is repetitive and does require work above her shoulder and that as a result of that work has sustained an injury to her right shoulder and elbow.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner did sustain an accident which arose out of and in the course of her employment with respondent on May 28, 2015 and that Petitioner developed right sided cubital tunnel syndrome and shoulder injuries, both of which required surgical intervention, as a result of this 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?**

Dr. Paletta agreed that the treatment provided for Petitioner's conditions was reasonable and necessary, although he concluded the conditions were not related to her employment. Having found in favor of Petitioner with regard to issues C & F above, the Arbitrator finds respondent is liable for the cost of medical expenses related to the treatment of Petitioner's right shoulder and right elbow.

Respondent shall pay reasonable and necessary medical services related to treatment of Petitioner's neck, right shoulder and right arm, as set forth in Petitioner's exhibit 1, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Based upon the above findings, and the record taken as a whole, the Arbitrator finds Petitioner is entitled to the claimed TTD benefits.

Respondent shall pay Petitioner temporary total disability benefits of $568.72/week for 12 weeks, commencing 9/14/16 through 12/7/16, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid.

<u>Issue (L)</u>: 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. Paletta provided a rating pursuant to the AMA guidelines as it relates to the shoulder at 8% of an arm at the shoulder. The Arbitrator gives *some* weight to this factor. No impairment rating was given regarding the right elbow.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a tire builder using her upper extremities, but on a different machine. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of her injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. Furthermore, Petitioner has hand and arm intensive employment as a tire builder. 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. Petitioner testified that she is improved after the surgery, but still has pain in her shoulder. Overhead work increases her pain. At work she uses her other arm more. She takes Ibuprofen daily for pain. She has pain while weed eating at home and cannot throw a ball without pain.

She has numbness in her elbow at the scar site. She has some periodic pain in her elbow. She sometimes still gets numbness in her ring and little finger. She has periodic pain in her arm. 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 right arm pursuant to §8(e) of the Act relative to her cubital tunnel and 12.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act relative to her shoulder injuries.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BOBBIE OVERTURF,

Petitioner,

vs. NO: 16 WC 18664

CONTINENTAL TIRE NORTH AMERICA,

Respondent.

20 I W CC0667

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 and permanent disability, and being advised of the facts and law, reverses the Arbitrator's finding that Petitioner's neck condition is causally related to the accident of September 7, 2014. Accordingly, the Commission vacates the Arbitrator's award of permanent disability benefits.

Supplemental Findings of Facts

Treatment records evidence Petitioner's long-standing history of neck pain; specifically, the records of Dr. Brian Harrison and Benton Community Healthcare evidence Petitioner's repeated complaints of neck pain prior to her accident of September 7, 2014- January 29, 2013, February 19, 2013, June 10, 2013, and June 30, 2014 with a diagnosis of torticollis. PX3. On June 27, 2013, Petitioner underwent an MRI of her cervical spine which showed multilevel cervical foraminal stenosis. PX5.

On September 7, 2014, Petitioner alleges sustaining an injury to her cervical spine. Petitioner's job duties required her to separate treads in large stacks from their backings in the process of fabricating tires. T. 20. The tire treads each weighed approximately 17 pounds, and the tread stacks stood above Petitioner's head. T. 23. Petitioner pulled a tread and felt pain from her neck into her shoulder. *Id.* The report of injury memorializes a consistent history of accident-

"Pain in neck and shoulders after pulling a tread out of the tread book. Right shoulder and right elbow." PX1.

Causal Relationship/Permanent Disability

On September 7, 2014, Petitioner presented to Midwest Occupational Medicine; the records reflect she complained of neck pain but was unclear if pain was work-related. Petitioner was unable to lift her arms above her head but exhibited good range of motion in her neck. Petitioner was provided an ice pack and temporary work restrictions of no lifting greater than 10 pounds. RX2.

Petitioner testified she then sought care from Dr. Jeffrey Jones, an orthopedic surgeon, believing she suffered from a cervical injury. T. 25. After examination, Dr. Jones advised Petitioner her pain was related to a shoulder problem and not her neck. *Id.* Dr. Jones referred Petitioner to Dr. Treg Brown who treated Petitioner's shoulder condition with injections and therapy while Petitioner continued to work full duty. T. 25-26.

Petitioner's pain continued to increase in her shoulder, and she developed numbness in her right hand and elbow in the following months. On May 28, 2015, Petitioner reported repetitive trauma symptoms which are the basis for a separate claim previously consolidated with the present matter. (See case 16 WC 18663).

On January 22, 2017, Petitioner reported an additional injury to her shoulder wherein she heard a pop while lifting a piece of machinery which is the basis for a separate claim previously consolidated with the present matter. (See case 17 WC 6622).

At hearing, Petitioner testified that she still experiences pain in her right shoulder and certain activities which require use of her arm above her shoulder increases her pain. T. 33. Petitioner ices her shoulder occasionally after work and takes Ibuprofen to control her pain. T. 34. Petitioner provided no testimony as to her neck condition.

Petitioner established that a work-related accident occurred on September 7, 2014, but the Commission finds Petitioner failed to prove that the current condition of ill-being regarding her neck is causally related. Petitioner had an extensive history of neck complaints before the accident. Following the accident Petitioner's treating physicians felt her complaints were not related to her neck and treated her shoulder instead. There is nothing in the record to support a conclusion Petitioner suffered any serious or permanent injury to her neck as a result of the work accident on September 7, 2014.

As indicated above, following her September 7, 2014 accident, Petitioner suffered two subsequent work-related injuries to her right shoulder. Those claims were consolidated with the present matter. The Commission finds Petitioner's ongoing shoulder and arm complaints are the result of the repetitive trauma injury manifesting on May 28, 2015 and the surgical interventions to Petitioner's shoulder and arm which followed. (See case 16 WC 18663) Accordingly, the Commission vacates the Arbitrator's award of permanent disability benefits in the present matter.

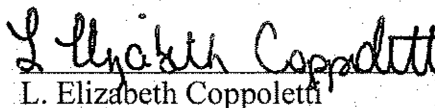
IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 30, 2019 is hereby reversed and modified for the reasons described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's cervical spine condition and shoulder condition is not causally related to the September 7, 2014 accident, and that the award of 5% loss use of the person as a whole is hereby vacated.

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

The bond requirement in Section 19(f)(2) 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: NOV 13 2020


L. Elizabeth Coppoletti

LEC/cak

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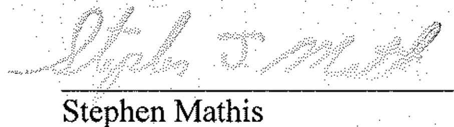
Stephen Mathis

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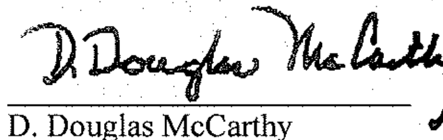

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OVERTURF, BOBBIE
Employee/Petitioner

Case# **16WC018664**

16WC018663
17WC000622
17WC030324

CONTINENTAL TIRE NORTH AMERICA
Employer/Respondent

20IWCC0667

On 9/30/2019, 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 1.86% 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:

5623 BEMENT & STUBBFIELD LLC
GARY BEMENT
5140 N ILLINOIS ST
FAIRVIEW HTS, IL 62208

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bobbie Overturf
Employee/Petitioner
v.

Continental Tire North America
Employer/Respondent

Case # **16** WC **18664**

Consolidated cases: 16 WC 18663
17 WC 0622
17 WC 30324

20 IWCC0667

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon** , on **8/7/19**. 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **9/7/14**, 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 $**39,996.69**; the average weekly wage was $**853.08**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**4,391.28** for other benefits, for a total credit of $**4,391.28**.

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

ORDER

TTD and medical benefits awarded in case number 16 WC 18663.

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, the Respondent shall pay Petitioner permanent partial disability benefits of $511.85/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

9/25/19
Date

SEP 30 2019

ICArbDec p. 2

BACKGROUND

Petitioner alleges four work accidents while employed by Respondent. Three accidents allege injuries to the right shoulder and right elbow (16 WC 18663, 16 WC 18664, 17 WC 6622). Respondent disputes accident and causation. The fourth claim alleges a right knee injury (17 WC 30324). Respondent disputes causation and the reasonableness and necessity of the knee surgery.

FINDINGS OF FACT

The Petitioner is employed as a tire builder with the Respondent. In September of 2014 she worked on an EST machine. She described this machine as one that builds the whole tire. She would have to load the treads, beads, and all the stock, which includes the tire's inner liner, treads, pads, breaker, which are all on large cassettes that are on rollers. Petitioner is required to push these cassettes around her work area. She further described that multiple tires may be built on the machines, which would have different types of tread. She would pull the tread off of a tread tray, which was on a tread book, hit a button to cycle the tread and then put another part of the tire, called bead, on the tire. She would build approximately 300 tires on an eight-hour shift. The tread comes out of something called a book, which has leaves below her shoulders to overhead. She would have to pull the tread off, put it on the machine, hit a button, twist to get a bead, which is a round part that goes on the tire, pull it off, put it on the machine and allow the tire to continue to cycle. She testified that the tread, made of rubber, would be sticky, and sometimes took some force to pull off. It also would include a breaker, which are rubber wires that make the inside of the tire. She would have to push the cassette into the machine, which would weigh several hundred pounds. She would also have to use a walkie to move the tread books in and out as necessary. More particularly, she testified that she had to use her hands and arms a lot throughout the process. She sometimes had difficulty lifting the tread out of the tread book. Sometimes it was overhead. She also had to pick up beads when they were on the bead rack. She testified that they were above her head and all the way down. When she had to push the pad cassettes in, which were also heavy items, they were also above her head to below her shoulders.

On March 21, 2014, Petitioner reported to Respondent she injured her right shoulder and neck pulling ply. (Rx. 2). Petitioner testified she did not file a work comp claim for the accident. Petitioner began treating with Chiropractor Kathalynas June 30, 2014. She reported a one year history of cervical and upper thoracic pain. The chiropractor diagnosed cervicalgia and migraine headaches. Treatment went through July 21, 2014. (Rx. 4). Petitioner worked full duty throughout this course of treatment.

On September 7, 2014, she was pulling a tread out of the tread book. The tread that day was 17 pounds and when she pulled it out, she felt a pain from her neck into her shoulder. She testified that the tread on that day that she was pulling was above her head. She pointed to her pain which was an area from her neck down to her right shoulder. She immediately filled out an accident report, although she continued to work with pain that day. She testified that every time she lifted something, she had extreme pain in her shoulder. She came under the care of Dr. Jones, an orthopedic surgeon in Herrin, Illinois. She believed she had sustained a neck injury. After some diagnostic testing, the Petitioner testified that Dr. Jones felt that it was more shoulder related and referred her to Dr. Brown, also an orthopedic surgeon in Herrin at the same clinic, the Orthopaedic Institute of Southern Illinois.

Dr. Brown treated her with injections and therapy. She continued to work her regular job while undergoing treatment. She continued to develop pain in her shoulder and by May of 2015 had developed pain

and numbness in her right hand and elbow. On May 28, 2015 she reported these repetitive trauma conditions. On September 12, 2016, she received surgery from Dr. Brown which included an arthroscopic rotator cuff debridement, debridement of the superior labrum, subacromial decompression, distal clavicle excision and an open ulnar nerve transposition.

After her post-surgical recovery time, she was able to return to work as a tire builder at Continental Tire. She did return to a different machine which is a finish machine, which she described was a little easier than the EST machine. On the finish machine, she has to build a carpus machine, which builds the inside of the tire and she finishes the outside. This job did not require as much stock prep or moving the cassettes as she had to on the EST machine. She did return to work full duty on the different machine.

In January of 2017, she felt a pop in her shoulder when she had to hit a lock on the breaker in the back of her machine when she felt another pop in her shoulder. She lost no time or received no additional treatment for that incident.

The Petitioner testified that she still has continuous pain in her right shoulder. Using a weed-eater causes increased pain. She is unable to throw a ball with her son. Any time that she has to hold her arm above her head causes additional pain. She does have pain while working, although she takes Ibuprofen daily to help control it. She often times has to ice her shoulder after work. While she describes that her shoulder is better now than it was before the surgery, she continues to have pain. Before surgery she developed headaches, which have now resolved. Raising her arm hurts, although she is able to lay on her right side and can wash and style her own hair. Pulling treads overhead does still cause her to have difficulty and she has to use her other arm more to help.

Her right elbow is better, although she has some numbness at the incision site, and sometimes the numbness shoots down her arm. The pain is better. She does sometimes have numbness that radiates through the whole hand. She does not feel that she has gained full strength back in either her shoulder or her elbow.

The Petitioner was seen beginning in September 2014 at Midwest Occupational Medicine, which is located at the Respondent's facility and was treated with an ice pack and Bio freeze and returned to full duty. The following day she was seen by Dr. Myler through Midwest Occupational Medicine and complained of neck pain and upper trapezius pain. He recommended the Petitioner do a course of physical therapy through the Work-Fit, which is also located at the Respondent's facility. He placed the Petitioner on a 10-pound work restriction. Meanwhile, her primary care physician recommended a CT scan of her neck and epidural injections by October 2014.

In May 2015, the Petitioner was again seen by Nurse Brian at the plant facility complaining of right shoulder, elbow and wrist pain. She reported this was due to the repetitive movements of her normal job. She reported that her hands would go numb intermittently and feel tingly almost constantly. She had pain in her right upper extremity that had been bothering her for several months. She was seen by the PA at Midwest Occupational Medicine on June 3, 2015 with complaints of numbness and tingling into her 4th and 5th digits of the right hand.

She had been referred to Dr. Jones, at the Orthopaedic Institute of Southern Illinois. An MRI in September 2015 showed disc osteophyte complexes at the lower cervical levels resulting in mild canal stenosis with indentation at the thecal sac. There was evidence of foraminal stenosis bilaterally at C4-5, C5-6, and C6-7.

There was no evidence of lateralizing disc herniation. The most significant foraminal narrowing was moderate to severe at the C4-5 level on the left with more moderate narrowing at C4-5 on the right. Dr. Jones ultimately felt that her problems in her neck and shoulder were more related to her shoulder than her neck, so he referred the Petitioner to Dr. Treg Brown, also at the Orthopaedic Institute of Southern Illinois. Dr. Brown testified that he started seeing her in May 2016 for Petitioner's shoulder complaints. She reported that she had pain that started in 2014. She described activities of pushing and pulling heavy cassettes and had two work-related injuries over the course of time.

He further stated that on physical examination, he found that she had pain with cross arm abduction and mild AC joint point. She had some findings consistent with biceps tendonitis and impingement signs consistent with rotator cuff tendonitis. The MRI was reviewed and showed some fraying of the rotator cuff, which is consistent with impingement type process and consistent with possible partial thickness rotator cuff tear. She had inflammation of her biceps and some only mild arthritic changes of her AC joint. At that point he felt that she had some rotator cuff tendonitis and impingement syndrome. He did feel that this could be due to the repetitive over-use she described from her work at Continental Tire. Since she had already had some physical therapy and anti-inflammatories, he recommended a steroid injection which was performed on the first visit.

On follow-up the Petitioner reported that the injection helped her neck pain but not her right shoulder. She still had complaints of pain throughout the day and night. She also had some numbness and tingling in the upper extremity. At that time, she continued to have light weakness of her rotator cuff but still had a 3 out of 3 impingement signs. His working diagnosis continued to be that her primary problems were rotator cuff impingement and cervical radiculopathy due to the complaints of numbness and tingling. He recommended nerve conduction studies. The EMGs showed mild carpal tunnel syndrome bilaterally at the wrist and mild cubital tunnel syndrome as well. He recommended that she have an ulnar nerve transposition and because of her lack of improvement of her prolonged period of time, he recommended an arthroscopic subacromial decompression, distal clavicle excision, rotator cuff debridement, and possible biceps tenodesis. He thought that she should not have a carpal tunnel release at this time, as three surgeries would cause excessive edema in her hand and possibly have a reverse effect on her carpal tunnel release.

During the surgery, Dr. Brown found a very small incomplete rotator cuff tear that was debrided. Her biceps tendon was normal and did not require any type of treatment. She had a small tear of the labrum which was debrided. He proceeded with the distal clavicle excision and subacromial decompression to adjust the impingement on her rotator cuff and once that shoulder procedure was completed, he performed an ulnar nerve transposition at the elbow.

Dr. Brown further testified that based on Petitioner's history of injury at work, and that she had not had any injury outside of work and that symptoms did not develop outside of work, he felt the symptoms were more likely attributed to her repetitive work.

Post-operatively Petitioner underwent a routine physical therapy protocol with modified duty restrictions. When he saw her on November 29, 2016, she felt that her shoulder was getting better, but she was still having some headaches. She completed her physical therapy at that time. He recommended that she see Dr. Alam to determine if her headaches could be related to the previous cervical issues. He felt that she could return to full-duty work on December 8, 2016 and did not need further treatment.

During exam on December 13, 2016 she had normal rotator cuff strength and had normal motion. She did have some tenderness of the superior aspect of the shoulder, which was to be expected following a distal clavicle excision. She continued to have some paraspinal and cervical tenderness. He then saw her again in January and gave a history that she had an aggravation again at work. She testified that she struck a bar on her arm which caused severe shoulder pain. He thought that she may have a strain of the biceps tendon and right rotator cuff capsule. He gave her medrol dose pack and sent her to physical therapy and believed that her condition would resolve. He saw her on February 14, 2017 when she was still complaining of shoulder pain. She felt that she had some popping that bothered her at night. At that time, she was seen by the PA who felt that she had some slight weakness in her rotator cuff and mild impingement findings and ordered an MRI. The MRI was essentially normal, and he felt that she could resume her normal duties and if her symptoms did not fully resolve, she could return to see him, and he released her from care.

Dr. Paletta testified on behalf of the Respondent. Dr. Paletta saw the Petitioner on multiple occasions. Once for her neck and shoulder on January 6, 2016, a second time for her neck and shoulder on January 16, 2017 and for her knee. Each time Dr. Paletta has reported that Petitioner's injury was unrelated to any activities at work. In particular, he testified that on January 6, 2016 he saw her for complaints of neck and shoulder pain. She told him that she was in a standing position working with a machine and that she does this with her hands sort of at the level between her waist and her chest, and that she has to push and pull on some rubber ply. She states that on that particular day when she was pushing and pulling on the ply, she was trying to unstick it and she noticed a stabbing pain in her shoulder because she thought she had pulled the ply either too forcefully or in the wrong way. She reported it the following day due to continuing shoulder pain and neck pain. Her primary symptoms on that date were that she had complaints of pain, particularly neck pain. She stated it went down her shoulders, into her arms, and all the way down to the hands on both sides. She complained of more pain in the right than the left but had numbness in both hands and she complained of pain particularly under the right shoulder blade. She was also complaining of headaches and that those headaches depended on how much she pushed and pulled at work. It was mostly neck pain, shoulder blade pain, pain down both arms, with some intermittent numbness and tingling. She also stated that she would get some occasional swelling at the front of the neck but that was intermittent. He did not feel that pain in her arm was typical of a shoulder injury. On examination, he found that there were no objective findings, although she did have some subjective complaints with mild weakness but that seemed to be due to pain. After examination, his diagnosis was that of cervicalgia with associated degenerative changes at the neck. He saw no evidence to support a diagnosis of primary injury or abnormality at the shoulder and thought everything was coming from the neck. He felt that the neck issues were long-standing and not related to her work activities and did not see any evidence of acute injury or disc herniation that he could relate to her job duties or any job injury.

He saw her for a second exam on November 6, 2017. At that time she reported that she continued to have complaints of ongoing pain in her neck and shoulder pain, and that she had gone on for further evaluation of the shoulder that included an MRI of the right shoulder that was completed at Herrin Hospital, along with an EMG and nerve conduction studies. It was his understanding that the nerve condition studies showed some mild carpal tunnel syndrome and cubital tunnel syndrome but no evidence of nerve issues originating from the neck and that the MRI of the shoulder showed some wear of the rotator cuff but no evidence of a complete tear but did show some biceps tendonitis. She reported to him that Dr. Brown had performed surgery on her shoulder including arthroscopy with debridement and clean-up of the labrum, distal clavicle excision and a subacromial decompression. She also reported that in the midst of recovering from that surgery that she had a

re-injury of the right shoulder in January 2017. At that time, she was pushing a bar and tried to turn off a switch and couldn't get the bar to turn off and felt pain in her shoulder. She returned to Dr. Brown.

Dr. Paletta felt that neither the incidents of 2014 or 2015 contributed in any way to the right shoulder surgery performed by Dr. Brown and felt that impingement syndrome occurs in patients who do repetitive overhead activities. He felt that the Petitioner did not describe that. She described that she was using her arms below shoulder level she described it as waist and chest and was pushing and pulling, which would not be a mechanism causing impingement syndrome. Furthermore, she didn't describe doing any repetitive reaching crossbody which could contribute the AC joint or acromioclavicular joint pathology and on additional examination she had no evidence of either impingement findings or AC joint pain.

When asked about the ulnar nerve and cubital tunnel syndrome issue, Dr. Paletta testified that the job activities as described could have contributed to the development of cubital tunnel syndrome.

Dr. Paletta did not dispute the diagnosis that Dr. Brown made, nor did he dispute the reasonableness and necessity of treatments. He was unaware, however, if she did have to do any overhead work and did agree that in his own review of the job activities, that as part of the job it did require the large books and cassettes to be pushed in and out and that often times those would be at shoulder height or above. He was unaware that she had even made a claim of repetitive trauma.

CONCLUSIONS

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

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

The Petitioner testified regarding a job that appears highly upper extremity intensive. Her job involves building tires on a machine. She is required to move large "cassettes" and "books" in and out of the machine throughout the day. She described having to pull rubber treads off of a "book". The book has shelves that go from the floor to above her hand. The rubber gets tacky and requires some force to pull the treads which weigh between 11 and 17 pounds each. She then twists to put the tread onto the machine at which time she kicks a pedal to cycle it. She then reaches for a "bead" which is a large ring. The beads are stored on racks that start above her knee and end above her shoulder. Taking the bead from the rack she twists to put it on the machine and again kicks the pedal to cycle the drum. She repeats this tire building process over 300 times per shift.

Petitioner first started having problems when on September 7, 2014 she was pulling a tread from above shoulder height. She had to jerk on it and felt a sharp pain in her neck into her shoulder. She received treatment from various providers including Dr. Jones. She was seen by Dr. Paletta pursuant to Section 12. It was felt that she had sustained a neck and shoulder strain, with the neck aggravating some pre-existing degenerative changes. She continued to work. Petitioner had no further significant treatment for her neck or shoulder until May 28, 2015 when she reported that she was having increasing pain in her right shoulder, now into her elbow and hands due to the repetitive nature of the work.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner did sustain an accident which arose out of and in the course of her employment with respondent on September 7, 2014 and that Petitioner sustained a cervical strain as well as a strain of her right shoulder as a result of this accident.

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

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

TTD and medical benefits are awarded in case number 16 WC 18663 and will not be duplicated herein.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a tire builder using her upper extremities. Petitioner continued to work full duty followind this accident. She did suffer a subsequent injury to her right shoulder on 5/28/15 (16 WC 18663). The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years of age at the time of the injury. She suffered a subsequent injury to her right shoulder. 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. Petitioner was treated for neck pain and shoulder pain with medication and physical therapy. She continues to have periodic headaches and neck and shoulder pain. She takes over the counter pain medication daily. 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 the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF JEFFERSON	)	☐ 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

BOBBIE OVERTURF,

Petitioner,

vs. NO: 17 WC 30324

CONTINENTAL TIRE NORTH AMERICA,

Respondent.

20IWCC0668

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, 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 30, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $576.01 per week for a period of 6 weeks, representing March 26, 2018 through May 6, 2018, that being the period of temporary total incapacity pursuant to §8(b) of the Act. Respondent shall be given a credit for benefits previously paid in the amount of $2,773.44.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable, necessary, and causally related medical expenses pertaining to the treatment of Petitioner's right knee as set forth in the Petitioner's Exhibit 1, as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $518.41 per week for a period of 32.25 weeks, as provided in §8(e) 12 of the Act, for the reason that the injuries sustained caused the 15% loss of use of the right leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 13 2020

LEC/cak

D: 9/15/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OVERTURF, BOBBIE
Employee/Petitioner

Case# **17WC030324**

16WC018663
16WC018664
17WC006622

CONTINENTAL TIRE NORTH AMERICA
Employer/Respondent

20IWCC0668

On 9/30/2019, 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 1.86% 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:

5623 BEMENT & STUBBFIELD LLC
GARY BEMENT
5140 N ILLINOIS ST
FAIRVIEW HTS, IL 62208

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Bobbie Overturf
Employee/Petitioner

Case # **17** WC **30324**

v.

Consolidated cases: **16 WC 18663**
16 WC 18664
17 WC 6622

Continental Tire North America
Employer/Respondent

20 I W CC0668

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon** , on **8/7/19**. 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. ☒ 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 **5/13/17**, 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*** 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 $**44,929.04**; the average weekly wage was $**864.02**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,773.44** for other benefits, for a total credit of $**2,773.44**.

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

ORDER

Respondent shall pay reasonable and necessary medical services pertaining to treatment of Petitioner's right knee as set forth in Petitioner's exhibit 1, 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.

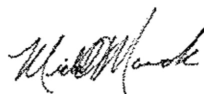
Respondent shall pay Petitioner temporary total disability benefits of $576.01/week for 6 weeks, commencing 3/26/18 through 5/6/18, as provided in Section 8(b) of the Act.

Respondent shall be given a credit 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, the Respondent shall pay Petitioner permanent partial disability benefits of $518.41/week for 32.25 weeks, because the injuries sustained caused the 15% loss of the right leg, as provided in Section 8(e) of the Act.

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

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



Signature of Arbitrator

9/25/19
Date

SEP 30 2019

BACKGROUND

Petitioner alleges four work accidents while employed by Respondent. Three accidents allege injuries to the right shoulder and right elbow (16 WC 18663, 16 WC 18664, 17 WC 6622). Respondent disputes accident and causation. The fourth claim alleges a right knee injury (17 WC 30324). Respondent disputes causation and the reasonableness and necessity of the knee surgery.

FINDINGS OF FACT

The Petitioner is a tire builder for the Respondent. She works on a tire building machine that involves the moving of stock, rubber, inner liner, and other components of a tire. She is required to move around her station to complete various parts of the tire building process.

On May 13, 2017 she was putting a breaker cassette into the tire machine. The breaker cassette is a long cassette about waist high on wheels. She is required to roll the cassette into the machine until locked in. She describes that the floor went slightly downhill and she couldn't get it to roll when she pushed it in, her right knee twisted in and she heard a pop.

The Petitioner filled out a report with the Respondent and ultimately came under the care of Dr. Richard Morgan, an orthopedic surgeon in Herrin. Dr. Morgan treated her, first conservatively, but later with surgery. She returned to her regular job after her release from care.

The Petitioner testified that she continues to have pain in her right knee. She develops swelling after a work shift, especially if she twists improperly. Her job requires her to kick a pedal about 1,000 times per shift, which causes discomfort. She has some difficulty with stairs, having to take one step at a time. She cannot squat or run. She takes Ibuprofen daily for pain.

Dr. Morgan testified that he took a history that the Petitioner complained that about three months prior to his examination (on 8/17), she was at work on a machine that has a kick step, and there was some type of a cassette she was moving. She does it many times a day, but on this particular episode, she was pushing the cassette and wrenched and twisted her right knee. She had immediate pain.

On physical examination she had full range of motion but pain with patellofemoral ballottement. MRI from June showed chondral edema to the medial facet of the patellofemoral joint with some subtle subacromial edema.

Dr. Morgan felt that she had some chondral damage to the patella, either from a subluxation of the patella or a direct strike to it. It appeared to be a shearing type of injury where she subluxed her patella in the course of twisting.

He recommended a Depo-Medrol injection and some physical therapy. He then treated with viscoelastic therapy through January 2017. On March 28, 2018 he performed arthroscopic surgery on her right knee, including an endoscopic lateral release and debridement of the medial femoral condyle. The post-operative diagnosis was lateral tracking syndrome with the early degenerative arthritis. In May 2018 he recommended home exercises and a knee brace at work.

When asked about causation, Dr. Morgan testified that this injury could have been from the repetitive nature of her job, but he thought it more likely an acute one-off type of injury where she was pushing this cassette forward and wrenched her knee.

Dr. Paletta examined the Respondent at the request of the Respondent. He reviewed medical records, films, and the deposition of Dr. Morgan. He felt that the Petitioner had some pre-existing patellofemoral issues but that the accident could have aggravated that condition. He agreed with the prescribed physical therapy and viscosupplement treatments. He did not believe that surgery was indicated. He opined that the work accident was not the causative factor in Petitioner's knee pain.

CONCLUSIONS

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

The Petitioner described a specific injury whereby she twisted her knee and felt a popping sensation while pushing a large cassette on May 13, 2017. She reported her injury timely and began conservative treatment. She came under the care of Dr. Richard Morgan.

Dr. Morgan prescribed conservative treatment including viscosupplement therapy. His testimony that the description of the acute injury was a reasonable cause of her knee pain. He diagnosed chondral damage to the patella, either from subluxation the patella or a direct strike to it. It appeared to be a shearing type of injury where she subluxed her patella in the course of twisting.

Dr. Morgan's diagnosis is not substantially disputed by Dr. Paletta, nor is the conservative treatment. Dr. Morgan's recommendation for surgery in light of limited improvement is reasonable. Dr. Paletta offered no reasonable treatment alternative. The Arbitrator finds Dr. Morgan's testimony more persuasive than that of Dr. Paletta.

Based upon the foregoing, and the record taken as a whole the Arbitrator finds Petitioner met her burden of establishing that her current condition of ill-being in the right knee is causally related to the accident of May 13, 2017.

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

Based on the above, Petitioner has proved that the treatment provided by Dr. Morgan for her right knee was not only causally related but reasonable and necessary. Bills included in Respondent's Exhibit 1 relative to treatment of the right knee are ordered paid pursuant to the Fee Schedule. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

It is undisputed that Respondent was totally disabled after surgery from March 26, 2018 through May 6, 2018 (5 6/7 weeks). TTD is ordered paid at rate of $576.01 for 6 weeks.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a tire builder. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years of age at the time of the injury. She continues to have pain and wear a knee brace. 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. Petitioner has pain in her right knee. She develops swelling after a long shift at work. She takes non-prescription pain medication. She cannot squat and has difficulty with stairs. She feels a popping in her knee if she runs. 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 right leg pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Starling Mullins,
Petitioner,

20 I W C C 0 6 6 9

vs.

NO: 15 WC 39166

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 5, 2020, is hereby affirmed and adopted.

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

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

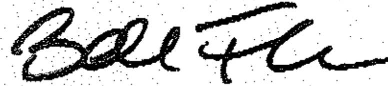
IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

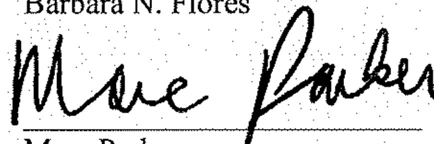
20 I W C C 0 6 6 9

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 19 2020
o10/22/20
DLS/rm
046

Deborah L. Simpson


Barbara N. Flores


Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

20 IWCC0669

MULLINS, STARLING Case# **15WC039166**
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

On 5/5/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5626 URSULA BABICZ & ASSOC
1 S 660 MIDWEST RD
SUITE 200
OAK BROOK TERR, IL 60646

0010 CITY OF CHICAGO DEPT OF LAW
MATTHEW A LOCKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

20IWCC0669

STATE OF ILLINOIS)
)SS.
COUNTY OF **Cook**)

- [ ] 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
CORRECTED

Starling Mullins,
Employee/Petitioner

Case # **15** WC **039166**

v.

Consolidated cases: **NA**

City of Chicago,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah J. Baker**, Arbitrator of the Commission, in the city of **Chicago**, on **February 19, 2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 20, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**72,189.73**; the average weekly wage was $**1,388.26**.

On the date of accident, Petitioner was **63** 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 $**106,041.59** for TTD, $**0** for TPD, $**103,738.05** for maintenance, and $**0** for other benefits, for a total credit of $**209,779.64**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act and as set forth in the Arbitrator's Conclusions of Law.

Respondent shall pay Petitioner permanent and total disability benefits of $**925.51**/week for life, commencing **October 17, 2017**, 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

April 30, 2020
Date

MAY 5 - 2020

CORRECTED
FINDINGS OF FACT

Testimony

Starling Mullins ("Petitioner") is a sixty-eight-year-old truck driver for the City of Chicago Department of Streets & Sanitation ("Respondent") with a high school education. The parties stipulated that Petitioner sustained a work-related accident on November 20, 2015. (Arb's Ex. 1.) At the arbitration hearing, Petitioner testified that on the date of the undisputed accident, Petitioner was driving a truck for Respondent when his truck hit a pothole and he experienced pain. Petitioner testified that he went home that night but eventually, he had to call an ambulance because of the pain. Petitioner testified that he has not worked since the accident.

Petitioner testified that he underwent various treatment for his neck and back, including surgeries. Petitioner testified that on February 10, 2016, he fractured his left ankle when he was attending a physical therapy appointment. Petitioner testified that surgery was recommended for his left ankle, however, he chose to forgo surgery because he is a diabetic and did not want to risk the complications from surgery. On October 16, 2017, Petitioner was released from medical care for his neck and back with permanent restrictions. After this date, Petitioner did not treat with any orthopedic physicians.

Petitioner testified that since his accident, his life has changed "ninety-five percent." Petitioner testified that currently, he sometimes wears a pressure stocking. Petitioner testified that he continues to have pain and he experiences difficulty walking. Petitioner also testified that he experiences right hand weakness and he is afraid to drive due to the feeling that the muscles in his right hand "just release." Petitioner testified that a friend drove him to the arbitration hearing. Petitioner testified further that the problems with his right hand increased after his neck surgery. Petitioner testified that he gets "coldness" in his hands. Petitioner testified that he lives alone in a two-story house and he is required to climb up stairs to get to his bedroom. Petitioner testified that he is required to hold on to the rails when he climbs stairs to keep from falling. Petitioner testified that he still takes medication for pain. Petitioner testified that he uses a cane because his left leg will "give out" sometimes. Petitioner testified that his left leg feels weaker than his right leg.

Petitioner testified that he conducts job searches on a computer with help from his niece. Petitioner testified that he does not know how to use a computer on his own. Petitioner testified that he has not received any job offers. Petitioner testified that he misses his job and he enjoyed his job with Respondent. Petitioner testified that he had back surgery in the late 1980's or the early 1990's and he recovered from that surgery successfully with no problems.

On cross examination, Petitioner testified that he started working for Respondent in 1998 and he drove a truck prior to working for Respondent. Petitioner testified that he has driven a truck since approximately 1977. Petitioner has a CDL license, which he last renewed in December 2018. Petitioner testified that he did not believe that he had to take a test or complete medical paperwork to renew his CDL license. Petitioner testified that he owns a vehicle. When

asked about Respondent's Exhibit Four (RX4), Petitioner testified that he received a Maximum Medical Improvement ("MMI") orientation packet from Respondent. Petitioner testified that he submitted a reasonable accommodation form to the Respondent. Petitioner also testified that he received a form to use for his job searches, which he submits to Respondent every week. Petitioner testified that he did not have copies of his completed job search forms.

On redirect examination, Petitioner testified that he submits job logs to Respondent once per week. Petitioner testified that if he did not submit job logs, he would not receive a benefit check.

On the Request For Hearing form, the parties stipulated that Petitioner is entitled to Temporary Total Disability ("TTD") benefits from November 23, 2015 to October 13, 2017. (Arb.'s Ex. 1.) The parties also stipulated that Petitioner is entitled to Maintenance benefits from October 14, 2017 to February 19, 2020 (the date of the arbitration hearing). (Arb.'s Ex. 1.)

Exhibits

On November 23, 2015, Petitioner was transported by ambulance to Norwegian American Hospital Emergency Room complaining of left arm stiffness, and pain to the lower back and left leg that began after a work-related accident a few days before. The records note a history of diabetes and previous back surgery in 1992. Emergency room physicians recommended that Petitioner undergo X-rays to the lumbosacral spine and an MRI of the spine. X-rays of the lumbosacral spine showed degenerative changes at L4-L5 and L5-S1 bilaterally. The lumbar spine MRI showed midline disc protrusion at L4-L5 with associated dural sac impingement, spinal stenosis, and lateral recess narrowing. The thoracic spine MRI showed left-sided extradural defect at C7-T1 with significant impingement on the left anterolateral spinal cord and nerve roots. Petitioner was diagnosed with sciatica of the left side and was prescribed Norco. Petitioner was discharged on November 25, 2015 and was advised to follow-up with his primary care physician. (Pet'r's Ex. 1.)

On December 7, 2015, Petitioner sought treatment from Dr. Sean Salehi with Neurological Surgery & Spine Surgery. Dr. Salehi reviewed the MRIs that Petitioner underwent at Norwegian American Hospital. Dr. Salehi opined that the MRI of the thoracic spine showed mild diffuse spondylosis. Dr. Salehi opined that the MRI of the lumbar spine showed a moderate-sized herniated disc at L4-L5 which resulted in moderate to significant central canal and significant bilateral lateral recess stenosis; moderate central canal stenosis at L3-L4 due to a congenitally small spinal cord and epidural lipomatosis; and moderate bilateral L4-L5 facet arthropathy with mild to moderate bilateral L5-S1 facet arthropathy. Dr. Salehi diagnosed Petitioner with lumbar spinal stenosis, a herniated lumbar disc with radiculopathy, and lumbar spondylosis with radiculopathy. Further, Dr. Salehi recommended that Petitioner start with conservative treatment in the form of physical therapy and a caudal Epidural Steroid Injection ("ESI"), and prescribed Ibuprofen and a lumbar corset. (Pet'r's Ex. 3.)

On January 11, 2016, Dr. Salehi recommended that Petitioner undergo a L3-L5 laminectomy with bilateral L4-L5 microdiscectomy due to Petitioner's increased symptoms and development of intermittent bladder incontinence. (Pet'r's Ex. 3.)

On February 23, 2016, Petitioner sought treatment from Dr. Joshua Hedman with Chicago Pain & Orthopedic, the same place he treated for his ESI injections, and complained of left ankle pain. Petitioner reported that on February 10, 2016, he twisted his left ankle and fell while performing physical therapy for his back. Petitioner also reported that his lower extremity weakness was the cause of his injury. Petitioner stated that he did not seek medical treatment immediately following the injury to his left ankle because he initially thought it was just a sprain. Petitioner informed Dr. Hedman that he went to the hospital and was told that he had an ankle fracture. Petitioner presented to the appointment in a wheelchair. Dr. Hedman reviewed the left ankle X-ray images that Petitioner brought with him and opined that they showed an oblique fracture of the lateral malleolus starting at the ankle joint level and extending a few centimeters proximally. Dr. Hedman opined further that the X-ray findings warranted open reduction and internal fixation of the left foot, however, there were several risk factors to consider, such as Petitioner's uncontrolled edema, unknown diabetes control, and history of smoking. Dr. Hedman opined that Petitioner had findings consistent with diabetic neuropathy and peripheral vascular disease. Dr. Hedman recommended that Petitioner undergo conservative treatment in the form of a pneumatic cast boot, recommended that Petitioner continue to use a wheelchair for ambulatory assistance, and prescribed a cane. Dr. Hedman advised Petitioner of the likelihood of future left ankle instability and continued pain. (Pet'r's Ex. 5.)

On March 16, 2016, Petitioner presented to Dr. John Cherf with the Chicago Institute of Orthopedics at Respondent's request pursuant to Section 12 of the Workers' Compensation Act. Dr. Cherf noted that Petitioner had a history of back problems that resulted in surgery in 1989 and Petitioner had spondylosis throughout his lumbar spine with a disc herniation at L4-L5. Dr. Cherf opined that "[b]ased on Mr. Mullins' history of not having any symptoms in his lumbar spine immediately prior to the work-related injury in question the potential need for his back surgery appear to be related to the injury in question." Dr. Cherf also opined that "there appears to be a temporal and causal relationship between Mr. Mullins' current back symptoms and the injury in question." Dr. Cherf opined that non-operative treatment was one option, and surgery was another option if Petitioner had neurological deterioration. Dr. Cherf found that Petitioner had not reached MMI. (Resp't's Ex. 2.)

On April 23, 2016, Petitioner underwent a laminectomy to L3-L5 and bilateral discectomy to L4-L5. (Pet'r's Ex. 3.) Petitioner was admitted to the hospital for post-operative monitoring. (Pet'r's Ex. 7.) A progress note dated April 24, 2016, states in the "HPI and Hospital course" section that: "[t]he patient, in fact, suffered a fractured left ankle during rehabilitation because he was weak and unable to mount the exercise bicycle, falling and causing the subsequent fracture."

On April 27, 2016, Petitioner underwent a right ankle X-ray while admitted at Community First Medical Center. The X-ray was indicated for "Right ankle injury and pain" and it showed soft tissue swelling but no other abnormality. (Pet'r's Ex. 7.)

On May 19, 2016, Petitioner followed-up with Dr. Hedman. Petitioner reported that he had fallen when getting out of bed in the hospital after his back surgery and sprained his right ankle. Petitioner stated that his right ankle had improved and he was able to weight-bear without

problems. With respect to the left ankle, Petitioner reported that he had no pain but he did have some swelling with increased activity. Petitioner reported that he was still using a cane and the pneumatic cast boot. Dr. Hedman recommended that Petitioner discontinue using the pneumatic cast boot but maintain limited weightbearing activity. Dr. Hedman also recommended that Petitioner begin outpatient physical therapy for the left ankle once he began for the back. Dr. Hedman prescribed minimal gradient compression socks for edema control and noted that Petitioner should obtain new left ankle X-rays prior to his next visit. (Pet'r's Ex. 5.)

On May 31, 2016, Petitioner underwent an X-ray of the left ankle. The X-ray showed an incomplete bone union of distal fibular fracture with alignment unchanged compared to a previous study dated May 17, 2016. (Pet'r's Ex. 8.)

On June 9, 2016, Petitioner returned to Dr. Hedman and reported that the right ankle gave him no problems. Petitioner also reported that the left ankle had improved but he still had some swelling and mild soreness. Petitioner's main complaint was weakness and giving out of the left knee which began after his back surgery. Petitioner stated that he was in physical therapy for the left ankle and back and he had not received the prescribed compression sock yet. Dr. Hedman opined that Petitioner's right ankle was at MMI and the left ankle was improving. Dr. Hedman recommended that Petitioner continue physical therapy for the left ankle. (Pet'r's Ex. 5.)

On June 27, 2016, Petitioner followed-up with Dr. Salehi and reported that his low back pain was tolerable but that he continued to have intermittent burning pain in the left forearm into the fourth and fifth digits of the left hand. Petitioner also reported that he used a cane because he had difficulty getting up from a sitting position without his left knee giving out on him. Dr. Salehi diagnosed Petitioner with lumbar spinal stenosis, a herniated lumbar disc with radiculopathy, and cervical radiculopathy. Dr. Salehi recommended that Petitioner continue physical therapy and requested that Petitioner bring his cervical spine MRI to the next appointment. (Pet'r's Ex. 3.)

On August 29, 2016, Petitioner returned to Dr. Salehi with images from a cervical spine MRI dated January 30, 2016. Dr. Salehi opined that it showed a large herniated disc at C3-C4 which caused significant spinal canal stenosis, as well as spinal cord compression and myelomalacia at C3-C4. Dr. Salehi opined further that the MRI showed a moderate to large herniated disc at the left C7-T1 which compressed the C8 nerve root. Dr. Salehi recommended that Petitioner undergo a C3-C4 and C7-T1 anterior cervical discectomy and fusion. (Pet'r's Ex. 3.)

On May 17, 2017, Petitioner underwent an anterior cervical discectomy and fusion at C3-C4 and C7-T1. (Pet'r's Ex. 3.)

On October 2, 2017, Petitioner underwent a Functional Capacity Evaluation ("FCE") at Athletico. The FCE report indicates that Petitioner could return to work at a sedentary physical demand level.

Petitioner followed-up with Dr. Salehi on October 16, 2017 and complained of continued numbness in the forearms and hands with associated weakness. Petitioner also reported having

some remaining pain the lower back but stated that he was not taking anything for pain, and that he had experienced some "near falls." On examination, Dr. Salehi noted that Petitioner had a slow gait, decreased strength in the right hand grasp and left hand grip, and decreased sensation in the bilateral forearms and hands. Dr. Salehi released Petitioner to work with permanent light duty restrictions of no lifting more than twenty pounds, no pushing or pulling more than thirty-five pounds, no overhead work, no bending or twisting more than three times per hour, and no driving a company vehicle. Dr. Salehi also recommended that Petitioner alternate sitting and standing every thirty to forty-five minutes as needed. Dr. Salehi opined that Petitioner was at MMI. (Pet'r's Ex. 3.)

A Labor Market Survey Report from Vocamotive dated August 9, 2018, indicates that a "blind" labor market survey was performed for Petitioner based on a review of documents. Petitioner was not interviewed. Information regarding Petitioner's educational background was not available to the Certified Rehabilitation Counselor ("CRC") who authored the report. The report identified the following job targets: service clerk, motor vehicle dispatcher, security guard, general merchandise salesperson, host, and doorkeeper. The CRC assessed that Petitioner was a person of advanced age who had no transferrable skills and had permanent work restrictions. The CRC opined that Petitioner had lost access to his usual and customary job and line of occupation as a Motor Truck Driver. The CRC opined further that Petitioner was prospectively employable. If Petitioner had a high school diploma or GED, he would be qualified to work additional jobs such as a Security Guard, Dispatcher, Clerk, and Customer Service Representative. If Petitioner did not have a high school diploma or GED, he would be qualified to work as a Retail Sales Clerk or a Cashier. The jobs that the CRC opined Petitioner was qualified to work had a range of salaries between $9.27 for a fast-food worker and $28.72 for a Motor Vehicle Dispatcher. The CRC opined that the labor market survey indicated Petitioner had the most probable wage-earning potential within the range of $12.00 and $16.00 per hour. (Resp't's Ex. 5.)

An attendance sheet from the City of Chicago Department of Streets and Sanitation and Department of Transportation MMI Orientation dated October 26, 2018, shows Petitioner's name and signature. (Resp't's Ex. 4.) The exhibit also contains a packet of information on searching and applying for jobs, requesting reasonable accommodations, and pension benefits with the City of Chicago. (Resp't's Ex. 4.)

The Arbitrator notes that no records or bills from Mercy Hospital were submitted into evidence although Mercy is listed on Petitioner's Exhibit List (Arb's Ex. 2).

CONCLUSIONS OF LAW

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

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

Petitioner testified that he underwent back surgery in the late 1980's or the early 1990's and he recovered from that surgery successfully with no problems. Petitioner also testified that

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prior to the undisputed accident on November 20, 2015, he was able to perform his full job duties as a truck driver for Respondent. The Arbitrator notes that the medical records show that Petitioner underwent back surgery in 1992. The Arbitrator notes further that Dr. Cherf examined Petitioner at Respondent's request and opined that although Petitioner had prior back problems and a previous back surgery around 1989, Petitioner's lumbar spine condition was causally related to the undisputed work accident. No additional section 12 reports were submitted into evidence.

The Arbitrator finds that Petitioner's testimony was credible and consistent with the medical records. The medical records and Petitioner's testimony demonstrate that Petitioner did not have lower back, neck, or bilateral ankle problems before the undisputed accident on November 20, 2015. However, after November 20, 2015, Petitioner experienced lower back and neck problems with associated radicular symptoms; and eventually, bilateral ankle problems due to weakness associated with the lower back and neck conditions. After Petitioner underwent a lumbar spine surgery and a cervical spine surgery, Dr. Salehi released Petitioner to work with permanent light duty restrictions. Based on Petitioner's unrebutted testimony and the medical records, the Arbitrator finds that Petitioner's post-operative lower back and neck, and bilateral ankle conditions of ill-being are causally related to the undisputed November 20, 2015 work accident.

II. 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 notes that there is a disagreement between the parties as to whether all reasonable and necessary medical expenses have been paid. The Arbitrator finds that it is unclear from the bills submitted by Petitioner and the payment log submitted by Respondent whether all reasonable and necessary medical expenses have been paid. Based on the above finding of causal connection, Respondent is required to pay the below listed reasonable and necessary medical bills pursuant to section 8(a) and section 8.2 of the Workers' Compensation Act:

Norwegian American Hospital
Dates of Service: November 23, 2015 through November 25, 2015; December 9, 2015

Neurological Surgery & Spine Surgery
Dates of Service: December 7, 2015 through October 16, 2017

Accredited Ambulatory Care
Dates of Service: January 5, 2016

Chicago Pain & Orthopedic Institute
Dates of Service: January 5, 2016 through July 12, 2016

Bone & Joint Clinic
Dates of Service: December 14, 2015 through July 26, 2017

Community First Medical Center
Dates of Service: April 15, 2016; April 23, 2016 through May 2, 2016; May 8, 2017; May 17, 2017 through May 19, 2017

Preferred Open MRI
Dates of Service: January 30, 2016; March 22, 2016; May 17, 2016; May 31, 2016

Sage Medical Solution (Medical Equipment)
Dates of Service: December 8, 2015 through May 26, 2017

Nova Pharmacy
Dates of Service: January 13, 2016; November 1, 2016

Athletico
Dates of Service: October 2, 2017

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

An employee is totally and permanently disabled when he is unable to make some contribution to the work force sufficient to justify payment of wages. *A.M.T.C. of Illinois v. Industrial Comm'n,* 77 Ill. 2d 482, 487 (1979). However, the employee need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. v. Industrial Comm'n,* 95 Ill. 2d 278, 286-87 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Industrial Comm'n,* 282 Ill. App. 3d 531, 534 (1st Dist. 1996).

If the claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove by a preponderance of the evidence that he fits into the "odd-lot" category – one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. *Valley Mould & Iron Co. v. Industrial Comm'n,* 84 Ill. 2d 538, 546-47 (1981). The claimant ordinarily satisfies his burden of proving that he falls into the odd-lot category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work; or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Alano,* 282 Ill. App. 3d at 534-35. Once the claimant establishes that he falls into the odd-lot category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Waldorf Corp. v. Industrial Comm'n,* 303 Ill. App. 3d 477, 484 (1st Dist. 1999).

On October 16, 2017, the date of Petitioner's last visit with Dr. Salehi, Petitioner reported experiencing "near-falls," pain in the lower back, and numbness and weakness in the forearms

and hands. Dr. Salehi noted that Petitioner had a slow gait, decreased strength in the right hand grasp and left hand grip, and decreased sensation in the bilateral forearms and hands. That day, based on an FCE, Dr. Salehi released Petitioner to work with permanent light duty restrictions of no lifting more than twenty pounds, no pushing or pulling more than thirty-five pounds, no overhead work, no bending or twisting more than three times per hour, and no driving a company vehicle. Dr. Salehi also recommended that Petitioner alternate sitting and standing every thirty to forty-five minutes as needed. The Vocamotive Labor Market Survey Report dated August 9, 2018, concludes that Petitioner is a person of advanced age who has no transferable skills. The Vocamotive Report indicates further that Petitioner had lost access to his usual and customary job and line of work as a Motor Truck Driver. However, the Vocamotive Report also indicates that Petitioner is prospectively employable as a Retail Sales Clerk or a Cashier.

Petitioner testified that he is sixty-eight (68) years old and has been driving a truck since 1977. Petitioner has worked for Respondent as a truck driver for the past twenty-two years, although he has not actively performed his job duties since the undisputed work accident on November 20, 2015. Petitioner testified that his highest level of education is at the high school level. Petitioner testified that he does not know how to use a computer on his own and his niece helps him when he needs to use the computer. Petitioner testified that he continues to experience right-hand weakness, difficulty walking, and left leg weakness for which he currently uses a cane.

Based on Petitioner's credible testimony and the medical records, the Arbitrator finds that the Petitioner is totally and permanently disabled under the "odd-lot" category. The Arbitrator finds that Petitioner has met his burden of proving that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. The Arbitrator finds that Respondent has failed to meet its burden of proving that Petitioner is employable in a stable labor market and that such a market exists. The Arbitrator notes that the Vocamotive Labor Market Survey Report acknowledges that Petitioner is of advanced age and has no transferable skills, which undermines the Vocamotive Report's conclusion that Petitioner is otherwise employable.

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

Jesse Mason,
Petitioner,

20 IWCC0670

vs.

NO: 19 WC 10607

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 21, 2020, 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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 19 2020
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DLS/rm
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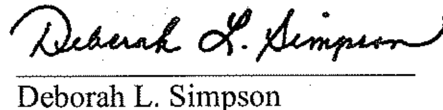
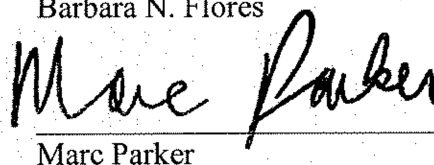

Deborah L. Simpson

Barbara N. Flores


Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 I W CC0670

MASON, JESSE
Employee/Petitioner

Case# **19WC010607**

CITY OF CHICAGO
Employer/Respondent

On 4/21/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% 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:

2208 CAPRON & AVGERINOS PC
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CHICAGO, IL 60603

0010 CITY OF CHICAGO CORP COUNSEL
MATTHEW A LOCKE
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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STATE OF ILLINOIS	)
	)SS.
COUNTY OF COOK	)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

JESSE MASON
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # **19 WC 10607**

Consolidated cases: ______

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **November 21, 2019**. By stipulation, the parties agree:

On the date of accident, **April 1, 2019**, 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 $**95,655.15**, and the average weekly wage was $**1,834.48**.

At the time of injury, Petitioner was **47** years of age, ***single*** with **0** dependent children.

Reasonable and necessary medical services and temporary total disability benefits have been paid by Respondent.

Respondent shall be given a credit of $**5,066.93** for TTD.

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.

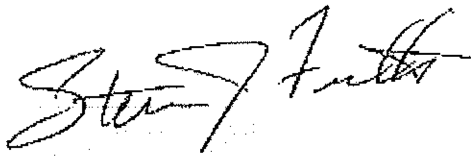
ORDER

Respondent shall pay Petitioner the sum of **$813.87**/week for a further period of **25** weeks, as provided in § **8(d)2** of the Act, because the injuries sustained caused **5% loss of a person-as-a-whole**.

Respondent shall pay Petitioner compensation that has accrued from **April 1, 2019** through **November 21, 2019**, 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

April 16, 2020
Date

APR 2 1 2020

JESSE MASON v. CITY OF CHICAGO

FINDINGS OF FACT

Petitioner Jesse Mason has been a bricklayer for Respondent City of Chicago for four years. On April 1, 2019, Petitioner was working in a jobsite hole. As he tried to grab a bucket of mortar from his laborer, the laborer released the bucket too quickly, causing it to pull Petitioner's left arm. Petitioner was referred to MercyWorks, where x-rays were negative. Petitioner was diagnosed with a left shoulder sprain and given pain medication.

Petitioner returned to MercyWorks on April 5, 2019 with continued left shoulder pain. Dr. Steven Anderson recommended an MRI, which Petitioner underwent on April 15, 2019. The MRI indicated a Bankart lesion and supraspinatus tendinosis. On April 16, 2019, Dr. Anderson noted a positive impingement test. Dr. Anderson diagnosed left shoulder rotator cuff tendinosis and referred him to an orthopedist.

On April 29, 2019, Petitioner saw Dr. William Heller of Midland Orthopedics. Following a physical examination, Dr. Heller prescribed a regimen of physical therapy. On May 31, 2019, Dr. Heller recommended three more weeks of physical therapy. Dr. Heller indicated that if Petitioner's symptoms were to worsen in the future, an arthroscopy may be discussed. Petitioner did not have an arthroscopy.

Petitioner testified that he continues to work for Respondent as a bricklayer. His left shoulder is sore at the end of the work-day and he has to ice it. He also notices pain when carrying his niece in his left arm or lifting water at the grocery store.

CONCLUSIONS OF LAW

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 admitted in evidence. The Arbitrator cannot give any weight to this factor.

ii) Petitioner was a bricklayer for Respondent, an occupation requiring strenuous physical labor. Petitioner was able to return to this job without restriction. The Arbitrator gives moderate weight to this factor.

iii) Petitioner was 47 years old at the time of his accident he had a statistical life expectancy of approximately 30 years. The Arbitrator gives moderate weight to this factor.

iv) Petitioner returned to his occupation as a bricklayer. There was no evidence that his earning capacity was adversely affected by his injury. The Arbitrator gives great weight to this factor.

v) Petitioner sustained a supraspinatus tendinosis to his left shoulder. He received a course of conservative care, including physical therapy, which resulted in a recovery sufficient to return to full duty work. The Arbitrator gives great weight to this factor.

After reviewing all the evidence, including the above five factors, the arbitrator finds that petitioner sustained a permanent partial disability of 5% of a person-as-a-whole, 25 weeks.

Steven J. Fruth, Arbitrator

April 16, 2020
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEVON SWART,

Petitioner,

20 IWCC0671

vs.

NO: 19 WC 24346

MCLEAN COUNTY SHERRIF'S DEPT.,

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, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part thereof.

I. Findings of Fact

Petitioner, a corrections officer, sustained a groin injury after being attacked by an inmate on October 22, 2018. When Petitioner initially presented to the emergency room on the accident date, his treatment focused on his right wrist pain from the altercation. He thereafter expressed complaints of increased right testicle pain to Michelle Steele, a nurse practitioner ("NP"), at IWIN on November 9, 2018. NP Steele attempted a manual detorsion and diagnosed Petitioner with right testicle pain in addition to a right wrist scaphoid fracture. Petitioner was then sent for an ultrasound, which showed increased blood flow to the right testicle and a small complicated hydrocele. NP Steele took Petitioner off work and prescribed Norco and over-the-counter analgesics.

When Petitioner returned on November 13, 2018, he reported that he was unable to get the Norco prescription filled and had been taking Naproxen instead. NP Steele diagnosed Petitioner with a right scrotum hydrocele and instructed him to follow up with his primary care physician. She further recommended that Petitioner wear supportive briefs or a jockstrap and provided light duty restrictions of lifting 20 pounds occasionally and 10 pounds frequently, no commercial

driving, no safety sensitive duties, and no combative situations.

A few months later, on February 22, 2019, Petitioner presented to Abraham Lincoln Memorial Hospital and complained of the sudden onset of right testicular pain an hour and a half prior to arrival. Petitioner indicated that it felt similar to his previous torsion. An ultrasound of the scrotum was concerning for right orchitis without epididymitis but showed no torsion or mass. Dr. Susan Harmon performed another manipulation of the right testicle, which relieved some of Petitioner's symptoms. Petitioner was diagnosed with right orchitis and a resolved right testicular torsion. Dr. Harmon directed Petitioner to then follow up with the urologist.

On the same day, Petitioner saw Dr. Piyush Pathak, a urology resident at the Springfield Clinic. Dr. Pathak reviewed Petitioner's ultrasound and found possible slight hyperemia of the right scrotum within a normal range as well as evidence of strong systolic and diastolic flow. He found no evidence of torsion on his examination or on the ultrasound. As such, Dr. Pathak saw no indication for urologic intervention. Petitioner thereafter followed up with Dr. William Severino, a urologist, at the Springfield Clinic on April 15, 2019. Dr. Severino diagnosed Petitioner with right testicular pain and ordered another ultrasound, which was performed on April 22, 2019 and yielded normal results with no evidence of testicular mass or torsion.

Petitioner returned to Dr. Severino on April 26, 2019. At that time, Dr. Severino indicated that he was not sure if Petitioner truly had a torsion in the past, because there was no urologist consulted or ultrasound performed when Petitioner was initially seen in the emergency room and first manually detorsed. Dr. Severino stated that Petitioner was thereafter told he had another torsion in February, but the urology resident had felt that he did not have a torsion and an ultrasound had shown normal blood flow to the testicles. Dr. Severino further indicated that both his examination of Petitioner on April 26, 2019 and the recent scrotal ultrasound were normal. Petitioner had no hydrocele or torsion at that visit. Dr. Severino stated that he was not sure why Petitioner still had testicle pain and he was not convinced that he required a bilateral orchiopexy.

On June 19, 2019, Dr. Lev Elterman of Advanced Urology, Ltd. authored a §12 report at Respondent's request. The report corresponds with his §12 examination of Petitioner performed on May 24, 2019. Dr. Elterman opined that Petitioner had right chronic scrotal pain that was causally related to the work accident. Dr. Elterman further noted that Petitioner was suspected of having intermittent torsion with two episodes of exacerbation. He believed that Petitioner's pain episodes were related to excessive tone of the cremaster muscle. However, at his examination, he found no evidence of any permanent injury, torsion, or current pathological objective findings. Dr. Elterman placed Petitioner at maximum medical improvement for his work-related injury, as Petitioner had not had a substantial exacerbation of pain since February. He opined that Petitioner was capable of working full duty without restrictions and required no additional treatment.

At the hearing, Petitioner testified that he eventually returned to full duty work, but he did not specify as to a date. Since Petitioner returned, he has missed only two days of work, including one day to see a doctor and another day when he had swelling in his groin. Petitioner testified that he is able to perform his job every day. Nevertheless, Petitioner testified that he now feels daily painful pressure in his groin with some days being worse than others. He testified that he now wears briefs, because he felt pain while walking in boxers. Petitioner testified that if he walks for

an extended period and stands up too quickly, his groin shoots up and causes a sharp pain. He testified that he also sometimes has severe pain after intercourse and a daily uncomfortable feeling that he did not have before. Petitioner did not have any groin problems prior to October 22, 2018.

Petitioner further testified that he has swelling in his testicle once a week. He notices the swelling when he has to walk seven miles or more at work. Petitioner testified that he also notices some pressure or torsion when he picks up his son. He also has issues when lifting anything heavy or trying to work out. Petitioner takes Ibuprofen for his pain and uses ice and heat twice a week.

II. Conclusions of Law

Following a careful review of the entire record, the Commission modifies the Decision of the Arbitrator to find that Petitioner sustained a 25% loss of use of the right testicle based upon its analysis of the §8.1b statutory factors.

In reviewing permanent partial disability, the Commission must consider the §8.1b enumerated criteria, including (i) the reported level of impairment pursuant to (a) [AMA "Guides to Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability as corroborated by treating medical records. 820 ILCS 305/8.1b(b). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.*

Regarding criterion (i), no AMA impairment rating was provided in this case. As such, the Commission assigns no weight to this factor.

Regarding criterion (ii), Petitioner was a corrections officer on the date of his accident and thereafter returned to his regular full duty position at an unspecified date. Petitioner testified to his ability to still do his job every day. The Commission assigns moderate weight to this factor.

Regarding criterion (iii), Petitioner was 26 years old on the accident date. Although there was no direct testimony as to how Petitioner's age affected his disability, the Commission presumes that Petitioner has a substantial number of years left in the workforce due to his young age. The Commission assigns moderate weight to this factor.

Regarding criterion (iv), there was no evidence that Petitioner's injury affected his future earning capacity, as Petitioner continues to work at his regular full duty job. Thus, the Commission assigns no weight to this factor.

Regarding criterion (v), Petitioner suffered two episodes of increased testicular pain and possible torsions in November 2018 and February 2019. Both episodes required manual detorsions or manipulations. During the November 2018 episode, an ultrasound further revealed a small complicated hydrocele. In November of 2018, Petitioner further treated with medication and work restrictions. Petitioner was also instructed to wear supportive briefs or a jockstrap. After last treating on November 13, 2018 for the first episode of increased testicular pain, Petitioner returned to the hospital on February 22, 2019 with another sudden onset of increased testicular pain. A second manipulation was thereafter required.

At the time of the hearing, Petitioner continued to have daily painful pressure in his groin. He now wears briefs, as he notices pain while walking in boxers. Petitioner testified to experiencing pain and/or swelling when he walked more than seven miles, stood up too quickly, had intercourse, picked up his child, lifted anything heavy, or attempted to workout. Petitioner requires Ibuprofen for the ongoing pain and has to ice or heat the area twice a week. The Commission puts significant weight on this factor.

Upon consideration of these factors, particularly Petitioner's daily complaints of ongoing pain and two manual manipulations, the Commission finds that Petitioner has sustained a 25% loss of use of the right testicle. The Commission modifies the Decision of the Arbitrator accordingly. 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 March 9, 2020, is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $505.71 per week for a period of 13.5 weeks, as provided in §8(e) of the Illinois Workers' Compensation Act, because the injuries sustained caused a 25% loss of use of the right testicle.

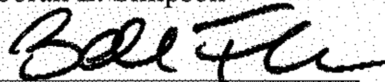
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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.

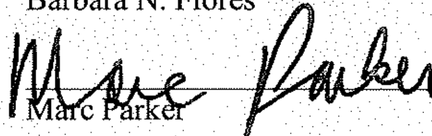
There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 19 2020

Deborah L. Simpson



Barbara N. Flores



Marc Parker

DLS/met
O: 10/8/20
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0671

SWART, DEVON
Employee/Petitioner

Case# **19WC024346**

McLEAN COUNTY SHERIFF'S DEPARTMENT
Employer/Respondent

On 3/9/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
300 HAMILTON SQ
PEORIA, IL 61601

20IWCC0671

STATE OF ILLINOIS)
)SS.
COUNTY OF **McLean**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Devon Swart
Employee/Petitioner

v.

McLean County Sheriff's Department
Employer/Respondent

Case # **19** WC **24346**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **January 29, 2020**. 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 [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 **20IWCC0671**

On **October 22, 2018,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, Petitioner's earning in the year preceding the injury were **$43,828.20,** the average weekly wage was **$842.85.**

On the date of accident, Petitioner was **26** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$ALL TTD PAID** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$ALL TTD PAID.**

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

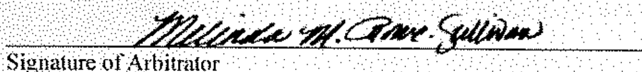
ORDER

Respondent shall pay for medical services **related to the right testicle as set forth in Petitioner's Exhibit 1** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **related to the right testicle as set forth in Petitioner's Exhibit 1** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$505.71/week** for a period of **10.8 weeks,** as provided in **Section 8(e)** of the Act, because the injuries sustained caused **20% loss of use of the right testicle.**

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

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



Signature of Arbitrator

3/3/2020
Date

MAR 9 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Devon Swart
Employee/Petitioner

Case # **19** WC **24346**

v.

Consolidated cases: N/A

McLean County Sheriff's Department
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on October 22, 2018 he was employed by Respondent as a Correctional Officer, and that on that date he was kicked in the groin and also broke his wrist. He testified that after he was kicked he went down to the ground and that, once the adrenaline went away, he started vomiting and noticed swelling. He testified that he went to see the facility's nurse who checked to see if there was blood in his urine, and that he then went to the emergency room.

Petitioner testified that he has undergone two manipulations or torsions of his testicle on separate occasions. He testified that he also saw a urologist. He testified that he was eventually returned to work regular duty.

When asked what he notices about his groin now, Petitioner responded that he has daily pressure in the groin. He testified that if he wears boxers he notices that it is more painful as he walks, so he now wears briefs. He testified that if he stands up too quickly, he feels sharp pain in his groin. He testified that he has had swelling in his testicle and that at times it has shrunk, and that he also experiences pain after sexual intercourse. Petitioner denied having had any issues with his groin before the date of accident.

Petitioner testified that he experiences swelling approximately once a week. He testified that the swelling happens after work if he has walked more than about seven miles. He testified that the pressure in his groin is painful, that he has pressure daily, and that some days are worse than others. He testified that when he experiences pain and swelling he uses ice and heat, and that he also takes Ibuprofen. He testified that he typically uses ice and heat on the weekends and usually once during the week.

On cross examination, Petitioner testified that he underwent two manipulations by his medical providers. He testified that he underwent at least two ultrasounds for this injury, the first of which was in November and the second of which was in February. Petitioner agreed that he has not had any further manipulations.

On cross examination, Petitioner agreed that, since seeing Dr. Severino and Dr. Elterman, he has not had any additional treatment. Petitioner agreed that he is able to do his job.

On cross examination, Petitioner agreed that his complaints related to walking and sex. He further testified that he also feels pressure when he picks up his son and when he lifts anything heavy.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Advocate Bromenn 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 October 22, 2018, at which time it was noted that he presented with complaints of right wrist pain. It was noted that Petitioner reported that he was involved in an altercation with an inmate at approximately 16:30, that the inmate reportedly fell on the affected arm causing injury, and that he had taken nothing for pain. It was noted that Petitioner had no previous injuries and no other complaints. Petitioner underwent x-rays of the right wrist on October 22, 2018, which were interpreted as an unremarkable study. The primary impression was noted to be that of acute wrist pain. Petitioner was recommended to wear a splint for comfort and to apply ice and elevate for comfort. It was noted that Petitioner was to follow-up as directed by his employer, and that a referral for Orthopedic follow-up had been placed. (PX2).

The medical records of Abraham Lincoln Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent an ultrasound of the scrotum on April 22, 2019, which was interpreted as normal with no evidence of testicular mass or torsion. The "Reason for Study" was noted to be that of intense pressure and pain lasting few minutes then decreases; previous history of testicular injury in October 2018 with right testicular torsion, surgery performed in November 2018; patient reports two instances of torsion since the injury. It was noted that the comparison ultrasound was dated February 22, 2019. (PX3).

The records of Abraham Lincoln Memorial Hospital reflect that Petitioner was seen in the emergency room on February 22, 2019, at which time it was noted that he was seen for right testicular pain. It was noted that it started just prior to arrival about 1½ hours and was still present, that the problem was described as severe, that Petitioner had had severe testicular pain involving the right testicle with swelling, that he had been unable to void, and that he had had no unprotected intercourse or exposure to a sexually transmitted disease. It was noted that Petitioner stated that the pain was so severe that it doubled him over, that he stated it felt just like his previous torsion, and that he did not take any pain medication at home nor did he attempt to manipulate the scrotum. It was noted that Petitioner had had similar symptoms previously, that he reported an episode that was diagnosed as a right testicular torsion in November 2018, that he stated that he was at work when it occurred, and that he went to the workman's comp doctor who "untwisted [his] testicle" and his pain was relieved. It was noted that Petitioner stated that he had had an ultrasound after that which showed resolution of the torsion, and that he denied ever having seen Urology for this. It was noted that Petitioner had moderate right-sided scrotal swelling with tenderness and severe tenderness of the right testicle. Petitioner underwent an ultrasound of the scrotum on February 22, 2019, which was interpreted as revealing (1) concern for right orchitis without epididymitis; (2) no torsion or mass. The "Reason for Study" was noted to be that of kicking injury to the scrotum in October 2018; torsion of the right teste with surgery performed in November 2018; pain in the right teste since that time; woke up this morning with acute testicular pain, greater than normal. It was noted that Petitioner's right testicle was gently manipulated in a counterclockwise motion and that he had partial relief of symptoms. It was also noted that Petitioner was offered additional manipulation and that he wanted to wait. The clinical impression was noted to be that of right orchitis; right testicular torsion (resolved). It was noted that Petitioner was recommended to follow-up with a urologist even if well. (PX3).

The medical records of IWIN were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on October 23, 2018, at which time it was noted that he stated that he injured his right wrist at work. It was noted that Petitioner stated that there was an altercation with an inmate where he grabbed the inmate's right leg and got kicked in the scrotum and fell on his right wrist. It was noted that Petitioner stated that he had nausea and vomiting afterwards from his scrotal injury, that he denied any scrotal concerns on that date, hematuria, or swelling, and that he stated

that he landed hyperflexing his right wrist. It was noted that Petitioner stated that it popped and had pain initially, that he now had right forearm swelling, and that he had been taking Ibuprofen and Motrin over-the-counter. The assessment was noted to be that of right wrist sprain and right forearm contusion. Petitioner was recommended to use a ThermalSoft Gel Cold/Hot Pack to reduce swelling/pain, was dispensed two Coban wraps, was given wrist exercises to improve range of motion, and was recommended to take over-the-counter Ibuprofen per the label for pain and swelling. Petitioner was issued work restrictions and was recommended to follow-up in 5-7 days or sooner, if needed. (PX5).

The records of IWIN reflect that Petitioner was seen on November 9, 2018, at which time it was noted that he stated that he was having increased testicular pain, that he stated that it just had not felt right since the injury, that he stated that on Tuesday, Wednesday, and Thursday he was doing a lot of climbing and steps and started to have increased testicle pain, that he stated Thursday's pain was even worse and that he went to bed early due to the pain, and that he stated that he woke up and the pain got so bad he had to curl up on the floor and was in tears. It was noted that Petitioner denied any swelling, discoloration, discharge, frequency, dysuria, or hematuria. It was also noted that Petitioner saw an orthopedic physician and was placed in a cast for a scaphoid fracture. It was noted that a manual attempt of detorsion was done in the office, with some pain relief received. It was also noted that an ultrasound of the scrotum was interpreted as revealing increased blood flow right testicle, may be the result of recently reversed torsion, reaction to recent injury, or orchitis; small complicated hydrocele versus area of hemorrhage/hematoma right hemiscrotum. The assessment was noted to be that of right wrist scaphoid fracture and right testicle pain. It was noted that Petitioner was referred to his primary care physician and was sent for an ultrasound to rule out torsion. Petitioner was recommended to continue with Orthopedics, to continue ice therapy as needed, and to continue over-the-counter analgesic per the label for pain and swelling. It was noted that Petitioner was also taken off work until his re-evaluation at the next appointment. (PX5).

The records of IWIN reflect that Petitioner was seen on November 13, 2018, at which time it was noted that he was seen for follow-up. It was noted that Petitioner stated that he continued to have right testicle pain, that he stated his pain was worse with standing and relieved when sitting, and that he stated that he had a follow-up appointment with his primary care physician on Thursday. It was noted that Petitioner was unable to get his Norco filled so he had been taking Naproxen for pain and swelling, that he stated that his scrotum did not feel right and that it felt like there was a rush of blood when he stood, and that his pain went into his right lower quadrant. It was noted that Petitioner denied any urinary or bowel symptoms or discoloration. The assessment was noted to be that of right wrist scaphoid fracture and right scrotum hydrocele. Petitioner was recommended to follow-up with Orthopedics, to continue ice therapy as needed, to continue over-the-counter analgesics per label for pain and swelling, and to wear supportive briefs or a jockstrap. Petitioner was returned to work with restrictions and was recommended to return in 7-10 days. (PX5).

The medical records of Springfield Clinic/Dr. William Severino were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on April 26, 2019, at which time it was noted that he had "somewhat of an unusual story" in that he was kicked in the scrotum in October 2018 and had pain, and that at some point in time he was seen in the emergency room and had a torsion that was "manually detorsed." It was noted that no urologist at that point in time was consulted which was a bit unusual, and that there was no mention whether Petitioner had an ultrasound prior to that that showed no flow so Dr. Severino was unsure if he truly had a torsion or not. It was noted that Petitioner continued to have right testicle pain and was told that he had another right-sided torsion in February, that he was seen by the Urology residents and felt to not have a torsion, and that an ultrasound showed normal flow to the testicles. It was also noted that a scrotal ultrasound recently performed was entirely normal. It was noted that Petitioner was examined by Dr. Severino and that his scrotum appeared normal, that both testicles were palpated and no mass, hydrocele, varicocele, or hernia were found on either side but that he might be a little tender on the superior pole on the right testicle. It was noted that Dr. Severino was not

convinced Petitioner needed a bilateral orchiopexy and that he was not sure why he still persistently had right testicle pain, and that if he did previously have a torsion it was not related to that. It was noted that Petitioner was to see Dr. Tadros since he was fellowship-trained in Andrology. (PX6).

The records of Springfield Clinic reflect that Petitioner was seen by physician's assistant Hoss-Green on April 15, 2019, at which time it was noted that he returned to the Urology clinic for follow-up of right testicular pain. The assessment was noted to be that of right testicular pain. Petitioner was recommended to undergo an ultrasound of the scrotum and was to follow-up with Dr. Severino after the ultrasound was completed. (PX6).

The IME Report of Dr. Elterman dated June 19, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report reflects that Petitioner underwent an IME on May 24, 2019. It was noted that Petitioner sustained a scrotum injury during an altercation at work as a correctional officer in prison, that it occurred on October 22, 2018, that he stated that he was "mule kicked" in the scrotum, and that during the altercation he fell and injured his right wrist as well. It was noted that later that day Petitioner developed vomiting 3-4 times and was seen by the jail nurse, that he then went to the emergency room, that he noticed swelling and pain primarily in the right scrotum, and that he was seen by nurse practitioner Michelle Steele on October 23, 2018 and was diagnosed and treated for his right wrist injury and that there was pain in the scrotum, but that he did not recall being examined in the scrotum at that time. It was noted that initially the pain was 9-10/10 in intensity, that the pain then subsided and felt like pressure, that it would increase with standing up, and that it would feel like the testicle would retract into the right groin. (RX1).

The report reflects that Petitioner was back to work full duty, that he still had pressure in the right scrotum with quick motion, and that the testicle would retract. It was noted that Petitioner had pain with sex and prolonged walking, that the pain would be 6-7/10 and lasted for 5-10 minutes, and that the testicle also "goes up." It was noted that a gentle exam of the penis showed normal shaft; foreskin was circumcised; gland was normal; urethral medius was normal size, location, and showed no evidence of hypospadias; scrotum skin was normal; there was no evidence of hydrocele or any other masses; epididymis on both sides was normal; testes were normal in size and texture and non-tender. (RX1).

The report reflects that Dr. Elterman opined that the current diagnosis was that of right chronic scrotal pain and that the current diagnosis was causally related to the work incident on October 22, 2018. It was noted that Dr. Elterman opined that Petitioner's pain episodes related to excessive tone of the cremaster muscle as he reported the testicle being drawn up into the right inguinal area with exacerbation of pain, that the phenomenon was not present on examination, and that there was no evidence of any permanent injury at the time of examination. It was noted that Dr. Elterman further opined that there was no evidence of testicular torsion at the time of examination. (RX1).

When asked whether the objective findings supported the subjective complaints, it was noted that Dr. Elterman opined that the objective findings of increased hyperemia following scrotal manipulation supported a pathological process on that side, and that initial ultrasound showed evidence of a small complicated hydrocele versus hematoma as a likely result of initial trauma. It was noted that Petitioner's symptoms were supported by past objective findings, and that the examination on that date did not reveal any pathological objective findings. It was noted that Dr. Elterman opined that the treatment and testing to date had been reasonable and necessary with respect to Petitioner's scrotum issues, and that he had reached maximum medical improvement as he had not had substantial exacerbation of his pain since his February 22nd episode. It was noted that Petitioner was back at work and able to perform full duty. (RX1).

The Payout Documentation was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The Urology Consult dated February 22, 2019 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that Petitioner was seen by Dr. Pathak at Memorial Medical Center, at which time it was noted that he presented with an acute onset of right scrotal pain starting that morning. It was noted that Petitioner had manual detorsion in Lincoln emergency department followed by scrotal ultrasound showing good flow bilaterally, possible slight hyperemia on the right side, and that he had a history of trauma (kick) to penis/scrotum in October 2018, that he noted that he had a brief period of ED (soft erections) which self-resolved after this, and that this was the second time he had had torsion after this. The assessment was noted to be that of possible torsion. It was noted that there was no evidence of torsion on present exam or ultrasound, that there was no indication for urologic intervention or admission, and that it was okay to discharge Petitioner from Urology with a follow-up in clinic in 2-3 weeks with Dr. Severino. (RX3).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident of October 22, 2018. In so finding, the Arbitrator relies on the opinion of Dr. Elterman, who opined that Petitioner's current condition was causally related to the accident at issue.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of October 22, 2018. As a result thereof, Respondent shall pay all reasonable and necessary medical services related to the right testicle as contained in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA impairment. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he was a Correctional Officer for Respondent at the time of the accident at issue. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 26 years old on the date of the accident at issue. In light of Petitioner's full duty release by his treating physician, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he returned to work as a Correctional Officer for Respondent. As there was no definitive evidence proffered at arbitration to demonstrate that Petitioner's work accident has impaired or otherwise affected his future

earnings capacity, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that when asked what he notices about his groin now, Petitioner responded that he has daily pressure in the groin. Petitioner testified that if he wears boxers he notices that it is more painful as he walks, so he now wears briefs. Petitioner testified that if he stands up too quickly, he feels sharp pain in his groin. Petitioner testified that he has had swelling in his testicle and that at times it has shrunk, and that he also experiences pain after sexual intercourse. Petitioner testified that he experiences swelling approximately once a week, that the swelling happens after work if he has walked more than about seven miles and that when he experiences pain and swelling he uses ice and heat, and that he also takes Ibuprofen. At the time of the April 26, 2019 visit with Dr. Severino, it was noted that Petitioner was examined and that his scrotum appeared normal, that both testicles were palpated and no mass, hydrocele, varicocele, or hernia were found on either side but that he might be a little tender on the superior pole on the right testicle. It was noted that Dr. Severino was not convinced Petitioner needed a bilateral orchiopexy and that he was not sure why he still persistently had right testicle pain, and that if he did previously have a torsion it was not related to that. (PX6). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration was mostly corroborated by his treating records at the conclusion of his treatment. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **20% loss of use of the right testicle** as provided in Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wallace F. Stutz,

Petitioner,

20 IWCC0672

vs.

NO: 18 WC 16086

Tuscola True Value Hardware, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, average weekly wage, benefit rates, 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 January 30, 2020, is hereby affirmed and adopted.

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $44,000.00. 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: NOV 19 2020
o: 10/8/20
BNF/wde
45

Barbara N. Flores

Marc Parker

Dissent in Part & Concur in Part

I respectfully dissent in part from, and concur in part with, the Decision of the Majority. The Majority affirmed and adopted the Decision of the Arbitrator who found that Petitioner's stipulated accident caused current conditions of ill-being of his left ring finger and right shoulder and awarded him 4.05 weeks of PPD representing loss of the use of 15% of the finger, and 25 weeks of PPD representing loss of 5% of the person-as-a-whole. I concur with the Arbitrator and Majority regarding finding causation to the finger condition and the award of associated benefits. However, I respectfully dissent from the Majority regarding the shoulder condition. I would have reversed the Decision of the Arbitrator finding that Petitioner's shoulder condition was causally related to the accident and vacated the awards associated with that condition of ill-being.

On December 7, 2017, Petitioner was working on furnaces when he fell down some stairs and landed on a concrete floor. Ambulance records indicate that Petitioner complained of pain in the right shoulder, right side, right hip/buttock and left ring finger. At the Emergency Department, he was given an injection in his shoulder and his left ring finger was splinted for a diagnosis of fracture. Thereafter, Petitioner had eight different doctor appointments through May 21, 2018 without any of any mention of right-shoulder complaints or finding of any right-shoulder issues.

Petitioner retained a lawyer and filed his Application for Adjustment of Claim on May 22, 2018 the day after his eighth follow up appointment. In the application, Petitioner cited a right-shoulder injury. Then, at his next appointment on June 11, 2018, which was his first appointment with Dr. Craddock, a Rheumatologist, Petitioner complained of right-shoulder pain for the first time since the visit to the Emergency Department almost seven month earlier. Dr. Craddock noted that Petitioner reported he had chronic pain "all over" for more than 25 years. Dr. Craddock also noted that she was "really unable to discern when his MSK issues change. If at all; the entire hx [Dr. Cradock got] is that his MSK sx are always the same, always there, and he just lives with them." The medical records also indicate that Petitioner was 77 years of age at the time of accident and had a had a history of osteoarthritis. In my opinion, Petitioner proved only that his pre-existing arthritic right-shoulder condition was temporarily exacerbated by the fall, and the exacerbation resolved after the injection at the emergency department.

For the reasons stated above, I concur with the Decision of the Majority on the issue of

causation to a current condition of ill-being of Petitioner's left ring finger, the award of medical incurred for treatment of the ring finger, and the award of PPD for the finger. However, I dissent from the Decision of the Majority in its decision to find Petitioner sustained his burden of proving that he sustained a current condition of ill-being of the right shoulder as a result of the work accident, its award of medical treatment for the shoulder, and the its award of loss of 5% of the person-as-a-whole for Petitioner's right shoulder condition of ill-being.

O-10/8/20
DLS/dw
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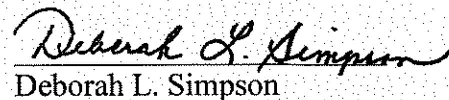


Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0672

STUTZ, WALLACE F Case# **18WC016086**
Employee/Petitioner

TUSCOLA TRUE VALUE HARDWARE INC
Employer/Respondent

On 1/30/2020, 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 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0258 HELLER HOLMES & ASSOC
BRIAN D HOLMES
1101 BROADWAY AVE
MATTOON, IL 61938

0332 LIVINGSTONE MUELLER ET AL
KENNETH BIMA
620 E EDWARDS ST
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS.
COUNTY OF **Champaign**)

- [ ] 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

Wallace F. Stutz
Employee/Petitioner

v.

Tuscola True Value Hardware, Inc.
Employer/Respondent

Case # **18** WC **16086**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Urbana**, on **12/6/19**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **12/7/17**, 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*** 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 $**32,002.76**; the average weekly wage was $**680.91**.

On the date of accident, Petitioner was **77** 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 $**Any** under Section 8(j) of the Act.

ORDER

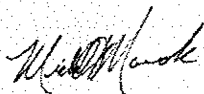
Respondent shall pay reasonable and necessary medical services of $31,403.42, as set forth in Petitioner's exhibits 7-10, as provided in Sections 8(a) and 8.2 of the Act, and shall reimburse Petitioner for $580.00 which he paid for medical expenses out of his own pocket.

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.

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, the Respondent shall pay Petitioner permanent partial disability benefits of $408.55/week for 29.05 weeks, because the injuries sustained caused the 5% loss of the person as a whole (25 weeks), as provided in Section 8(d)2 of the Act and 15% loss of the left ring finger(4.05weeks), 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.



Michael K. Nowak, Arbitrator

1/28/2020
Date

JAN 3 0 2020

BACKGROUND

There are two components to this claim. It is one accident, but there is a component for the Left ring finger and the right shoulder shoulder.

With respect to the left ring finger, the only issues in dispute are average 5 weekly wage and permanent partial disability. With respect to the right shoulder, Respondent also disputes causation, medical and permanency, as well as the average weekly wage issue. However, Respondent's dispute as to medical is only as to liability based on the issue of causation. They do not dispute the reasonableness or necessity of the treatment.

In addition, the parties stipulated that the total medical charges are as follows:

Presence Covenant Medical Center	$17,688.60 (Pet. Ex. 10)
Arrow Ambulance	$ 1,925.00 (Pet's Ex. 7)
Care and treatment at Christie Clinic	$ 5,591.00 (Pet's Ex. 8)
ATI Physical Therapy	$ 6,198.82 (Pet. Ex. 9)

Of the total medical expenses of $31,403.42 the Petitioner has paid $280 to ATI and $300 to Arrow Ambulance out of his pocket.

FINDINGS OF FACT

The parties agree that on December 7, 2017, Petitioner was employed by the Respondent as an installer of air conditioning and heating units, and servicing and maintaining heating and air conditioning units. While on a service call to check on and service the heating and air conditioning system in a building owned by Jim Higgins, owner of Tuscola True Value Hardware, Inc., Petitioner was injured. At about 5:00 p.m. on the date of the accident, while Petitioner was searching in the dark for the light switch, he fell head long down the basement stairs because a door which should have been closed was in fact left open. Petitioner was preparing to go to the basement to check on the status of the heating system in a utility room located there. The stairway had 13 steps. He fell about halfway down the 13 steps, then went off the side of the stairway and landed on the concrete floor. He was not clear whether he blacked out. He found himself on his stomach and remained on the ground for two or three minutes before he tried to get up. After the fall, he felt immediate pain in his left hand and right shoulder. After getting up off the floor, he felt around until he found the light switch, turned the lights on and found his cell phone which had been lost during the fall. He called a fellow employee, J. D. or Jason, for help. Shortly thereafter, Arrow Ambulance arrived and took him to Presence Covenant Medical Center in Urbana.

The Arrow Medical Services narrative states that the Petitioner "had fallen down 7-8 steps and then rolled off of those steps and fallen approx. 5 feet to a concrete ground. . . The pt stated that he was having pain in his right shoulder, right side, right hip, and right buttock. The pt stated that he was also having pain in his left ring finger that had a minor deformity." (Pet. Ex. 3).

David F. Kavanaugh, D.O., the E.R. physician, recorded a similar history and states, "Following the fall, he developed right thigh pain, right shoulder pain, and left ring finger pain. His pain is exacerbated with movement." The immediate medical treatment was focused on the deformed left ring finger which had "an

obvious deformity." The x-ray of the left hand disclosed a fracture of the base of the middle phalanx of the fourth finger with degenerative changes noted in the wrist joint. (Pet. Ex. 3). The finger was splinted and he was given a shot. An x-ray of the right shoulder failed to reveal a fracture or dislocation. A CT scan of the brain was unremarkable. X-rays of the femur and hip did not reveal any fracture or dislocation. The physician's impression was "possible soft issue injury in the anterior abdominal and pelvic wall. No definite solid organ or hollow organ injury is noted in the abdomen and pelvis." The comments stated "Fracture, contusion, sprain."

Petitioner was off work on December 8, a Friday, and the following Monday, December 11. He followed up with his primary care treaters at Christie Clinic. Sami Zabaneh, M.D., saw the Petitioner on 12/8/17. Dr. Zabaneh noted in the "history of present illness" that Petitioner had neck stiffness, tingling, numbness in the arms, the legs. No CT scan of the neck was done. He is not complaining of anything other than the pain in the right hip. The only thing that was abnormal is that he broke his fourth finger. It's immobilized. Is seeing orthopedic soon." (Pet. Ex. 4). On examination, he had tenderness over the fourth digit of the left hand.

Subsequent visits were with a physician assistant, Ryan T. Snowden, whose focus was on follow-up care of the finger fracture. On the 12/11/17 visit, the history included swelling and redness about the left fourth finger and decreased range of motion. The treater described the injury as a closed displaced fracture of the middle phalanx of the left ring finger. Snowden decided to buddy tape the finger over the next two weeks and then do a repeat x-ray.

Petitioner was seen again on 12/27/17. Petitioner continues to have pain and swelling of the fourth finger and decreased range of motion. Snowden ordered a repeat x-ray of the left fourth finger. The x-ray report showed "increased endosteal callus formation at the cortical avulsion fracture dorsally off the base of the middle phalanx with associated soft tissue swelling. Dorsal displacement of the distal fragment is unchanged." Moderate osteoarthritis was again noted. (Pet. Ex. 4). Based on these findings, Snowden directed Petitioner to buddy tape the finger for another three weeks.

On 1/17/18, Petitioner reported his symptoms are the same as at his previous visit. He is still unable to bend the finger. Snowden continued with conservative treatment, directing the Petitioner to protect and buddy tape the fingers. Petitioner was to work on gentle range of motion. He also provided a sample of Pennsaid cream to apply topically to the finger as needed.

On the recheck of the left fourth finger on 2/7/2018, again Petitioner stated he is unable to bend the finger, has swelling, and continues to experience pain about the finger. The P.A. recommended that Petitioner be referred to an orthopedic surgeon for further evaluation of the fracture, but "the patient is not interested in seeing an orthopedic surgeon at this time." (Pet. Ex.4). At the hearing, Petitioner confirmed that, stating that he would not undergo any surgery on the finger even if it was recommended as he does not want to undergo a surgical procedure.

Petitioner testified that Snowden treated him for his finger. During cross examination, he stated that the P.A. did not bring up any issue about the shoulder. He was sent to Snowden for the finger, and the P.A. did not ask him about the right shoulder. He also testified that initially he had hoped the shoulder would get better on its own.

Petitioner noticed that he continued to have right shoulder pain and that he was not getting the strength back in the shoulder. He could not raise the right arm above the level of his chest, and the requirements of his job include overhead work. He was seen on 6/11/18 by Ruth A. Craddock, M.D. at Christie Clinic. (Pet. Ex. 5) Petitioner described the fall of 12/7/17 where he hurt his right shoulder and that it has hurt ever since. The shoulder did not hurt before the fall. He noted that his right shoulder was x-rayed when he fell in December, but Dr. Craddock was not able to find a right shoulder x-ray. The Presence Covenant records of the E.R. visit, however, contains an x-ray report of the right shoulder dated 12/8/17. (Pet. Ex. 3). Dr. Craddock ordered a shoulder x-ray which was negative for fracture or dislocation. It did disclose moderate AC joint arthritis. (Pet. Ex. 5) Dr. Craddock's office note is incomplete because it does not mention referral to physical therapy. However, the ATI Physical Therapy records contain a prescription for physical therapy on the right shoulder, signed by Dr. Craddock. (Pet. Ex. 6)

The intake assessment of ATI states that the Petitioner has signs and symptoms consistent with the physician's diagnosis of a right impingement syndrome and right shoulder pain. (Pet. Ex. 6) On the initial evaluation, Petitioner was found to have decreased range of motion, strength, joint mobility, soft tissue mobility and increased pain as well as impairments with posture. Under nature of injury, the Petitioner reported that he had an accident on 12/7/17 when he fell down a flight of 17 steps and stated he fell onto the right shoulder when first landing before tumbling down and then off the stairs. He was taken to the hospital and received multiple x-rays of the right shoulder which were negative per report. He described a fracture of his fourth digit of the left hand in the fall. He received a referral for PT as he is having more issues moving his right upper extremity. He also noted that he has to lift constantly at work and the weight varies from one pound to 250 pounds. He reported current limitations with dressing, donning-doffing shirts, coats, lifting overhead, overhead tasks, physical activities required for work tasks, pulling and pushing tasks. His prior level of function was unlimited with all activities. At rest he reports pain of 2 over 10 but during activity it is 8 over 10 with functional activities of lifting overhead with discomfort or constant pain.

Petitioner received 13 sessions of physical therapy from 7/6/18 through 8/2/18 which included exercises, hot pack and cold pack, ultrasound and electrical stimulation. The physical therapy, however, did not restore him to his pre-injury condition. In the discharge summary of 8/2/18 it states that Petitioner has made objective improvements with ROM, joint mobility, strength, and soft tissue mobility. However, Petitioner continues to present with impairments involving ROM, soft tissue mobility, strength, posture, pain, and joint mobility. This limits his ability to perform the following tasks: dressing, donning/doffing shirts, coats, lifting overhead, overhead tasks, physical activities required for work tasks, pulling/pushing tasks. He has less pain but no significant change with his ADL's except for hair care. "He experienced a flare up in symptoms yesterday at work with heaving resisted pulling tasks for changing out gas lines. He continues to have limitations with ABD and AROM but increased pain present with all AROM directions this date and MMT that were not previously present. Patient has reached maximum benefit from therapy and will benefit from referral to orthopedic specialist for further intervention." (Pet. Ex. 6).

As of the hearing date, Petitioner still has pain in that finger, he cannot bend the finger. He cannot bring the finger down to touch the palm of his hand. He cannot snip with the left hand and has difficulty handling things. He cannot even feel with that left finger such as trying to pick up a dime from the floor. He has trouble opening jars and holding a coffee mug using the left hand. He hardly has any strength in the left hand compared to the right hand. It is just entirely different than his right hand.

Petitioner further testified that he does not have near as much strength in his right shoulder as before the injury. The pain is tolerable and lasts for seconds when he has pain. He is very leery when he has to do work using both arms with his shoulders because of the weakness in his right shoulder. He has tried ice and heat on the shoulder but that does not help him. He takes Tylenol and Ibuprofen for pain management. He reiterated that he does not want any surgery on his shoulder even if it were to be recommended.

CONCLUSIONS

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

Respondent claims that the complaints concerning the right shoulder are not related to the accident of 12/7/17. The greater weight of the evidence establishes otherwise. Even though Petitioner had pre-existing arthritis, he did not have pain or any limitations of the right shoulder prior to the date of injury. It is reasonable to infer that a fall down and off a stairway onto the concrete ground, sufficient to cause an avulsion fracture to the left ring finger, was also sufficient to injure the right shoulder. Complaints of pain in the right shoulder were recorded by the paramedics of Arrow Ambulance and by the ER physician. When it became apparent to Petitioner that the pain and limitations in the use of the shoulder were not going to get better, he sought and obtained care and treatment for the injury to the right shoulder.

It is not lost on the Arbitrator that Petitioner saw a number of doctors between the date of accident and 6/11/18 when he was seen by Ruth A. Craddock without their records noting shoulder complaints however, the Arbitrator notes that while physician assistant, Ryan T. Snowden did not note complaints regarding the right shoulder both he and Petitioner were well aware that he was treating Petitioner's fractured finger. Likewise doctors who saw Petitioner for matters such as diabetes follow ups understandably did not note any orthopedic issues.

The Petitioner had not received any treatment or had any complaints with his right shoulder until the accident. Right shoulder complaints were noted immediately after the accident. Further Petitioner credibly testified that despite his hope to the contrary, his shoulder symptoms did not abate, and he finally saw Dr. Craddock.

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

Issue (G): What were Petitioner's earnings?

Petitioner testified that he essentially worked on his own once Respondent referred him a client in need of heating and/or cooling services. Petitioner testified that he did not always work 40 hours per week and that overtime hours were not mandatory. Petitioner testified that at the time of the incident he was earning $17.00 an hour and he had earned that rate for a long time. The only other evidence offered regarding this issue was Petitioner's wage records as reflected in RX2. The wage records reflect time periods from 12/07/16 – 12/08/17. Petitioner's overtime hours were not mandatory therefore they are excluded from the average weekly wage calculation.

At the time of hearing Respondent claimed Petitioner's average weekly wage was $657.70. AX1. In their proposed decision Respondent claimed the correct average weekly wage was $615.44.

The Arbitrator notes that the documents contained in RX2 are inconsistent with one another.

The wage statement work sheet indicates that Petitioner earned $28,938.76 over 44 weeks actually worked for an average weekly wage of $657.70. RX2, p.1.

The wage statement Form indicates Petitioner's total earnings were $32,002.76. RX2, p.3. Respondent's proposed decision claim of an AWW of $615.44 is arrived at by dividing the earnings shown in RX2 by a full 52 weeks. The Arbitrator finds that this calculation method ignores the portion of section 10 of the Act which indicates that if an employee misses 5 or more calendar days in the 52 weeks preceding the accident the total earnings are to be calculated based upon the number of weeks and parts thereof actually worked. Section 10 provides, in pertinent part:

> ...but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted....

The Arbitrator finds that based upon RX2, p.3 the Petitioner's regular earnings during the 52 weeks preceding the accident totaled $32,002.76. It is also clear from the wage statement form that Petitioner missed 25 work days during this period. The Petitioner ordinarily worked a 40 hour work week. Therefore, the total amount of the time missed is the equivalent of 5 work weeks. Therefore, the proper average weekly wage is arrived at by dividing the total earnings of $32.002.76 by 47 weeks (52 -5) for an average weekly wage of $680.91.

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

Respondent did not dispute the reasonableness and necessity of the medical care Petitioner received. Rather Respondent only disputed its liability for the medical expenses related to the right shoulder based on issue F above. Having found in favor of Petitioner with regard to this issue, the Arbitrator finds that Respondent is responsible for all medical expenses as a result of this accident.

Respondent shall pay reasonable and necessary medical services of $31,403.42, as set forth in Petitioner's exhibits 7-10, as provided in Sections 8(a) and 8.2 of the Act, and shall reimburse Petitioner for $580.00 which he paid for medical expenses out of his own pocket. 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 (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's job title is as a heating and air conditioning installer and service contractor which involves taxing lifting and heavy labor as described by the Petitioner. Petitioner testified that he has been at this job for 21 or 22 years and that he works full-time five days a week. Petitioner is required to use his left hand and finger in installing and servicing heating and air conditioning units. He has difficulty performing his job due to the fact that the left finger does not bend and does not have feeling. Holding out the left hand at the arbitration hearing, the knuckle of the left ring finger was noticeably larger than the knuckles on the other fingers of his hand, and in demonstrating the use of the hand, he could not bend the distal portion of the left finger and could not touch his palm with the tip of the finger. He continues to have pain but he noted that he does not complain unless he absolutely has to. Further, the injury has impaired the Petitioner's use of the right shoulder in his occupation. He cannot do overhead work with the right arm, unlike before the injury when he had no limitations. His job involves heavy labor in connection with the installation of heating and air conditioning equipment. According to Petitioner, he does not have nearly as much strength in the right arm and shoulder and he is very leery of doing any labor involving the use of both shoulders. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 77 years of age at the time of the injury. Petitioner is still working full-time. Petitioner's job is physical in nature. Further, an injury sustained by an elderly employee will impact that employee much greater than a younger person. 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. Petitioner was released from care for the left finger on February 7, 2018 when he declined referral to an orthopedic surgeon for further evaluation of the fracture. As for the right shoulder, the last date of treatment was August 2, 2018, his last physical therapy session. (Pet. Ex. 6).

With regard to the left ring finger, Petitioner cannot bend the distal portion of the finger and cannot touch the finger to his palm. The knuckle is visibly larger than the other knuckles on his left hand. He cannot use snips, does not have the strength in his left hand he had before and continues to have pain although it is tolerable. He cannot grip the way he normally does and cannot do fine tasks such as picking up a dime from the ground. He has difficulty holding a coffee cup in the left hand due to weakness and the limitation in movement of the left ring finger.

Regarding the right shoulder, he does not have nearly the same amount of strength as he does in the left shoulder. He does not do overhead work due to the pain and limitation of movement, not being able to get his left arm above approximately shoulder level. He continues to have pain and takes Tylenol and Ibuprofen.

The physical therapy notes upon discharge state that Petitioner continues to have significant changes with ADL's such as dressing, donning/doffing shirts, coats, lifting overhead, overhead tasks and pushing and pulling tasks as work. (Pet. Ex. 6). Petitioner testified that he does not have these problems with his left shoulder. 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 left ring finger pursuant to §8(e) of the Act and 5% loss of use of the person as a whole as a result of his shoulder injuries pursuant to §8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $408.55/week for 29.05 weeks, because the injuries sustained caused the 5% loss of the person as a whole (25 weeks), as provided in Section 8(d)2 of the Act and 15% loss of the left ring finger(4.05weeks), as provided in Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SAAD AL-AZZAWI,

Petitioner,

20 IWCC0673

vs.

NO: 17 WC 04734

WALMART,

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 medical expenses, causal connection, temporary total disability, and permanent partial disability, and being advised of the facts and law, affirms the Decision of the Arbitrator, with exception of the Page 8, paragraph 4 under Section (F) of the order.

The Commission having reviewed the evidence in its entirety disagrees with the commentary expressed by the Arbitrator at Page 8, paragraph 4 under Section (F) of the Decision and hereby strikes the afore-mentioned language, and otherwise affirms and adopts the remainder of the Decision filed June 5, 2019.

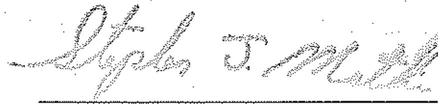
IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 5, 2019 is hereby affirmed with the exception of the Arbitrator's commentary at paragraph 4, page 8, under Section (F), which is hereby stricken from the Decision.

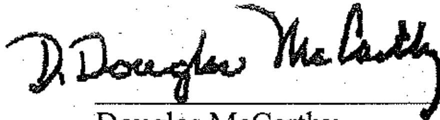
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

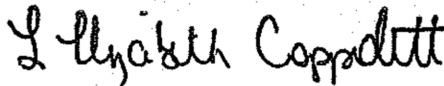
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: NOV 19 2020
o-10/7/2020
SM/msb
44


Stephen Mathis


Douglas McCarthy


L. Elizabeth.Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AL-AZZAWI, SAAD
Employee/Petitioner

Case# **17WC004734**

WALMART INC
Employer/Respondent

20IWCC0673

On 6/5/2019, 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 2.25% 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:

4340 EFTEKHARI LAW OFFICES LLC
EHSAN EFTEKHARI
701 MAIN ST SUITE 203
EVANSTON, IL 60202

5074 QUINTAIROS PRIETO WOOD & BOYER
JULIE M SCHUM
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

20IWCC0673

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

Saad Al-Azzawi
Employee/Petitioner

Case # **17** WC **04734**

v.

Walmart, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, 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. [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 ______

<u>*S. Al-Azzawi v. Walmart, Inc.*</u>, 17 WC 04734

20IWCC0673

FINDINGS

On **10/28/2016**, 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, in part,*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**7,540.00**; the average weekly wage was $**145.00**.

On the date of accident, Petitioner was **57** 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.

To date, Respondent has paid $**5,720.00** in TTD and/or for maintenance benefits, and is entitled to a credit for all amounts paid.

Respondent is entitled to a credit of $**810.17** under Section 8(j) of the Act, per the agreement of the Parties.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $145.00 per week for 28-5/7 weeks, commencing October 29, 2016 through May 17, 2017, as provided in Section 8(b) of the Act.

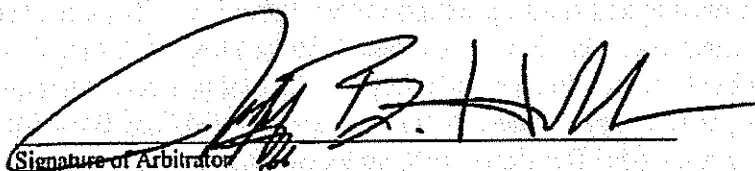
Respondent shall pay reasonable and necessary medical services of $5,149.84, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner permanent partial disability benefits of $145.00 per week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 10/28/2016 through 12/7/2018, 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

<u>**June 4, 2019**</u>
Date

JUN 5 - 2019

FINDINGS OF FACT

Petitioner testified via an Arabic/English translator.

While the Parties stipulated that Petitioner was 57 years old on the accident date of 10/28/2016, the medical records reflect a date of birth of 8/1/1969 (ArbX 1), making him 47 years old at the time.

Petitioner began working for Respondent in May of 2014. His job duties included receiving full boxes of product, unpacking them and putting items on shelves. He worked part time at this job.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 28, 2016. Petitioner was stocking cleaning supplies. Some of the boxes were big and heavy. "...I was just carrying one of the boxes. I didn't feel anything, and I just fell on the ground. I had severe pain in my back. I could not even stand on my leg because it was shaking a lot." Petitioner's manager was present at the time and an ambulance was called.

Petitioner was transported to Northwest Community Hospital. The paramedic notes state that a translator was utilized. The handwritten history was "pt was moving boxes and felt pain in lower back...radiate to mid back, 7/10 pain." The typed narrative states the patient strained his back while lifting a box at work. The box was filled with laundry detergent tubs and weighed 40 pounds. The patient did not fall. The patient denied a prior back history. The pain was 7/10 and radiated to the lower mid back. (PX B)

At Northwest Community Hospital, the history was provided by the patient and his friend, "a language interpreter was used." Petitioner complained of an acute onset of low back pain that radiated to the bilateral lower back and legs. The RN's note says no radiation to the legs. The pain was sharp and it hurt to twist and bend. Petitioner reported that he had experienced a similar problem a year ago, after heavy lifting. On examination, Petitioner exhibited normal range of motion, no neuro deficits and paralumbar tenderness. X-rays of the lumbar spine revealed no abnormal findings and were unremarkable for his age. Petitioner was given a Toradol injection, along with injections of Dilaudid, Zofran and Valium. The diagnosis was low acute back pain. Follow up instructions are not well documented. It does not appear that an off-work slip was given. (PX B)

Petitioner testified that prior to October 28, 2016, he had not sustained any back injuries. On cross-examination, Petitioner testified that the emergency room medical record, noting he had prior back injuries, specifically the year before his alleged accident, was incorrect.

Petitioner testified that he has been off work since the accident. He was paid TTD for 8 months. RX 1b shows that TTD was paid from 10/29/2016 to 6/5/2017 (total paid: $5,720.00).

Petitioner was next seen for treatment by Dr. Najat George of Medical Health Clinic on October 29, 2016. Petitioner reported back pain with numbness and tingling of the lower extremity. "Patient presents for follow up for back pain with numbness and tingling of LE. He denies recent ER or Hospital visits, denies any red flag sign and symptoms. Without any recent fall, trauma, or accident." On exam, Petitioner exhibited pain and tenderness with range of motion. His general appearance was said to be abnormal. The Back/Musc-Skeletal and neuro exams were normal. Dr. George diagnosed Petitioner with acute or chronic back pain with radiculopathy, numbness and tingling of the lower extremity. Petitioner was referred for physical therapy, Ibuprofen was

refilled, muscle relaxer was prescribed as needed and the patient was instructed to monitor for the development of new neurological symptoms and was to follow-up as needed. There is no mention of any instruction regarding work status. There is no mention of any injury at work. (PX D)

On November 5, 2016, Petitioner again presented for a follow-up with Dr. George for chronic back pain and numbness and tingling of the lower extremities. Petitioner again denied recent ER or Hospital admission, recent trauma, fall or accident. He denied "any red flag signs or symptoms." The physical exam was unchanged, including an abnormal general appearance. Petitioner was again diagnosed with acute or chronic back pain with radiculopathy, numbness, and tingling of the lower extremities. The instructions remained the same, including no mention regarding work status. (PX D)

On cross examination, Petitioner disputed the accuracy of Dr. George's November 5 chart saying "denied recent ER or Hospital admission, recent trauma, fall or accident." Petitioner said that he did tell Dr. George of his work accident (something that is not reflected in PX D).

Subsequently, Petitioner followed-up with Dr. George on November 14, 2016 and on November 19, 2016. The November 19 chart is the first where it is indicated that the Back/Musc-Skeletal exam was abnormal. General appearance was still noted to be abnormal. The diagnosis and treatment plan remained the same. Petitioner was advised to follow-up as needed. (PX D)

An MRI of Petitioner's lumbar spine, ordered by Dr. Elias, was performed on December 1, 2016. There were many degenerative changes noted. The study was interpreted to show mild to moderate spinal stenosis at L4-5 and mild spinal stenosis at L1-2 and L3-4. Bulging discs were seen at L1-2, L3-4, L4-5 and L5-S1. An osteophyte and mild left foraminal narrowing at L5-S1 was noted. Dr. Elias' involvement in this case was not explained. (PX F)

Petitioner began treatment with Dr. Neema Bayran of the Pain Institute of Illinois on December 30, 2016. Petitioner reported low back pain, with radiation into the post-lateral aspect of his right thigh, down into his right foot. He complained of numbness and tingling into his right toes. The history was that on October 20, 8016, he injured his back at work, while putting goods on the shelves. Specifically, Petitioner advised he was lifting a box that weighted approximately 30-40 pounds when he was injured. The physical exam was largely benign, with slightly decreased range of motion, no tenderness over the midline or over the paraspinal muscles bilaterally, good strength and reflexes, some decreased sensation on the right in the L5 dermatome, positive SLR on the right, negative on the left. Dr. Bayran referred Petitioner for physical therapy and advised that Petitioner should remain off of work. (PX H)

Subsequently, on February 10, 2017, Petitioner presented to Dr. Bayran for a follow-up appointment. Petitioner advised he had pain in his lower back, with radiation into his legs bilaterally. Furthermore, he reported occasional numbness in his right leg and toe. During this visit, Petitioner confirmed he had yet to start physical therapy. Examination of Petitioner revealed there was no tenderness over the midline or over the paraspinal muscles bilaterally. Petitioner was diagnosed with radiculopathy of the lumbar region. Dr. Bayran recommended Petitioner begin physical therapy and return to work with the following restrictions: no lifting, pulling, or pushing, more than 10 pounds and with frequent 15 minute breaks every two hours. (PX H)

According to Petitioner, he tried to return to work 4 times, but he could not work.

Petitioner then presented for followed-up with Dr. George on February 13, 2017. Petitioner reported continued back pain. Examination of Petitioner's back revealed pain and tenderness with range of motion. Dr. George

diagnosed Petitioner with tingling and numbness of the lower extremities and acute back pain. Petitioner was advised to continue with physical therapy. (PX D)

On March 17, 2017, Petitioner presented to Dr. Bayran for a follow-up appointment. Petitioner reported continued back pain with radiation into his legs bilaterally. Petitioner advised that he has found a light duty job. Petitioner was diagnosed with radiculopathy of the lumbar region. Petitioner was advised he may return to work with the following restrictions: no lifting, pulling, or pushing more than 10 pounds and with frequent 15 minute breaks every two hours. (PX. H)

On March 25, 2017, Petitioner was again seen by Dr. George for chronic back pain. Dr. George reaffirmed his prior diagnosis of chronic back pain and numbness and tingling of the lower extremities. (PX D)

At trial, surveillance video of the Petitioner at Respondent's store on March 26, 2017, at approximately 7:08 a.m., was shown. Petitioner is seen entering an employee room, removing his jacket, and exiting the room. Petitioner does not exhibit difficulty removing his coat or demonstrate signs of pain. (RX 2) Petitioner testified on Re-Direct that he was "controlling himself" when he was inside the room, although he said that he reached out to his back. When he was outside the room, he had pain in his back and leg. "So I was trying to work. Maybe I was unable to work." He had difficulty lifting from the ground.

Trial testimony establishes that other video was available to the Parties. Dr. Mather's deposition establishes that there was more video taken on March 26, 2017, but it was not submitted at trial. (RX 3)

Petitioner was seen by Dr. Bayran on March 28, 2017. Petitioner reported that on March 25, 2017, he was only able to work four hours. Dr. Bayran recommended that Petitioner remain off of work. (PX H).

On April 18, 2017, Petitioner presented to Dr. Salehi of Neurological Surgery & Spine Surgery. Petitioner reported while he was taking boxes off of a pallet, he felt intense pain in his low back, which caused him to fall to the ground. Examination of Petitioner's back revealed lumbar spinal tenderness to palpation. Range of motion was decreased. SLR was positive on the right for back pain and negative on the left. Gait was said to be a little slow. No spasm was noted. Strength was normal, except for right psoas and quads, which were 4+/5. Decreased sensation in a non-dermatomal pattern was noted in the RLE. DTR's were normal bilaterally. Dr. Salehi reviewed the MRI and thought that it showed 4 level disc disease, except for L2-3, without height loss; circumferential disc bulges at 3 levels; centrally herniated disc without neural compression at L1-L2; and no significant foraminal stenosis at any level. Facet arthropathy was seen at L4-5 and L5-S1. Petitioner was diagnosed with degenerative disc disease of the lumbar spine and lumbosacral spondylosis, rendered symptomatic by his alleged back injury. Dr. Salehi advised that he does not recommend either a fusion or decompression for Petitioner. He recommends Petitioner undergo a 1-2 bilateral L4-5 and L5-S1 facet injection. Dr. Salehi advised that should Petitioner's pain persist, despite the injection, he may benefit from a trial spinal cord stimulator but did not recommend it at that time. Petitioner was advised he may follow-up with Dr. Salehi as needed. (PX L)

Petitioner returned to Dr. Bayran on April 28, 2017 and reported that he continued with low back pain, that radiated to his legs bilaterally, which was worse on the right side. Dr. Bayran recommended thatPetitioner undergo a medial branch block injection at L3, L4, and L5 and advised Petitioner to remain off of work. (PX H)

Petitioner was seen by Dr. Steven Mather, an orthopedic surgeon, on May 17, 2017, for an Independent Medical Exam. (RX 4) Dr. Mather noted that Petitioner had very diffuse complaints of pain and several positive Waddell signs. For instance, Petitioner had pain with axial compression, pain with simulated axial rotation, and

severely limited range of motion of the lumbar spine, not noted by other treating physicians, and pain complains with supine straight leg raises. Dr. Mather opined that Petitioner's MRI was essentially normal, with a slight disk bulge at L1-L2 and a very minor disk degeneration at L5-S1, which Dr. Mather noted were age appropriate findings. The history was of an onset of back pain secondary to lifting 80 to 90 pound boxes. Petitioner complained of low back pain up into the thoracic spine and into the lower extremities. Dr. Mather noted that Petitioner's subjective complaints failed to correlate with the physical exam or MRI study, which were said to be benign. Petitioner exhibited pain behaviors. He had tenderness from T9 down, which was diffuse and not well localized. There were other nonphysiologic complaints and nonorganic signs demonstrated. Dr. Mather opined that Petitioner did not require injections, since he did not meet the criteria specified by American Pain Society Guidelines of 2009. The diagnosis was: 1.) Thoracolumbar strain, resolved; 2.) Psychogenic pain/functional overlay. Dr. Mather noted that Petitioner had reached maximum medical improvement and required no further treatment or diagnostic testing. Petitioner was capable of returning to work without restrictions. An AMA Impairment Rating was performed and Dr. Mather determined that Petitioner had 0% whole person impairment. (RX 4)

Petitioner did not return to work, and he continued with the palliative care provided by Drs. George and Bayran.

Petitioner saw Dr. Bayran on June 30, 2017, alleging lower and upper back pain, along with pain in both of his legs. Dr. Bayran diagnosed Petitioner with lumbar spondylosis, secondary to disc protrusion at L4-5 and L5-S1/Spondylolisthesis at L3-4. (PX H)

On July 8, 2017, Petitioner followed up with Dr. George and reported chronic back pain. Dr. George diagnosed Petitioner with chronic back pain with radiculopathy, numbness and tingling of the lower extremities.
Petitioner was seen by Dr. George on July 15, 2017. (Px. D). He reported chronic back pain with radiculopathy. Dr. George diagnosed Petitioner with chronic back pain with radiculopathy, numbness and tingling of the lower extremities, and weakness of the lower extremities. (PX D)

At his August 8, 2017, follow-up with Dr. Bayran, Petitioner continued to complain of low back and leg pain. Petitioner was advised to remain off of work. (PX H)

Petitioner was seen by Dr. Bayran, and he continued to report low back pain. Dr. Bayran referred Petitioner for an intra-articular facet joint injection at L4-5 and L5-S1 bilaterally and advised him to remain off of work. (PX H)

On September 15, 2017, Bayran preformed an intra-articular facet joint injection at L4-5 and L5-S1. (PX Q)

Petitioner continued treating with Dr. Bayran on September 29, 2017 and reported low back pain, stating the injection only provided relief for two days. Dr. Bayran referred Petitioner see Dr. Salehi for further treatment recommendations and advised Petitioner should remain off of work. (PX H)

At his follow-up appointment with Dr. Bayran, Petitioner reported low back pain and was again advised to seek treatment with Dr. Salehi and remain off of work. (PX H)

Petitioner presented to Dr. Bayran on December 12, 2017 and continued to report low back pain, though he advised he was working part time. Apparently, Petitioner was seen by Dr. Salehi in November of 2017, although there is no other mention of this in evidence. He reported that, per his visit with Dr. Salehi, Petitioner was not a candidate for surgery, but Salehi recommended the spinal cord stimulator. Dr. Bayran recommended

Petitioner undergo a trial for the spinal cord stimulator and that he could work part-time. This was the last visit with Dr. Bayran. (PX H)

Petitioner testified on cross examination that he has not worked for any other employer since October of 2016.. However, he then admitted that he was in fact working part-time, as indicated by the December 12, 2017 medical record.

On January 1, 2018, Petitioner followed-up with Dr. George. Petitioner reported chronic back pain and worsening weakness of both lower extremities. Petitioner was diagnosed with chronic back pain with radiculopathy, tingling, and weakness of lower extremities. He continued treating with Dr. George for back pain, along with numbness and tingling of the lower extremities, on April 4, 2018. Dr. George diagnosed Petitioner with acute chronic back pain with radiculopathy and numbness and tingling of the lower extremities. (Petitioner presented to Dr. George for an additional time on April 7, 2018 He reported continued back pain, numbness and tingling of his extremities and there were no significant changes since his last visit. He was diagnosed with continued back pain and tingling and numbness. The last visit with Dr. George was on April 28, 2018. The diagnosis and treatment plan remained the same. Petitioner continued on 600mg Ibuprofen Q8hr and muscle relaxers, prn. He was to monitor for neurologic changes and follow up as needed. (PX D)

The Parties took the Evidence Deposition of Dr. Mather on November 2, 2017. (RX 3) Dr. Mather is a board certified orthopedic surgeon. 99% of his treatment practice deals with the adult spine. He testified consistent with his report. Petitioner demonstrated an inconsistent SLR response. He had diffuse tenderness. There was actually 5/5 Waddell's. There was no sign of any nerve impingement. Petitioner had a lumbar strain as a result of the 10/28/2016 event. It has resolved. Petitioner is at MMI. He needs no more treatment. He can return to work at full duty. The treatment to the time of the May 17, 2017 exam was reasonable and necessary. A diagnosis of radiculopathy requires that the clinical exam correlates with the imaging and subjective complaints. Here they don't line up. Cross examination of Dr. Mather failed to lessen the impact of his opinions. (RX 3)

CONCLUSIONS OF LAW

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

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 the 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)

20 I W C C 0 6 7 3

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

Petitioner's current condition of ill-being regarding his low back (to wit: resolved lumbar strain, resolved and at MMI as of May 17, 2017, per Dr. Mather) is causally related to the injury. Any other condition of Petitioner's low back is not causally related to the injury.

The Arbitrator bases this finding on the credible and persuasive opinions of Dr. Mather and the medical records.

The treating records and Petitioner's testimony do not support his claim.

First, the records of Dr. George certainly support an inference that Petitioner had been seen by Dr. George in the past for back pain ("...presents for follow up for back pain with numbness and tingling of the LE."). Follow up implies prior treatment for that condition. One may argue that the chart reflects follow up post the ER visit of the day before, but one would be wrong because Dr. George charted "(h)e denies recent ER or Hospital visits". Dr. George's notes of October 29, 2016 do not reflect any history of a work injury and an ER visit the day before. Petitioner denied that he had prior back problems and testified that he told Dr. George about his work injury. Based upon the Arbitrator's review of Dr. George's records, this testimony is not believed.

The Arbitrator believes that Petitioner did exhibit the inconsistent, nonphysiologic and nonorganic complaints, symptoms and examination that was documented by Dr. Mather. If the IME reveals psychogenic or functional overlay etiology for the patient's complaints and alleged disability, the complaints and alleged disability are not related to the work accident. Further, Petitioner's credibility is called into question as well.

The Arbitrator is also troubled by the December 1, 2016 MRI order. Who is Dr. Elias, and how did he come to order an expensive study for Petitioner?

The evidence adduced does not support a finding beyond causation to a lumbar strain that had resolved and was at MMI by May 17, 2017.

(J) Medical expenses

Based on the opinions of Dr. Mather, Petitioner is awarded medical expenses through May 17, 2017. All other claimed expenses are denied as not being causally related and not reasonable and necessary to cure or relieve the effects of the injuries.

The following bills are awarded:

Medical Health Clinic (Dr. N. George): (DOS: 11/29/16-3/25/17)	**$2,870.00**
NorthShore University Health Sys.: (DOS: 12/1/2016 – MRI)	**311.84 -****
Pain Center of Illinois (Dr. N. Bayran): (DOS: 12/30/16-4/28/2017)	**1,443.00**
Neurological Surgery and Spine Surgery (Dr. S. Salehi): (DOS: $/18/2017)	**525.00**
TOTAL:	**$5,149.84**

**- The bills were paid by Public Aid and this represents the negotiated rate for these bills, under *Perez v Illinois Workers Compensation Commission.* 2018 IL App. (2d) 170086WC

The bills from ATI and Northwest Community Hospital were paid by workers' comp. The bills from Prescription Partners, Ashland Medical and Illinois Back and Neck Institute are denied on the basis of the Arbitrator's finding regarding the issue of causation, above.

The awarded bills are pursuant to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills that it has paid and is entitled to reductions in the awarded amounts pursuant to the Fee Schedule and any negotiated rate.

(K) TTD

The TTD rate is $145.00/week, pursuant to §8(b)1.

TTD is awarded for the time period of 10/29/2016 through May 17, 2017 (28-5/7 weeks), based upon RX 1 b and the opinions of Dr. Mather.

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

Section 8.1(b) of the Act sets forth five factors which constitute the basis for the Commission's determination of the permanent partial disability level. Those factors are as follows:

1. The purported level of impairment;
2. The occupation of the injured employee;
3. The age of the employee at the time of the injury;
4. The employee's future earnings capacity; and
5. Evidence of disability corroborated by the treating medical records.

Impairment Rating

Respondent submitted the impairment rating calculation of Dr. Mather into evidence. Dr. Mather determined 0% whole person impairment. This factor is given great weight in determining PPD.

Occupation

Petitioner was employed as a part time stock person at the time of the accident. Per Dr. Mather, he is able to return to work at full duty. The Arbitrator places some weight on this factor in determining PPD.

Age

Petitioner was 47 years old at the time of the work accident on October 28, 2016. Given the fact that Petitioner likely has almost 15 years of work life (albeit working part time?) until retirement, with a resolved back strain condition, the Arbitrator places some weight on this factor in determining PPD.

Future Earnings Capacity

The record shows Petitioner's future earning capacity as a part time stock person has not been legitimately affected by his back injury. Per Dr. Mather, the injury does not appear to have had a detrimental effect on Petitioner's earning capacity. This factor is given some weight in determining PPD.

Evidence of Disability Corroborated by Treating Records

Based upon the Arbitrator's finding on causation and MMI, the treating medical records do not support any residuals from the injury, other than a resolved back strain. Minimal weight is placed on this factor in determining PPD.

Based on the review of all of the above factors and considering the Record as a whole, the Arbitrator finds that the injuries sustained caused Petitioner to suffer the 5% loss use of the person as a whole, as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF MADISON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Herman Berkemann,

Petitioner,

vs. Nos. 17 WC 29862
18 WC 16106

Beelman Ready Mix,

Respondent.

20 IWCC0674

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

The Commission agrees with the Arbitrator that the work-related left knee and leg condition precludes Petitioner from returning to his regular job as a cement truck driver for Respondent on a daily, full-time basis. Petitioner has been conducting a diligent job search, and in September of 2019 he started a formal vocational rehabilitation program with England & Company Rehabilitation Services. The Commission finds that vocational rehabilitation should continue.

The Commission notes the Arbitrator's award of maintenance benefits actually encompasses periods of temporary total disability and maintenance. The parties stipulated that Respondent paid all temporary total disability benefits through July 8, 2019. The Commission finds Petitioner reached maximum medical improvement on July 24, 2019, and accordingly extends the period of temporary total disability through that date. The Commission awards maintenance benefits from July 25, 2019 through the conclusion of the arbitration hearing on December 13, 2019.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 3, 2020, 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 $532.65 per week for a period of 2 2/7 weeks, from July 9, 2019 through July 24, 2019, 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 compensation, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner maintenance benefits of $532.65 per week for a further period of 20 2/7 weeks, from July 25, 2019 through December 13, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence pursuant to §§8(a) and 8.2 of the Act and subject to appropriate credit. To the extent Respondent claims §8(j) credit, Respondent shall indemnify and hold Petitioner harmless from claims by any providers of the services for which Respondent claims the credit.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide vocational rehabilitation to Petitioner.

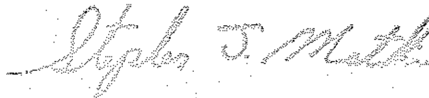
IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written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

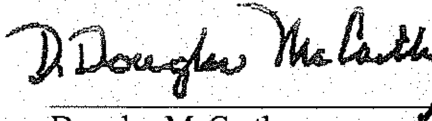
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

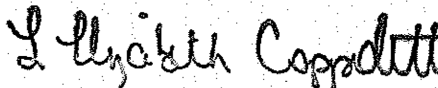
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,000.00. 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: NOV 19 2020
o-10/20/2020
SM/sk
44


Stephen Mathis


Douglas McCarthy


L. Elizabeth Coppoletti

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

BERKEMANN, HERMAN
Employee/Petitioner

Case# **17WC029862**
18WC016106

BEELMAN READY MIX
Employer/Respondent

20 IWCC0674

On 3/3/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY & CHAPPELL
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

5263 HARRIS DOWELL FISHER & YOUNG
J BRADLEY YOUNG
15400 S OUTER 40 SUITE 202
CHESTERFIELD, MO 63017

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)

HERMAN BERKEMANN
Employee/Petitioner
v.
BEELMAN READY MIX
Employer/Respondent

Case # 17 WC 29862

Consolidated cases: 18 WC 16106

An *Application for Adjustment 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 **December 13, 2019**. 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(s) of accident, **May 30, 2017, and January 25, 2018,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,546.96**; the average weekly wage was **$798.98**.

On the date of accident, Petitioner was **55** 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 **all paid ($45,329.82)** for TTD, $- for TPD, $- for maintenance, and **$5,079.26 paid as a PPD advance** for other benefits, for a total credit of **$50,409.08**.

Respondent is entitled to a credit of **any benefits paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) and § 8.2 of the Act.

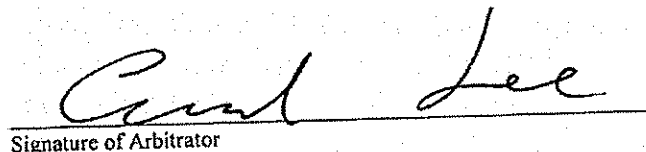
Respondent shall have credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit.

Respondent shall pay Petitioner maintenance benefits of $532.65/week for a further period of **22 4/7** weeks, commencing **July 9, 2019** through **December 13, 2019**, 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

3/3/20
Date

ICArbDec19(b)

MAR 3 - 2020

FINDINGS OF FACT

This matter previously came to trial before the Arbitrator on October 11, 2019. At that time, the Arbitrator consolidated for trial two claims for injury sustained respectively on May 30, 2017, bearing Claim # 17 WC 29862, and on January 25, 2018, bearing Claim # 18 WC 16106. Although Respondent indicated that causal connection was in dispute on the Request for Hearing form, Respondent stipulated that causal connection was not in dispute. (T.5 **[10/11/19]**) The parties agreed the dispute pertained to "whether or not [Petitioner's] ability to return to work is within the restrictions set forth by Dr. Bradley or Respondent's examiner . . ." *Id.* Respondent also disputed Petitioner's average weekly wage, and liability for medical expenses. *Id.* The hearing was ultimately bifurcated based on an agreement reached between the parties. (T.58 **[10/11/19]**) On continuation of the hearing, the parties agreed that all benefits had been paid up to July 8, 2019. (T.4-5 **[12/13/19]**) The only issue in dispute on continuation of the hearing was Petitioner's entitlement to TTD and/or maintenance from July 9, 2019, through the date of the hearing. *Id.*

Petitioner testified he is a cement truck driver for Respondent, Beelman Ready Mix. (T.8-9 **[10/11/19]**) The parties stipulated he suffered an injury when on May 30, 2017, he twisted his left knee while alighting his concrete truck after checking the oil. *Id.* at 10. He described the incident as follows:

> On May 30th of 2017, 6:30 in the morning, we were called in to work to haul concrete. The dip stick on my truck is halfway into the motor, so I get onto the tire to reach the dip stick to pull to check the oil. When I stepped back off the truck tire, there was a rock underneath my foot, and that's what caused the injury. (T.10 **[10/11/19]**)

He testified that he never suffered any prior left knee injuries, problems, diagnostic studies, or missed any time from work on account of his left knee. *Id.* at 9.

Petitioner sought treatment with his primary care provider, PA-C Poettker, that day, who took a history of the injury and noted that Petitioner twisted his left knee while getting down from his truck when he "hit a rock and heard his knee pop." (PX3, 5/30/17) Physical examination demonstrated positive grind and McMurray's testing, and Ms. Poettker's assessment was "left knee pain – suspicious for meniscus tear." *Id.* X-rays, however, were normal. *Id.* Ms. Poettker recommended an MRI and a referral to Dr. Ungacta, and advised Petitioner to return to the clinic should his condition worsen. *Id.* Petitioner was also taken off work "until cleared by health provider." *Id.*

The recommended MRI was completed on June 1, 2017, and demonstrated evidence of tears of the medial and lateral menisci. (PX4, 6/1/17) Articular cartilage loss and irregularity were also noted within the patellofemoral joint along with anterior signal abnormality suggestive of bursitis. *Id.*

Petitioner was seen by Dr. Ungacta on June 8, 2017, with medial and lateral left knee pain rated 5/10 as a result of landing on a rock and twisting his knee. (PX5, 6/8/17) Petitioner reported his pain was aggravated by activities of daily living and that he was using ice and Aleve to reduce his symptoms. *Id.* Physical examination demonstrated tenderness over the lateral tibiofemoral joint line with patellofemoral crepitus and antalgic gait. *Id.* Although the MRI findings showing evidence of medial/lateral meniscus tearing were noted, Dr. Ungacta's assessment was left knee sprain from work-related injury. *Id.* He noted outside of the portion of his report dedicated to physical examination findings that Petitioner also exhibited moderate swelling along with the noted tenderness over his joint lines. *Id.* He recommended an ultrasound-guided left knee intra-articular joint injection, which was performed in his office. *Id.* He also recommended physical therapy, oral and topical anti-inflammatory medication for Petitioner's knee, and an adjustable hinged knee brace. *Id.*

When Petitioner returned to Dr. Ungacta on June 21, 2017, he reported improvement in his static pain level, which he currently rated as 1/10, but increased pain when climbing stairs. (PX5, 6/21/17) He recommended additional physical therapy. *Id.* Dr. Ungacta recommended allowing Petitioner to return to work if Petitioner was cleared to perform his job activities "in a safe fashion" by his physical therapist. *Id.*

Petitioner returned to Dr. Ungacta on June 29, 2017, with substantially increased pain rated 7/10. (PX5, 6/29/17) He reported a sharp pain in his lateral and medial when stretching his leg out. *Id.* The nursing comments noted, "*PT STATES THAT HE WENT BACK TO WORK ON TUES AND BY WED HE WAS HAVING A LOT OF PAIN. PT STATES THAT ON TUES HE WORKED 10HRS AND WED HE WORKED 6HRS. PT CALLED STATING THAT HIS KNEE IS VERY SWOLLEN.*" *Id.* His physical examination again showed tenderness over his medial joint line of his left knee and moderate swelling and reduced range of motion. *Id.* Later in the same report, however, Dr. Ungacta noted, "He has returned to work with return of his symptoms to the point of severe knee swelling that precludes him from getting into a truck." *Id.* Dr. Ungacta noted Petitioner's MRI findings validated his injury and recommended proceeding with left knee arthroscopy and partial medial and possible lateral meniscectomy. *Id.* He also recommended aspiration of Petitioner's knee with another cortisone injection to provide Petitioner symptomatic relief. *Id.*

Surgery was completed on July 17, 2017, and consisted of a left knee arthroscopic partial medial and lateral meniscectomy and left knee chondroplasty several compartments in his patellofemoral joint. (PX6, 7/17/17) Intraoperative findings confirmed medial and lateral meniscus tearing. *Id.* Petitioner reported marked improvement following his surgery. (PX5, 8/17/17) He still continued to have some pain with activities such as kneeling and an achy sensation, but Petitioner reported this as moderate in level. *Id.* Dr. Ungacta recommended Petitioner continue taking his anti-inflammatory medications and gave additional prescriptions for Mobic and Prilosec. *Id.*

20IWCC0674

Petitioner again attempted to return to work after his surgery, and returned to Dr. Ungacta on September 1, 2017, with significant pain rated 6/10 in the medial aspect of his left knee. (PX5, 9/1/17) A diagnostic ultrasound was performed and it showed severe, 5+ effusion with osteophyte formation over the medial joint line. *Id.* Dr. Ungacta aspirated Petitioner's knee and sent the sample for analysis for cell count and uric acid. *Id.* He again took Petitioner off work. *Id.* When Petitioner's swelling had not abated after a week of rest, Dr. Ungacta recommended the following:

1. [T]he patient continues to have significant swelling to the left knee. The swelling occurred after returning to work.
2. I would recommend no work until his pain and swelling is resolved.
3. I would recommend that we proceed with hyaluronic acid treatment, Supartz injections x5 weekly.
4. I will see the patient back after we get approval from Workmen's Comp. insurance company for Supartz injections.
5. The patient has underlying arthritis with injury to this knee as a result of a work-related injury. He is not respondent to knee arthroscopy with chondroplasty and partial meniscectomy.
6. He is unable to go back to work secondary to significant swelling and pain. No sign of injection. All labs are normal for infection.

Addendum 2017-09-11

> The patient is currently not responding to knee arthroscopy as well as intra-articular cortisone injection. The patient has underlying arthritis with exacerbation of his symptoms with a work-related injury. The only other option at this point is for a surgical approach which would be a total knee replacement versus hyalouronic acid injection for treatment of his symptoms. His symptoms are primarily to [sic] focus of my treatment. If I am able to resolve his symptoms over the short-term which would be months to years with an option such as hyaluronic acid treatment, the injections [sic]. This be [sic] a reasonable approach given the patient's age and work status . . . (PX5, 9/7/17-9/11/17)

Dr. Ungacta continued to attempt to get workers' compensation approval for his recommended course of care and stated on follow-up, "Is [sic] obvious that this patient needs further care possibly with hyaluronic acid injections. We are waiting to get work comp approval. However his swelling has returned significantly so. It was a very tense and very painful effusion. Today I aspirated 80 cc of serosanguineous fluid from the left knee. No work until further notice." (PX5, 9/14/17) Dr. Ungacta ultimately referred Petitioner to Dr. Matthew Bradley for continuation of his care. (T.13-14 **[10/11/19]**)

Petitioner came under the care of Dr. Matthew Bradley on September 19, 2017, and he took the history of Petitioner's injury. (PX8, 9/17/17) He noted that Petitioner suffered what he

believed to be a hyperextension type injury with immediate pain as a result of his accident and noted that Petitioner's knee "about buckled on him." *Id.* He noted the history of Petitioner's care and Petitioner's complaints of popping, clicking, and catching with a sharp, stabbing pain in the same location in which he was symptomatic prior to his surgery. *Id.* Examination of the left knee demonstrated reduced range of motion, significant pain to palpation along the medial joint line, audible clicking with McMurray testing, and residual effusion. *Id.* Dr. Bradley viewed Petitioner's pre-surgery MRI scan and noted that is showed a very large tear to the posterior horn of the medial meniscus with mild degenerative changes. *Id.* His assessment was left knee pain and complex tear of the medial meniscus. *Id.* Since Petitioner had already undergone significant treatment, including aspiration, physical therapy, activity modification, anti-inflammatory medication, and surgery, without resolution of his complaints, Dr. Bradley recommended an MRI Arthrogram to rule out a recurrent tear of the meniscus. *Id.*

Petitioner underwent the MRI on September 29, 2017, and returned to Dr. Bradley on October 3, 2017. (PX8, 10/3/17; PX9). Dr. Bradley noted that it showed extrusion of the medial aspect of the medial meniscus with bone to bone contact and underlying edema. (PX8, 10/3/17) He administered a Kenalog injection for relief and noted that Petitioner may require a total knee arthroplasty if his condition did not improve. *Id.* However, on November 8, 2017, Petitioner underwent a "Fit for Duty" or "WorkSTEPS" evaluation at Respondent's request which indicated that Petitioner was able to resume all tasks associated with his employment based on criteria provided only by Respondent and brief observations of Petitioner performing purportedly similar tasks. (PX7, 11/8/17) The tasks and criteria were as follows:

JOB SPECIFIC

Name	Description	WHR	Body Mechanics	Met Requirement
Task 1	The candidate will be required to ascend/descend 12 steps of a vertical ladder without exceeding 80% of the tho MPHR for a total of 2 repetitions.		Good	Yes
Task 2	The candidate will successfully simulate rolling a tarp utilizing BTE tool #181 at chest high for 15 reps forward and 15 reps backward resisted by 21#.		Good	Yes
Task 3	The candidate will be responsible for continuously shoveling in the shovel pit at a comfortable pace for 3 minutes without exceeding 80% of the candidate's MPHR.		Good	Yes
Task 4	Candidate will lift a truck tire requiring 65# of force from the floor to an upright position, and then lower back to the floor using good body mechanics for two repetitions.		Good	Yes
Task 5	Candidate will perform a simulated 5th wheel pulling task using the BTE work simulator. Using good body mechanics, the candidate will lean over as if reaching under the trailer and pull on the handle to generate 80# of force. The candidate will perform three repetitions. (BTE work simulator parameters: Attachment #901; shaft height 56"; force of 750 in lbs; rubber stop placement at position 8; and resistance in one direction only.		Good	Yes

No pain rating was documented for Petitioner during the test. *Id.*

When Petitioner returned on November 2, 2017, Dr. Bradley noted that Petitioner reported improvement in swelling, but continued to have significant pain. (PX8, 11/2/17) Dr. Bradley noted the absence of any intervening trauma, falls, or infections, and Petitioner's unsuccessful attempt(s) to return to work. *Id.* Petitioner's presentation on physical examination was unchanged, and Dr. Bradley administered yet another injection in Petitioner's left knee. *Id.*

Petitioner sustained an aggravating injury to his left knee when he again attempted to return to work on January 25, 2018. Although Petitioner remained symptomatic at his follow-up appointment on February 8, 2018, Dr. Bradley noted that he believed Petitioner's injection was tempering Petitioner's pain to a sufficient degree that would allow him to work and tolerate his pain. (PX8, 2/8/18) Dr. Bradley and Petitioner agreed to manage his condition nonoperatively as long as possible, though Dr. Bradley noted that Petitioner would ultimately require knee replacement in the near future. *Id.*

On March 5, 2018, Dr. Bradley noted that despite all efforts, Petitioner continued to marked unmanageable pain and swelling in his left knee. (PX8, 3/5/18) He stated:

> . . . Mr. Berkmann has never really gotten significantly better. He has continued to have pain and swelling in this knee. He certainly had some underlying degenerative disease at the time of his injury, but the torn meniscus and the resection of this large amount of meniscus had led to significant worsening of his underlying arthritis and the introduction of some post-traumatic arthritis. We have tried multiple non-operative treatment means, including injection therapy, all of which have failed to provide adequate pain relief.
>
> At this time, I feel that the best treatment for Mr. Berkemann to give him good sustained pain relief while maintaining function of his knee would be that of a left total knee arthroplasty. . . *Id.*

Dr. Bradley administered an injection for symptomatic relief and scheduled Petitioner for surgery. *Id.*

Dr. Bradley performed a left total knee replacement with injection on June 13, 2018. (PX8, 6/13/18) Follow-up visits show that Petitioner experienced improvement in his pain level, range of motion, and strength, and was actively participating in physical therapy, but he had difficulty with swelling with prolonged standing and pain with increased activity. (PX8, 8/9/18) Petitioner was given more anti-inflammatory medication and topical analgesic cream and encouraged to continue with his physical therapy and home exercise program. *Id.* Petitioner was given another injection on September 12, 2018, but continued to have pain rated 4/10 along with tightness over his anterior knee in the area of his quadriceps tendon. (PX8, 10/4/18) Dr. Bradley ordered an ultrasound which demonstrated some slight thickening at the insertion of Petitioner's quadriceps tendon. *Id.* Dr. Bradley believed this was related to scar tissue and recommended that Petitioner continue stretching. *Id.*

On November 12, 2018, Petitioner reported that he was able to walk well and carry objects; but when he attempted to go up or down stairs or inclines, he rapidly developed severe pain. (PX8, 11/12/18) Notwithstanding, Petitioner was attempting to condition himself to return to work but was "not having much success." *Id.* He indicated that Petitioner would likely need a functional capacity evaluation to assess his ability to return to work. *Id.* Dr. Bradley also recommended and performed a PRP injection, but Petitioner reported that his pain was more constant than it had been on follow-up. (PX8, 11/26/18, 12/20/18) Dr. Bradley opined that

Petitioner had developed chronic inflammation at the medial quad insertion, which was a location that was cut and repaired during surgery for his total knee arthroplasty. (PX8, 12/20/18) He expressed concern that the repair at the end of the knee replacement surgery had not healed or had come apart, and he recommended surgical exploration of Petitioner's distal quadriceps with likely repair of his medial insertion with debridement of the chronic inflammation and scar tissue in the area. *Id.* He also stated that this recommended surgery was a direct sequel of Petitioner's ongoing work injury and the related arthroscopy and knee replacement. *Id.*

Petitioner returned to Dr. Bradley on February 4, 2019, again with reported pain at the insertion of his quad tendon into his patella medially rated 5/10. (PX8, 2/4/19) Petitioner reported that his pain was relieved by none of the modalities at his disposal. *Id.* An ultrasound showing thickening of the striations of the quadriceps muscle fibers near the insertion of the patella was taken, and Petitioner's knee was aspirated. *Id.* The fluid appeared normal. *Id.*

On February 26, 2019, Dr. Bradley performed a left knee quadriceps tendon debridement and repair, partial synovectomy, and excision of two (2) inclusion cysts. (PX8, 2/26/19) Immediately following surgery, Petitioner reported extreme pain rated 10/10 and tightness on the anteromedial aspect of his quadriceps. (PX8, 3/6/19) X-rays demonstrated that Petitioner's hardware was in good alignment with no signs of loosening. *Id.* However, Petitioner began having difficulty bending his leg back. (PX8, 3/20/19) Dr. Bradley encouraged Petitioner to continue to try to be active. *Id.* Follow-up visits show that Petitioner continued to have significant pain rated 6/10. (PX8, 5/13/19) On May 13, 2019, Dr. Bradley stated, "At this time I see no other treatments or modalities that would reliably and predictively improve Mr. Berkemann's function or pain level. He has our phone number and can/will call with any concerns or new issues. Will not schedule follow up at this time." *Id.*

Respondent sent Petitioner for another "WorkSTEPS" evaluation on July 22, 2019, which again indicated that Petitioner was able to perform his job duties based on Petitioner being able to perform two (2) repetitions of the designated tasks:

JOB SPECIFIC

Name	Description	WHR	Met Requirement
Task 1	Candidate must lift a 94# bag of Portland cement from a pallet to a 50" platform then return it to the starting position. Candidate must perform 2 repetitions.		Yes
Task 2	Candidate must lift a 94# bag of Portland cement from a 50" high platform, carry the bag 20' and return to the starting position. Candidate must perform 2 repetitions.		Yes
Task 3	Candidate must lift from ground and carry a bag weighing 50# up and down 8 rungs of an inclined ladder. Candidate must perform 2 repetitions.		Yes

(RX5). No pain rating was recorded for Petitioner during the test. *Id.*

Petitioner attempted to again return to work, but returned to Dr. Bradley on July 24, 2019, and reported that he was unable to perform his job duties. (PX8, 7/24/19) Dr. Bradley

noted that Petitioner was at maximum medical improvement, but again noted that Petitioner was plagued with pain and swelling due to the increased activity level upon his return to work:

> At this time, I feel Mr. Berkemann has reached MME. He had an FCE like exam called STEPS and was able to do all the duties required of him at work; however, he can only do these functions a limited number of times. His job requires repetitive activity and prolonged standing and walking. In my medical opinion, Mr. Berkemann is NOT able to return to his work in the capacity he was in prior to his injury. *Id.*

Petitioner testified at his first hearing that the functional capacity evaluation that was performed at Apex Physical Therapy "was a little unfair" because it he felt it was not characteristic of the type of work that he performed. (T.27 **[10/11/19]**) When asked to explain, he stated:

> A: [Sic]: For one was going up the stairs was a four step stairs, and there is no real stairs at our job that works like that. Number two was the ladder that I was to climb was not straight up and down but was also at a 45-degree angle, and carrying 50 pounds up, I did do it, but it's not a fair test.
>
> Q: And why do you say that, sir?
>
> A: Because carrying material straight up a ladder is harder than it is at a 45-degree angle, and our truck ladders on concrete trucks are straight up and down. (T.27 **[10/11/19]**)

When asked how his knee reacted following the functional capacity evaluation, Petitioner testified, "It was okay because I didn't put any weight on my left knee." (T.28 **[10/11/19]**) Petitioner stated that he "did one step at a time, and I used my right leg." *Id.*

Petitioner was asked at the first hearing if he thought he could do just the driving portion of his job in his condition at the time of the hearing, and he stated, "Yes, sir." (T.28-29 **[10/11/19]**) Yet, there were still aspects of his job which he felt he could not do. He stated, "I can't crawl on the floor, change truck tires and shift the gears in the truck secondary to difficulty "picking [his] leg up with [his] muscle the way it is." (T.29 **[10/11/19]**) Petitioner testified that Respondent's drivers are responsible for the maintenance of their own vehicles, and he is physically unable to maintain his. (T.29-31 **[10/11/19]**) Respondent introduced pictures of a cement truck as its Exhibits 1-4. Petitioner also testified that when drivers aren't driving they are responsible for taking care of the yard and must at times "go up on the roof of the building and shovel rock and sand because a bin's run over." (T.28-29 **[10/11/19]**) Although there were aspects of his job he was physically unable to do, he desired to return to work. (T.32)

Petitioner testified on cross-examination that he had not attempted to go up and down a ladder like the one depicted in Respondent's Exhibit 2 since Dr. Bradley placed him at maximum medical improvement on May 13, 2019. (T.40) When asked whether he believed he could do so in his condition at the time of the hearing in October 2019, the following exchange took place:

Q. So as you sit here today, you think you could go up and down that ladder four times a day, but you don't know how many more times during a workday you could do that; is that fair?

A. That's correct, but he is also not carrying 50 pounds on his shoulder either. (T.41 [10/11/19])

Petitioner was unsure of whether or not he could lift and fold multiple chutes like the ones depicted in Respondent's Exhibit 3. (T.42 [10/11/19]) Petitioner testified that the chute shown in Respondent's picture was at shoulder level. *Id.* However, he testified, "When all the chutes are on, there are either four or five chutes that go on the concrete trucks. The first chute that gets picked up is almost to the ground, and I have to squat to do that. I cannot squat in my current position [sic]." *Id.* He believed that if the chutes were at shoulder level however, he could manage to do so four times a day. *Id.* at 43. Petitioner testified that consistent with the restrictions of Dr. Bradley, he could occasionally perform his job duties, but not on a repetitive basis. *Id.* at 57. At the conclusion of testimony, the parties held a brief discussion off the record and then agreed on the record that Petitioner would attempt to return to work with modified restrictions and accommodations by Respondent. (T.58 [10/11/19]) Pursuant to the parties' agreement, hearing was bifurcated until it could be determined whether or not Petitioner was able to work with modified restrictions. *Id.* at 58.

Petitioner underwent a second "WorkSTEPS" evaluation which consisted of the following criteria (PX7, 10/17/19):

JOB SPECIFIC

Name	Description	WHR	Met Requirement
Task 1	Candidate must lift a 94# bag of Portland cement from a pallet to a 50" platform then return it to the starting position. Candidate must perform 2 repetitions.		Yes
Task 2	Candidate must lift a 94# bag of Portland cement from a 50" high platform, carry the bag 20' and return to the starting position. Candidate must perform 2 repetitions.		Yes
Task 3	Candidate must lift from ground and carry a bag weighing 50# up and down 8 rungs of an inclined ladder. Candidate must perform 2 repetitions.		Yes

During this evaluation, Petitioner was noted to have a pain rating of 5/10 lifting floor to knuckle and 12" to knuckle, 5/10 at the bottom of a squat, 6-7/10 after ladder climb testing, and 8-9/10 during the goniometry/squatting test. *Id.* Petitioner thereafter attempted to resume work. The hearing resumed on December 13, 2019, and Petitioner testified when attempted to return to work for Respondent, his knee again had an adverse reaction to his job duties. (T. 6-7 [12/13/19]) He stated:

> [Sic]: We got called in to go to work to load out loads. It was raining so our orders got cancelled so we worked in the shop to do maintenance on trucks and just walking on concrete and maintaining the truck my knee swelled up and started throbbing and I couldn't take it no more. (T.7 [12/13/19])

Petitioner testified that when he returned to work on October 22nd, he readied his truck, drove to his job site, installed three (3) 50 lb. concrete chutes, and attempted to begin pouring; however, his "truck failed a little bit" and he had to repair a blown air line for his brakes. *Id.* at 8-10. Afterwards, he finished pouring, left the job site and cleaned out his truck, and returned to Respondent's plant. *Id.* at 9-10. He testified that although he spent probably only an hour on his feet during this project and was seated during the actual pouring of the concrete and while driving, by the time he arrived back at the plant his left knee was already swollen and throbbing. *Id.* at 10-11. He advised his supervisor and was told to see a physician. *Id.* at 11.

Petitioner reported to St. Joseph's urgent care Highland and was evaluated with x-rays the following day in St. Joseph's emergency room the following day. (PX6, 10/22/19-10/23/19) The history of present illness noted that Petitioner was a 57-year-old male with a history of left total knee replacement who went back to work and experienced increased chronic knee pain as a result of "climbing ladders and doing physical activity." *Id.* The record noted that although Petitioner had not been cleared to return to work by his surgeon, Dr. Bradley, Petitioner was "released by physician through workman's compensation" and "exacerbated his chronic knee pain." *Id.* Petitioner advised the attending nurse that he "worked for 2 ½ hours yesterday and began having pain and swelling." *Id.* Physical examination showed swelling, medial joint line and patellar tenderness, and crepitus with patellar mobility. *Id.* X-rays showed that Petitioner's prosthesis was in place and demonstrated no acute bony abnormality. *Id.* Petitioner was taken off work until he could be evaluated by Dr. Bradley. *Id.*

Petitioner returned to Dr. Bradley on October 31, 2019, at which time repeated his opinion that he did not believe Petitioner was able to return to his work in the capacity he was in prior to his injury. (PX8, 10/31/19) Dr. Bradley advised Petitioner that there was nothing much he could do for his knee. (T.12 [**12/13/19**]) Petitioner testified that he awoke at 6:00 a.m. the morning of the December 13th Arbitration hearing and within 15 minutes his knee began swelling and throbbing. *Id.* at 12-13. Petitioner testified that wearing his brace controls the throbbing, but his knee still swells despite using his brace. *Id.* at 13. He wears a compression stocking every night and takes Aleve when his knee begins to throb. *Id.* at 13-14.

Petitioner has been searching for work within the sedentary demand capacity because he cannot perform any prolonged standing. *Id.* at 14. His attempts thus far have been unsuccessful. *Id.* at 14-15. He has a high school diploma with some incomplete training in carpentry. *Id.* at 15. He believed he would benefit for vocational assistance to help him find a job that would accommodate his restrictions. *Id.* at 15. Petitioner enlisted the services of England and Company. (PX16) His job searches, status reports, and vocational invoices were entered into evidence. (PX16; PX17)

Petitioner confirmed on cross-examination that he suffered no new injuries to his left knee. (T.25-26 [**12/13/19**]) Petitioner testified that the source of his pain has remained the same since the injury and has never changed. *Id.* at 28-29. He stated, "It's always been the same,

across the top, yes, sir, and down the side a little bit. Never changed." *Id.* at 28-29. Petitioner acknowledged that he was no longer required to get up on the roof and shovel rock or sand. *Id.* at 34. However, Petitioner again testified that any prolonged standing aggravates his knee. *Id.* at 36-37. On Re-direct, he stated, "I mean, within ten minutes when I wake up in the morning, it starts swelling up. It's just standing on it, so every time I do anything with it, it aggravates it." *Id.* at 37. He testified that aggravating activities also including pushing the clutch and brake pedals on his truck. *Id.* at 37.

Petitioner's wife also testified at Arbitration. *Id.* at 38-39. She testified that when Petitioner came home after attempting to work in July of 2019, his left knee was "twice the size of his other knee." *Id.* at 39. She further described, "His pants on that leg, it was so tight that I don't know how it fit in the pants." *Id.* at 39. She also observed Petitioner's left knee following his return to work in October of 2019, and stated that it was again swollen twice the size of his right knee. *Id.* at 40. She testified that her husband currently wore a compression sleeve 24 hours a day and only removed same to shower. *Id.* at 40.

Petitioner also called Respondent's General Manager, Mr. Kevin Whipple. *Id.* at 41-42. On direct examination, he testified that he could not recall anything in Petitioner's testimony to which he would object. *Id.* at 43-44. On cross-examination, he testified that Beelman uses and relies on Work Steps functional capacity evaluations to evaluate every injured worker for fitness to return to work. *Id.* at 46. He admitted that when Petitioner returned to work on July 22nd, he was unable to perform all of his job duties, even though he purportedly did no "substantive work." *Id.* at 47-48. On re-direct examination, he testified that he did not consider maintenance on the truck "substantive work." *Id.* at 50-51. He testified that since Petitioner had only returned to work for a very short period of time, there "wouldn't have been a lot of maintenance being done on the truck." *Id.* at 51. He admitted that when he stated that Petitioner "refused to work," Petitioner brought a note from Dr. Bradley keeping him off work. *Id.* at 51.

Respondent called its Plant Manager, Todd Langenhorst, to testify. *Id.* at 52. He testified that he was working the day Petitioner returned to work on October 22, 2019. *Id.* at 52-53. He testified that Petitioner arrived at his scheduled time and prepared his truck for loading. *Id.* at 53. He confirmed that Petitioner was scheduled to deliver concrete to the Village of Beckemeyer, and that he was required to put chutes on his truck and prepare for the concrete pour. *Id.* at 55. He testified that after the pour, Petitioner was responsible for washing his chutes, folding them, loading/hanging them back on his truck, dumping excess concrete at a dump site, and washing out his truck. *Id.* at 55-56. He also confirmed that Petitioner would be required to climb to the top of his truck to wash his hopper. *Id.* at 55. He testified that when Petitioner returned to the plant 2 hours later after completing the above tasks, Petitioner advised him that he was unable to work further because his leg was hurting and that he needed to go home. *Id.* at 56-57. Petitioner returned the following day with a physician's note from the emergency room. *Id.* at 56-57. He did not believe that the work Petitioner performed that day was more physically demanding than

the activities in the Work Steps FCE and believed it was within Petitioner's physical ability according to the opinion of Dr. Farley. *Id.* at 57-58.

On cross-examination, he testified that he could not recall Petitioner making an attempt to return to work on July 15, 2019. *Id.* at 59. He admitted that drivers' jobs involve "a lot of maintenance. What specifically – we do our own PMs" or preventive maintenance. *Id.* at 59-60. He testified that drivers change their own oil and keep their truck clean. *Id.* at 60. He testified that Petitioner was a good driver and worker and an honest person. *Id.* at 60-61. When asked whether he observed any swelling when Petitioner advised him he was hurting, he candidly testified, "He was wearing jeans but he was favoring his leg." *Id.* at 61.

Respondent had Petitioner evaluated by Dr. Clinton Smith for a "DOT" Department of Transportation) examination on July 22, 2019, and he testified by way of deposition on October 10, 2019. (RX6; RX7) Dr. Smith testified that he is a chiropractic physician Respondent enlisted to perform a "recertification physical examination" of Petitioner. (RX7, p.5, 9-10) Dr. Smith testified that Respondent/Beelman "probably misunderstood" the purposed of the "return to duty (observed)" box in the top left corner of the authorization form, and stated, "I believe that Beelman probably misunderstood – misunderstands the return to duty nomenclature here. Return to the duty typically refers to drug testing. I think Beelman was trying to get the information across to us that they had an individual that had been injured or something and they wanted them to return to duty. But in the parlance of the FMCSA, return to duty, where it says observed, is typically reserved for follow-ups when somebody tests positive for drugs, and we did not do a drug test on him. So that means that they were probably just doing this in error. They checked it in error." *Id.* at 11.

Dr. Smith candidly testified that "generally speaking" he did not have any experience with determining whether employees were physically able to return to work at Beelman Ready Mix. *Id.* at 12. He has made such evaluations for other companies in the past, but Respondent had never requested that he perform a return to duty evaluation. *Id.* at 12. He has, however, performed DOT examinations for individuals who had been employed at Beelman. *Id.* at 13. His only job was to determine whether Petitioner was medically fit to operate a commercial motor vehicle or a school bus, and the form which he completed was specifically designed to be submitted to the State of Illinois. *Id.* at 13-14. Dr. Smith testified that Petitioner was qualified to operate a commercial vehicle, provided that he was wearing corrective lenses for his vision. *Id.* at 14-15. He found no indications that Petitioner's left knee prevented him from returning to work as a commercial driver. *Id.* at 20.

On cross-examination, Dr. Smith acknowledged that he only determined whether Petitioner met federal regulations for returning to work as an ordinary truck driver, not whether Petitioner could return to work in the context of his workers' compensation case. *Id.* at 21, 26. He noted that Petitioner was "having some swelling post-surgery" in his note, but he did not review any imaging studies, review any medical records from any medical providers, or have any

awareness of any restrictions imposed on Petitioner by his medical providers. *Id.* at 22. He was not aware of any of Petitioner's treatment or his current work status. *Id.* at 24. He was not aware that when Petitioner presented to work shortly after his DOT examination, he went to the emergency room for increased swelling and pain just four hours later; but he had no reason to dispute same. *Id.* at 24. He never received a description of Petitioner's job duties from Beelman and had no reason to dispute that Petitioner's job required repetitive activity and prolonged standing and walking. *Id.* at 25. He had no basis on which to dispute the restrictions of Petitioner's physician which indicated he was not able to return to work for Beelman. *Id.* at 25.

Respondent also took the deposition of Samuel Munie, the therapist who performed Petitioner's "WorkSTEP evaluations. (RX9) Mr. Munie testified that the purpose of his assessment was to determine Petitioner's ability to return to the functional duties of Respondent's workplace. *Id.* at 7. He testified that according to his evaluation, Petitioner was able to meet all of Respondent's job requirements. *Id.* at 7-8, 11. He testified that his test included a simulated cement sack lift and a sack lift and ladder climb, and Petitioner was able to perform those duties during his test. *Id.* at 8. He testified that he also performed a physical examination of Petitioner's knee as a part of his evaluation. *Id.* at 8.

On cross-examination, Mr. Munie testified that he is a representative of Apex's comprehensive occupational program or ACOMP. *Id.* at 15. He testified that Petitioner's job duties were provided to him by his ACOMP's director. *Id.* at 15. When asked how the director obtained Petitioner's job duties, he testified that he could answer specifically because he was not party to the process; but he stated that the information is typically obtained by talking to employers or visiting the job site. *Id.* at 15. When asked whether the information was provided directly by Beelman, he stated, "I don't know that. I wasn't part of that." *Id.* at 16. He had no idea whether Petitioner was involved in providing any information for the job description. *Id.* at 20. He only know that his director "gathers this information based on his assessment of jobs" and provided it to him, and "that's the extent of [his] knowledge." *Id.* at 19. He did not know whether Petitioner's description of his job duties was different from the test he administered. *Id.* at 20. He did not ask Petitioner for any information or ask him to complete any forms regarding his job duties to determine whether his evaluation was accurate. *Id.* at 20-21. He had no information regarding Petitioner's work schedule or whether he worked any overtime. *Id.* at 22.

Respondent had Petitioner evaluated on several occasions by Dr. Timothy Farley. (RX8, p.6) He evaluated Petitioner and produced reports on January 22, 2019, June 25, 2019, and November 19, 2019. (RX8, p.5-6; RX11) Dr. Farley testified by way of deposition on September 3, 2019. (RX8) He testified that Petitioner's BMI placed him in the morbidly obese category, and that Petitioner also had degenerative changes in his left knee. *Id.* at 8-9. He testified that Petitioner's BMI put increased weight upon the cartilage surfaces of his knee and would accelerate the degenerative changes in over his lifetime. *Id.* at 9. He also testified that Petitioner's BMI placed him at risk for accelerated failure of his prosthesis and failure of fixation. *Id.* at 9-10. He did not believe, however, that his BMI affected his recovery. *Id.*

Dr. Farley testified that in his first report, he indicated Petitioner's PRP injection was not necessary, because he believed it was an experimental procedure that lacked supporting evidence of its value. *Id.* at 10. He acknowledged that it is used "in certain circumstances," but he did not believe it reasonable for encouraging post-operative quadriceps healing. *Id.* at 11. With respect to the surgical exploration of Petitioner's quad tendon and cyst removal performed prior to the second evaluation in June, Dr. Farley testified that he saw no diagnostic evidence that there was an actual tear to Petitioner's quadriceps tendon. *Id.* at 13. He agreed, however, that a quad tear was not an unreasonable diagnosis to consider if a patient is not thriving after knee replacement surgery. *Id.* at 13-14.

Dr. Farley testified that he could not locate any objective evidence that would point to the source of Petitioner's ongoing pain, and he believed that Petitioner was maximum medical improvement. *Id.* at 15. Dr. Farley testified that based on his evaluation of Petitioner on June 25, 2019, he believed that Petitioner was able to return to his normal job duties without modification. *Id.* at 15-16. He did not believe that Petitioner required any permanent restrictions as a result of his work injury. *Id.* at 16. He also performed an impairment rating, which he believed converted to 25% disability of Petitioner's left knee. *Id.* at 16.

On cross-examination, Dr. Farley agreed that Petitioner's need for total knee replacement was directly related to his work injury. *Id.* at 19. He did not believe Petitioner was a candidate for PRP injection, however, on account of his knee replacement, because Petitioner did not suffer from a degenerative condition of a tendon. *Id.* at 19-20. He acknowledged that he did not review or administer a functional capacity evaluation for Petitioner, and testified that he rarely utilized functional capacity evaluation. *Id.* at 20. He acknowledged that he has assigned work restrictions for patients without using an FCE in the past. *Id.* at 20-21. In his reported dated November 19, 2019, Dr. Farley indicated that he was not aware of any examination findings by Dr. Bradley or emergency room staff that indicated Petitioner suffered significant swelling in October of 2019. (RX11) He saw no change or aggravation in Petitioner's condition, and indicated that his opinion about Petitioner's ability to work and his impairment rating remained unchanged. *Id.*

Petitioner's treating surgeon, Dr. Bradley, also testified by way of deposition. (PX15) He testified he is a board certified orthopedic surgeon who performs 300 to 350 knee surgeries per year. *Id.* at 5. Of the surgeries performed, he estimated that about three (3) to four (4) per week are knee replacements. *Id.* at 5. He also performed IMEs for insurance carriers or employers, though he estimated that it was rare, less than five (5) per year. *Id.* at 5-6.

Dr. Bradley testified that he kept detailed records in his care and treatment of Petitioner, reviewed records and diagnostic studies from other providers, and reviewed a utilization review and the fit-for-duty evaluation requested by Respondent, and reviewed pictures of Petitioner's truck and job activities. *Id.* at 7. He also possessed reports from Dr. Farley. *Id.* at 7-8. After summarizing Petitioner's care and treatment received prior his assumption of Petitioner's care, he noted Petitioner's lack of any problems prior to the accident and noted Petitioner's treatment thus

far had not provided substantial pain relief. *Id.* at 9-10, 13-14. He believed based on Petitioner's history and the objective medical findings, that Petitioner suffered a pretty large tear to the posterior horn of his medial meniscus and aggravation of the degenerative disease inside of his knee on account of his work injury and the subsequent surgery. *Id.* at 11-12.

When Dr. Bradley obtained new imaging studies of Petitioner's knee, he saw the extensive removal of the meniscus on account of the large size of the tear along with edema, fluid, and degenerative change inside, outside, and underneath the knee cap. *Id.* at 12-13. His assessment was post-meniscal surgery pain and acute exacerbation of underlying arthritis. *Id.* at 13. He stated:

> I don't think there's any argument that – some of his arthritis certainly preexisted this injury – but it certainly wasn't painful to him. I think the injury he sustained was an acute tear to his meniscus in addition to or subsequently causing an exacerbation of his arthritis. Unfortunately, when he had his meniscus cut back and removed, that just further irritated and exacerbated the arthritis, so I believe that his injury certainly contributed to and is a major factor in his exacerbated arthritis and is the sole cause of his meniscal tear. *Id.* at 14.

Dr. Bradley testified that despite his best efforts to treat Petitioner conservatively, Petitioner ultimately required knee replacement. *Id.* at 14-16. With regard to Petitioner's continued treatment and surgical intervention, he stated:

> I felt it was all a continuation. I don't think he had fully recovered from his work injury, so all of my treatment recommendations were a direct sequel of a continued injury from work . . . *Id.* at 14.

Dr. Bradley testified that it was common for patients with knee replacements to require restrictions:

> It's very difficult after having a knee surgery to participate in repetitive activities like Mr. Berkemann's doing – climbing ladders, lifting up heavy objects, twisting and turning on a repetitive basis day in and day out, is very difficult.
>
> Those are things that can be done minimally. I don't think there would be any problems having him climb up a ladder to get something out of the gutter of his house or at work one time, but repeatedly doing the activities that he does at work I think would be very [sic] for somebody with a total knee to be able to do that.
>
> Having said that, if it didn't create any pain, if it was something he could do, I would not restrict that, but in my experience, most patients can't do those kind of repetitive things after a knee replacement. *Id.* at 17.

He stated he treated Petitioner for nearly two years and had "discussions with him at almost every appointment" about his job duties. *Id.* at 17. He explained, "In order to write him restrictions and recommendations, I need to understand what it is he does at work, so those have

been an ongoing discussion that we have had, and we have quite frankly had the discussion that after his knee surgery he may very well not ever be able to do those without a significant amount of pain." *Id.* at 17-18.

Dr. Bradley testified that as he slowly tried to reintroduce Petitioner to work as tolerated by increasing the allowed activities. *Id.* at 18. He also recommended a PRP injection, because he had to cut part of Petitioner's quadriceps tendon to get the knee prosthetic in place. *Id.* at 19. He testified that this sparked inflammation of that tendon, and he believed that that was the source of Petitioner's continued pain. *Id.* at 19. He stated he has had success in treating that side-effect in the past with PRP injection. *Id.* at 19-20. He testified that the other option for treating Petitioner's tendon was surgical debridement, but he wanted to avoid subjecting Petitioner to any further surgery at all cost. *Id.* at 19-20. He testified that over the last five (5) to six (6) years that injection has emerged in orthopedic surgery conferences and literature as "a tool of the trade" or standard treatment option for Petitioner's problem. *Id.* at 21. It did not, however, achieve the desired result in Petitioner's case. *Id.* at 21-22. He therefore operatively debrided the tendon and found calcium deposits in the tendon while he was removing scar tissue. *Id.* at 22.

Dr. Bradley testified that he was hopeful that Petitioner would be able to return to his previous line of work and agreed he recommended a functional capacity evaluation. *Id.* at 23-24. However, he stated that Petitioner's condition repeatedly gave rise to his belief that Petitioner would not be able to return to work. *Id.* at 24. He noted that Petitioner was able to complete the activities tested during his functional capacity evaluation, but only for a limited number of times. *Id.* at 23-24. Dr. Bradley stated he ultimately did recommend permanent restrictions for Petitioner that restricted him from repetitive activities. *Id.* at 24. He testified that based on the job description provided to him, the FCE results, and the photographs of Petitioner's job activities, he did not believe that Petitioner would be able to return to his previous job. *Id.* at 25. He explained:

> You know, during the FCE and every time I've seen him, he is able to do a lot of these activities on a single or a limited basis, but with repetitive activities, he continues to get pain that's been very consistent, very reproducible, very understanding given the treatment -- the surgeries he's had.
>
> When you look at the pictures, he's got to go up into the cement truck. The steps are very, very high. It does have a railing to help him out. He's climbing pretty much straight up a ladder on the back of the cement truck. These are activities that, as I've stated before, my total knee patients -- are very difficult to do repetitively.
>
> And in Mr. Berkemann's individual self, he was unable to demonstrate the ability to repetitively do those to myself and his fit-for-duty, so I just don't -- I don't think he'll be able to return in the same capacity that he had done previously. *Id.* at 26.

On cross-examination, Dr. Berkemann testified that Respondent's utilization reviewer misunderstood the purpose and location of the injection. *Id.* at 32-33. Dr. Bradley testified he

didn't administer an "intra-articular" PRP injection into Petitioner's knee, which was the assumption of the reviewer, which resulted in an off-basis assessment of his recommendation. *Id.* He testified that injection was administered peritendinously around the quadriceps. *Id.* Dr. Bradley testified that literature supported the use of PRP for tendonitis, including at the quadriceps tendon. *Id.* at 34-35. He testified that the injection and surgery was not to address a tear, but to address the chronic inflammation that was causing Petitioner pain. *Id.* at 37.

Turning to the fit-for-duty assessment, Dr. Bradley testified that this only established that Petitioner could perform the subject activities twice in a single day. *Id.* at 42-43. He testified that said test did not establish that Petitioner could continue to do those activities more than twice or do so on consecutive days. *Id.* at 42-44. He testified that Petitioner had "always been very straight forward with [him] and said he can do anything at work on a limited bases. It just can't be done repetitively." *Id.* at 43-44. He stated, "[h]e's always said the more he does a repetitive activity, the more pain." *Id.* Respondent discussed the provided pictures of Petitioner's job duties to inquire as to how often Petitioner could perform the depicted duties, to which Dr. Bradley stated, "I think he can do it once or twice in one day. I think it would be very difficult for him to do this four or five days a week." *Id.* at 46-48. He also stated that these activities would put "a significant amount of stress on the quadriceps tendon" and that "these kinds of activities . . . are going to create some pain for him." *Id.* at 48.

When asked whether Petitioner directed or requested him to restrict his activity, Dr. Bradley stated, "No, I don't have patients ask me to do anything or not. I offer my medical opinion based upon what I believe is in their best interest, now what their thoughts are." *Id.* at 52. He confirmed that Petitioner's restrictions of no repetitive activities remained, that he was at maximum medical improvement, and that there was nothing further he could do for his condition. *Id.* at 53-54.

The Arbitrator had an opportunity to view and listen to Petitioner for almost two (2) hours over two (2) separate hearings and finds him to be a very credible witness.

CONCLUSIONS OF LAW

<u>Issue (F)</u>: Is Petitioner's current condition of ill-being causally related to the injury?
<u>Issue (L)</u>: What temporary benefits are in dispute? (TTD)

The parties agreed that the central issue in dispute in this case is whether Petitioner can resume working as a cement truck driver for Respondent, and agreed that the disability period in dispute is from July 19, 2019, through the date of hearing.

The Arbitrator finds based on the manifest weight of the evidence that Petitioner is unable to return to his employment as a cement truck driver for Respondent. In support of this determination, the Arbitrator notes the following facts:

1) No physician disputes that Petitioner's left knee condition was caused by his accidental work injury.

2) Petitioner attempted to return to work on multiple occasions, but was unable to do so without significant pain and swelling. Respondent's Plant Manager, Todd Langenhorst, acknowledged Petitioner was "favoring his leg" when he attempted to return to work in July of 2019. (T.61 [**12/13/19**]) Petitioner's wife testified that on each occasion Petitioner attempted to return to work, his left knee was swollen to twice the size of the contralateral side. *Id.* at 39-40.

3) Neither Mr. Munie, the therapist, nor Dr. Smith had adequate knowledge of Petitioner's job duties to opine whether he would be able to perform them on a sustained basis.

4) The FCEs performed by Mr. Munie were not reflective of Petitioner's actual job duties. Aside from Petitioner's testimony that the steps used were not vertical as shown in Respondent's exhibits, each evaluation lasted only a trivial amount of time. The tasks that required the use of Petitioner's left knee were only performed for two (2) iterations to conclude that Petitioner was able to return to full-duty work.

5) Dr. Farley's opinion was not supported by the evidence. He provided no logical explanation for Petitioner's ongoing complaints and limitations. He merely opined based on his inability to identify the source of Petitioner's ongoing condition of ill-being that Petitioner should have been able to return to work.

6) Dr. Bradley's opinion was credible and supported by the objective evidence. Dr. Bradley noted that Petitioner's complaints were supported by the objective medical evidence which showed he suffered from chronic inflammation despite his extensive care. Although Petitioner could perform his job duties occasionally, he noted that Petitioner could not do so repeatedly or on a daily, full-time basis. He testified that Petitioner was at maximum medical improvement and that his restrictions of no repetitive use of his left knee were permanent.

Based upon the foregoing, Respondent shall continue to pay Petitioner maintenance for the disputed period of disability beginning on July 9, 2019, through the date of hearing on December 12, 2019.

This award shall in no instance be a bar to further hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

JANINE MERKEL,
Executor of the Estate of
JOSEPH G. MERKEL, II, Deceased,

Petitioner,

20IWCC0675

vs.

NO: 16 WC 14209

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the decision regarding permanent partial disability (PPD) benefits. First, on page 5 (unnumbered) under factor (iii) of the Section 8.1b(b) analysis, we strike the sentence that begins with "Because of Petitioner's advanced age..." and replace it with, "The Commission notes Petitioner died on July 4, 2016, of unrelated causes."

Based on our review and analysis of the five factors, we reduce Petitioner's PPD award from 5% to 3% loss of use of the person as a whole under Section 8(d)2 of the Act. However, we modify the award to reflect that Petitioner's estate is only entitled to the 3-1/7 weeks of PPD benefits that had accrued at the time of Petitioner's death. The Arbitrator properly cited *Bell v. IWCC* for the proposition that Petitioner's estate is entitled to accrued, unpaid benefits that were due and owing at the time of his passing. *Dec. at 5 (unnumbered).* However, the Arbitrator did not determine what those accrued benefits were.

We find that the number of weeks of benefits that had accrued is inextricably related to the issue of nature and extent. Petitioner died 3-1/7 weeks after reaching maximum medical

improvement. He returned to work full duty on June 13, 2016 and passed away on July 4, 2016 from causes unrelated to his work accident. In *Nationwide Bank & Office Mgmt. v. IC,* the appellate court found that "benefits which accrued up to the date of death were payable to the estate, regardless of dependency, while benefits which did not accrue until after the date of death were abated." 361 Ill. App. 3d 207, 211 (1st Dist., 2005). Since PPD benefits are payable in weekly installments, the only PPD benefits to which Petitioner's estate is entitled are those that accrued prior to his death, which is 3-1/7 weeks. We therefore modify the decision to reflect that Petitioner's estate is entitled to 3-1/7 weeks of PPD benefits under Section 8(d)2 of the Act.

Finally, we note that the Arbitrator's decision awarded 8-6/7 weeks of temporary total disability benefits to Petitioner, but Respondent had already paid these benefits and this was not an issue at trial.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner's estate the sum of $755.22 per week for a period of 3-1/7 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 3% loss of use of the person as a whole, but only 3-1/7 weeks of permanent partial disability benefits had accrued at the time of Petitioner's death from causes unrelated to his work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the outstanding medical bill of RM Anesthesia directly to the provider for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

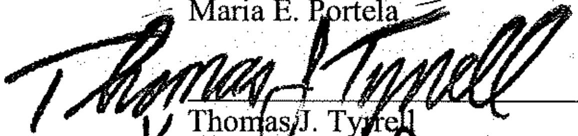
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

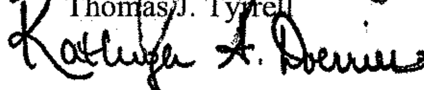
Pursuant to §19(f)(2) of the Act, Respondent is not required to file an appeal bond in this case. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 19 2020

Maria E. Portela



Thomas J. Tyrrell



Kathryn A. Doerries

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O: 10/20/20
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MERKEL, JOSEPH
Employee/Petitioner

Case# **16WC014209**

20IWCC0675

CITY OF CHICAGO
Employer/Respondent

On 4/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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
JOSEPH W LAUER
155 N MICHIGAN AVE SUITE 540
CHICAGO, IL 60601

0010 CITY OF CHICAGO LEGAL DEPT
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

20 IWCC0675

- [ ] 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

Joseph Merkel
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 16 WC 14209

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 , Arbitrator of the Commission, in the city of Chicago, on March 20, 2019. 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. [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. [x] Other Death of the Petitioner

20 I W CC0675

FINDINGS

On April 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*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $100,167.16; the average weekly wage was $1,926.39.

On the date of accident, Petitioner was 59 years of age, 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 $11,374.87 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $11,374.87.

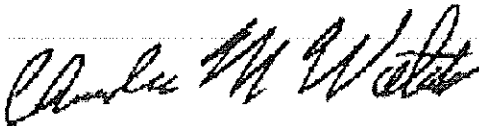
Respondent is entitled to a credit of $0.00 under Section 8(j) of the Act.

ORDER

- THE ARBITRATOR FINDS THAT THE PETITIONER'S CURRENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE 04/07/2016 WORK-RELATED ACCIDENT.
- THE ARBITRATOR FINDS THAT THE PETITIONER IS ENTITLED TO TTD BENEFITS FROM 04/12/2016 TO 06/12/2016 REPRESENTING 8 6/7 WEEKS.
- THE ARBITRATOR FINDS THAT ALL REASONABLE AND NECESSARY MEDICAL BILLS SHALL BE PAID INCLUDING THE RM ANESTHESIA BILL PURSUANT TO SECTION 8(A) AND 8.2 OF THE ACT AND THE FEE SCHEDULE.
- THE ARBITRATOR FINDS THAT THE PETITIONER SUSTAINED PERMANENT PARTIAL DISABILITY TO THE EXTENT OF 5% LOSS OF USE OF A PERSON AS A WHOLE PURSUANT TO SECTION 8(D)(2) OF THE ACT REPRESENTING 25 WEEKS AT THE RATE OF $755.22 TOTALING $18,880.50. THE ARBITRATOR FURTHER FINDS THAT THIS AWARD SHALL BE PAID TO THE PETITIONER'S ESTATE.

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

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



Signature of Arbitrator

March 24, 2020
Date

APR 2 - 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION

Janine Merkel, Executor of the Estate of Joseph G. Merkel, II, deceased,
Employee/Petitioner

v. Case # **16** WC **014209**

City of Chicago,
Employer/Respondent

PETITIONER'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

On March 20, 2019, the parties presented the above matter to the Honorable Arbitrator Charles Watts. The only issues in dispute are –unpaid anesthesia bill, nature and extent and death of Petitioner. (See Arbitration exhibit "1" – Request for Hearing). Below are Petitioner's Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

On April 7, 2016, Mr. Joseph G. Merkel, II, was injured in the course of his employment while working as a Plumbing Inspector for the City of Chicago. Mr. Merkel suffered a right inguinal hernia. (See medical records from Presence Resurrection Medical Center, Petitioner's exhibit "1"). On April 27, 2016, Dr. Daniel Dahlinghaus performed surgery in the form of a repair of the right inguinal hernia and an excision of the lipoma of the cord. Dr. Daniel Dahlinghaus repaired the inguinal hernia using two (2) separate extra-large sized Marlex mesh plugs and Onlay Marlex mesh noting an approximate size of 1.5 cm x 4 cm. Dr. Dahlinghaus' post-operative diagnosis was right inguinal hernia, lipoma of the cord. Following surgery, Dr. Dalinghaus imposed a six-week 10-pound lifting restriction. (Petitioner's exhibit "1").

It appears from the progress notes from Northwestern General Surgeons, Ltd. that Mr. Merkel reached maximum medical improvement (MMI) and was released from doctor's care on June 13, 2016. (See medical records from Northwestern General Surgeons, Ltd., Petitioner's exhibit "2"). The City of Chicago paid for all of Mr. Merkel's medical treatment except the anesthesia bill for the anesthesia administered during the surgery. The City also paid Mr. Merkel total temporary disability benefits from April 12, 2016 until June 12, 2016. (See City of Chicago Workers' Compensation payment ledger, Petitioner's exhibit "3" and RM Anesthesia bill, Petitioner's exhibit "4"). Mr. Merkel worked as a Plumbing Inspector for the City of Chicago until July 4, 2016, when he died from causes unrelated to this case. Mr. Merkel's death certificate was presented to the Court and the Arbitrator took judicial notice of the document.

On February 17, 2017, the Honorable Judge Susan Coleman entered an Order in case number 2017 L 446 finding that Mr. Merkel left the following heirs – Joseph G. Merkel, III (adult - son) and Janine L. Merkel (adult - daughter). (See 2-17-17 Order, Petitioner's exhibit "5").

During the hearing, Janine Merkel, Mr. Merkel's adult daughter, testified that at the time of Mr. Merkel's work-accident and death, she was twenty-four years old and lived with Mr.

Merkel. Janine's mother had already passed away so she relied heavily on her father's support. Mr. Merkel provided Janine with a place to live, food and paid for her car insurance, health insurance, cell phone and student loans.

Joseph G. Merkel, III, Mr. Merkel's adult son, testified that at the time of his father's work-accident and death, he was twenty-eight years old, lived at home and also relied heavily on his father for support. Mr. Merkel provided his son, Joseph G. Merkel, III, with a place to live, food and also paid for his car insurance and health insurance. Both Janine and Joseph Merkel, III testified that their father provided them with 95% of what they needed.

CONCLUSIONS OF LAW

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?

This is an accepted claim. The City of Chicago paid for Mr. Merkel's medical treatment, including his hernia surgery. For some unknown reason, the City did not pay for the bill for the anesthesia administered during the surgery. Because the surgery was reasonable and necessary and said treatment is not in dispute, the Arbitrator hereby orders that Respondent shall pay the submitted outstanding medical bill directly to the provider pursuant to Sections 8(a) and 8.2 of the Act and the fee schedule.

L. What is the nature and extent of the injury?

This is a post-September 1, 2011, accident. Neither party presented an AMA impairment rating. Thus, the Arbitrator will award permanent disability after considering the relevant four of the five factors as enumerated in Section 8.1b of the Act:

(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 injury;
(iv) The employee's future earning capacity; and;
(v) Evidence of disability corroborated by the treating medical records.

At the time of his injury, Mr. Merkel was fifty-nine (59) years old. He worked as a Plumbing Inspector for the City of Chicago. The medical records prove that Mr. Merkel suffered a right inguinal hernia and lipoma of the cord that required surgical intervention.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report 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 Plumbing Inspector at the time of the accident and that he was able to return to work in his prior capacity. Because the Petitioner was able to return to work, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was fifty-nine (59) years old at the time of his work-related accident. Because of Petitioner's advanced age, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner returned to work and did not suffer any loss in future earning capacity. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered a right inguinal hernia and lipoma of the cord that required surgical intervention. 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 Man as a Whole pursuant to §8(d)(2) of the Act. Respondent shall pay the estate of deceased Petitioner the sum of $18,880.50 ($755.22 x 25 weeks) as permanent partial disability pursuant to Section 8(d)(2) of the Act.

O. Death of the Petitioner

On April 7, 2016, Mr. Merkel suffered an inguinal hernia as the result of an accepted work-related accident. On April 27, 2016, Dr. Daniel Dahlinghaus surgically repaired the hernia. On June 13, 2016, Mr. Merkel reached MMI and returned to work as a Plumbing Inspector for the City of Chicago. On July 4, 2016, Mr. Merkel died from causes unrelated to this case. Mr. Merkel's right to permanent partial disability and payment of unpaid related medical expenses had accrued prior to his death because he reached MMI.

On February 17, 2017, the Honorable Judge Susan Coleman entered an Order finding that Mr. Merkel's estate consisted of the following heirs - Joseph G. Merkel, III (adult - son) and Janine L. Merkel (adult - daughter). Under *Bell v. Illinois Workers' Compensation Commission*, 2015 IL. App. (4th District) 140028, the estate of the Petitioner is entitled to collect accrued, unpaid benefits that were due and owing at the time of the employee's passing. *See Bell*, 2015 IL. App. (4th District) 140028. Based on the foregoing, the Arbitrator finds that the estate of the Petitioner is entitled to collect accrued permanent partial disability and unpaid bills as set forth above.

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

Cheryl M. Soucy,

Petitioner,

vs. No. 15 WC 11924

All Truck Transportation Co., Inc.,

20IWCC0676

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

The Commission modifies the Arbitrator's Decision to reflect the parties' stipulation on review to an average weekly wage of $915.83, corresponding to a temporary total disability rate of $610.55 and a permanent partial disability rate of $549.50. Further, the Commission corrects the order part of the Decision to reflect a temporary total disability period from **January** 26, 2015 through March 20, 2015.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 26, 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 $610.55 per week for a period of 7 5/7 weeks, from January 26, 2015 through March 20, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses Petitioner incurred through March 19, 2015, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $549.50 per week for a further period of 25 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 5 percent of the person as a whole.

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

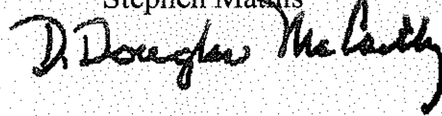
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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.

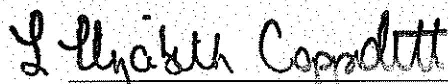
NOV 19 2020

DATED:
o-10/07/2020
SM/sk
44

Stephen Mathis



Douglas McCarthy



L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SOUCY, CHERYL
Employee/Petitioner

Case# **15WC011924**

20IWCC0676

ALL TRUCK TRANSPORTATION INC
Employer/Respondent

On 12/26/2018, 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 2.48% 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:

2811 CIARDELLI CUMMINGS & CAMPAGNA
MARC R CAMPAGNA
70 E LAKE ST SUITE 1000
CHICAGO, IL 60601

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

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

CHERYL SOUCY
Employee/Petitioner

Case # **15 WC 11924**

v.

Consolidated cases: ______

ALL TRUCK TRANSPORTATION, INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **8/24/2017**. 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. [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. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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: **§8(a) payment of vocational assessment expenses.**

FINDINGS

On **1/5/2015**, 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 in the neck ***is not*** causally related to the accident, but Petitioner's left shoulder condition ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$56,566.64**; the average weekly wage was **$1,087.82**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$50,955.45** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$50,955.45**.

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

ORDER

The Arbitrator finds that Petitioner sustained an injury to the left shoulder and awards Petitioner **5% person-as-a-whole, 25 weeks**, pursuant to §8(d)(2) of the Act, at the PPD rate of $652.69.

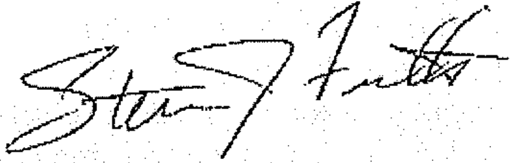
The Arbitrator denies all requests for medical treatment and medical bill payments subsequent to March 19, 2015.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits from **March 26, 2015 through March 20, 2015**, at a rate of $725.13/week, at which time she had reached MMI with her left shoulder.

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 2 6 2018

Cheryl Soucy v. All Truck Transportation
10 WC 011924

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the 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/TPD; ***L:*** What is the nature and extent of the injury?; ***O:*** Is Petitioner entitled to reimbursement for vocational rehabilitation costs?

Petitioner claims an average weekly wage of $1,087.82, which Respondent disputes. Respondent claims Petitioner's average weekly wage was $885.92.

FINDINGS OF FACT

Petitioner Cheryl Soucy testified that she was injured January 5, 2015 while working for Respondent All Truck Transportation. She had worked as a full-time city truck driver for Respondent since August 2014. She typically worked between 60 and 70 hours per week. Overtime was consistent and mandatory. Her base pay was $15.00/hour. Petitioner testified that her job duties included picking up loads, delivering them, as well as inspecting the trucks and trailers. Petitioner's Exhibit #20 was her job description, which Petitioner described as "no touch." Those requirements included servicing the truck with oil, fuel, and radiator fluid to maintain tractor-trailer. However, there were no requirements regarding loading or unloading freight or cargo. She also testified that the job description was inaccurate because she was required to unload her trailer for certain clients, such as Valspar Paints.

Petitioner identified Petitioner's Exhibit Number 13 (payroll records and pay stubs) as an accurate record of her wages with Respondent. Her base pay was $15.00/hour, but she worked mandatory overtime of 60 – 70 hours per week.

Petitioner has held a CDL class "A" driver's license since 2013. Prior to 2013 she held a class "B" license. Petitioner's prior work history consisting of various class "B" and class "A" commercial driving positions since 2006.

On November 6, 2008 Petitioner had an X-ray of the cervical spine at Advocate Good Samaritan Hospital for "severe headache." It was noted that Petitioner had cervical spondylosis with bilateral neural foraminal encroachment at C4-5, C5-6, and C6-7 (RX #14).

Petitioner testified she was involved in a motorcycle accident the summer of 2010. She was treated in the emergency department of Advocate Good Samaritan Hospital June 6, 2010 (RX #6). She gave a history of the motorcycle accident and migraines, hypercholesterolemia, and depression. She complained of neck pain, left shoulder pain, and left knee pain. There were no complaints of back pain. A CT scan of the cervical spine showed various degenerative changes: space narrowing at C6-7; bulging discs at C2-3, C3-4, C4-5, and C5-6; small posterior lateral endplate spurs at C4-5; moderate endplate spurs at C5-6; moderate narrowing of the left C5-6 neural foramen by uncinate process spur; small posterior endplate spurs at C6-7. X-rays of the left knee, left shoulder, and left hand were unremarkable. Petitioner was discharged with diagnoses of cervical and lumbar sprain.

Petitioner testified that she was feeling great between the motorcycle accident and work accident on January 5, 2015. She was not under the care of any doctor except for her primary care physician, Dr. Julie Limon. Petitioner testified that she had no prior sharp, radiating left arm pain and had no treatment for her shoulder in the 3 years before her accident. She testified that she had not injured her neck in any accident other than the one in Summer 2010 and that accident at issue.

On January 5, 2015, Petitioner arrived at work between 5:00 and 6:00 a.m. She testified there was an ice storm over the weekend and the door to her truck was frozen shut. To gain access to the cab of her truck, she used a credit card to remove ice from the door. She also beat on the door from the outside to loosen the ice. Petitioner then began pulling and tugging on the door, hoping to break it free from the ice. She heard a pop and felt a snap in her left shoulder with the tugging. After she felt the pop, Petitioner enlisted the help of co-worker Kevin Flagg, who helped her pull on the door until it broke loose and opened.

Petitioner testified that her assigned truck was old and dilapidated. She had had trouble with the driver's door for some time before her accident.

Petitioner testified that when she first heard the popping sound in her left shoulder, but she did not have immediate pain. However, once she got into her truck, got the door closed and was ready to begin working, she felt sharp pain in her left shoulder and arm. She continued working for a few hours, delivering one or two loads. She reported the injury to Respondent's safety manager that same day and was instructed to go to Excel Occupational Health (Excel).

Petitioner went to Excel on January 5, 2015, where she was seen by Dr. Edward Pillar (PX #3). Petitioner gave a history of her left shoulder and arm pain, with tingling

in the left-hand fingers. There were no documented complaints of neck pain. On examination there was tenderness to palpation in the left bicipital groove, but no other areas of tenderness around the shoulder. There is full active range of shoulder motion. Dr. Pillar's impression was a left shoulder strain with mild neuropraxia in the hand. He recommended ice and an anti-inflammatory for the left shoulder pain and cleared her for work without restrictions.

Petitioner continued working full duty for Respondent for another 2 or 3 weeks. Her duties included 3 large Valspar loads in 3 consecutive days. The Valspar freight required her to manually unload numerous pallets of paint cans, which involved pulling and pushing the pallets onto dollies to unload them. Afterward Petitioner felt sharp shoulder pain and her left arm felt like it was being stabbed.

Petitioner consulted her primary physician Dr. Limon January 26, 2015, complaining of left shoulder pain and "knife-like" pain radiating down her left arm (PX #4). Petitioner reported that her complaints began before Christmas when she had to repeatedly open and close her truck door. Dr. Limon diagnosed left shoulder pain and strain. Dr. Limon recommended physical therapy on January 26 and an MRI on February 9. Petitioner began physical therapy at Athletico February 4, 2015 (PX #5).

Petitioner had a left shoulder MRI February 12, 2015, which showed supraspinatus tendinosis without evidence of a tear, and a normal rotator cuff. On March 9, 2015 Dr. Limon noted the MRI findings. Petitioner still complained of weakness and inability to lift a few pounds. Petitioner declined an orthopedic referral at that time.

On March 16, 2015 Petitioner saw Dr. Limon with complaints that a drive to Missouri in a Toyota RAV-4 for 8 hours had aggravated her shoulder. Petitioner then requested the orthopedic referral. There were no documented complaints of neck pain after this driving trip. Petitioner returned to Dr. Limon April 13, 2015 with complaints of allergies. There were no documented complaints of left shoulder or left arm pain or neck pain.

Petitioner was evaluated for physical therapy at Athletico February 4, 2015 (PX #5). The Hedges Clinic (Dr. Limon) referral dated February 3, 2015 noted Petitioner's diagnosis was shoulder sprain. Petitioner marked a body diagram on the outpatient screening form, noting her problem was her left shoulder and left arm since January 5, 2015. The intake/functional status summary noted her complaint of very severe shoulder pain, noted at 7/10. She presented with limited range of motion in all directions and with left arm muscle weakness. She tested positive for rotator cuff and impingement special tests. Petitioner reported deficits in reaching, lifting, sitting to

standing, pushing, pulling, carrying, bathing, dressing, grooming, driving, and work-related activities. Although a date of injury of January 5, 2015 was noted, Petitioner stated her problems have been ongoing since mid-December and her pain was getting increasingly worse. Petitioner reported that she had to repeatedly open and close the door to her truck that was out of alignment and did not close properly. She reported that she had been sent to Excel and returned to work. Petitioner stated she worked through her pain for 3 weeks but on January 20 she was assigned to unload to truckloads of freight. She also reported her highest level of pain was 10/10. Petitioner began a regimen of physical therapy 3 times a week for 4 weeks.

Respondent's job requirements for van drivers was included in the Athletico records (PX #5 & PX #20). Petitioner completed a Functional Job Demand Form, wherein she reported the heaviest weight she lifted to shoulder height was 50 – 75 lbs. She also reported that she carried boxes weighing 10 – 25 lbs. over 150 – 200 feet. Also, she reported that she had to push/pull pallets of Valspar paint weighing up to 525 lbs. The Functional Job Demand Form is not dated but is included with records relating to Petitioner's 2016 regimen of care.

Petitioner had 15 sessions of physical therapy through March 20, 2015. Therapy through March 20 was solely directed to her left shoulder. There were no documented complaints of neck pain or limitation in the Athletico records until March 20.

On February 13, 2015 Petitioner reported to her therapist that she did not have a tear in her shoulder and that she was then ready to work because she was going back to work full duty on March 10. On February 16 Petitioner complained of soreness due to helping in-laws clean out their basement after flooding. On reevaluation February 25, 2015 Petitioner presented with increased range of motion and strength but reported functional deficits with pushing up out of a chair, lifting, pushing/pulling, carrying, reaching, and driving.

On March 17, 2015 Petitioner complained that her arm was "killing her" following the drive to Missouri. A Hedges Clinic (Dr. Limon) referral dated March 16, 2015 again noted Petitioner's diagnosis was shoulder sprain. Petitioner complained to 7/10 pain. On March 20, 2015 Petitioner presented with complaints of neck and shoulder pain. She reported that she had seen an orthopedic specialist who thought the problem was coming from her neck. The therapist's impression was that Petitioner's chief complaint was neck and shoulder pain.

Petitioner's records at Athletico, PX #5, resumed on April 18, 2016, following Petitioner's cervical fusion surgery. She received therapy for her neck through October 13, 2016, although there were occasional complaints of shoulder pain documented.

Petitioner saw Dr. Kevin Koutsky at Elmhurst Orthopaedics March 19, 2015 (PX #8). Petitioner complained of left shoulder and left neck pain which radiated down the left "lower" [*sic*] extremity with numbness and tingling in the first, second, and third digits. She reported that her symptoms began January 5, 2015 after a work-related accident. Petitioner stated she was a driver and had been driving all day and performing activities including cranking the dolly and pulling pins. She then developed sharp pain in the shoulder and neck which went down to the elbow. Her primary physician had ordered physical therapy and a shoulder MRI.

On exam Dr. Koutsky found weakness in the left shoulder abductors and decreased pin-prick sensation along the lateral border of the left forearm which extended into the thumb and index finger. There was a positive left-sided Spurling's. Hoffman's and Lhemitte's were negative. There was negative apprehension, sulcus, and drop arm tests. There was a positive impingement sign on the left. Dr. Koutsky noted the February 12, 2015 left shoulder MRI had findings consistent with tendinosis and tendinitis, but with no clear evidence of labral or rotator cuff tears.

Dr. Koutsky diagnosed left shoulder pain and cervical radiculopathy. Petitioner also some left shoulder impingement and tendinitis. He noted that these injuries were related to a work injury on January 5, 2015. He recommended a cervical MRI, an EMG/NCV, and continued physical therapy for the shoulder and neck. Dr. Koutsky also took Petitioner off work.

PA Russell Wudel in Dr. Koutsky's office ordered a TENS unit, a cold therapy unit, and a home exercise kit on March 19, 2015. Dr. Koutsky reviewed the cervical MRI with Petitioner on March 26, noting degenerative disc disease at multiple levels, generalized spurring at C4-5, C5-6, and C6-7. On April 6, 2015 Dr. Koutsky discussed referral to a pain management clinic. Petitioner returned to Dr. Koutsky on April 23 complaining of debilitating pain in both her neck and her shoulder. Dr. Koutsky noted that Petitioner should continue with physical therapy. He further noted that authorization was given for pain management and that he would order an EMG for Petitioner's continued weakness, numbness, and tingling in her left arm and hand. It was also noted that home medical equipment had not been authorized. An injection by Dr. Udit Patel on April 23, 2015 provided significant but temporary relief from her left arm radiculopathy.

On referral by Dr. Koutsky Petitioner evaluated for physical therapy at Physico Sports and Rehabilitation on March 24, 2015 (PX #6). Petitioner was evaluated for cervical and left shoulder pain. She gave a history of a work-related injury on January 5, 2015. She reported that she was pushing and pulling greater than 500 pounds pallets, which she did repetitively, initially starting the pain in her left shoulder. Petitioner

reported numbness and tingling in the left arm and numbness in the left hand. She also reported occasional radicular symptoms in the right arm as well. Petitioner reported that she was worked for a trucking company, which was no touch freighting. Her job required her to drive up to 14 hours a day, pick up and deliver freight, and that she was not supposed to lift.

The examination showed decreased cervical range of motion and decreased left shoulder range of motion. There was also decreased strength in shoulder musculature. Petitioner received therapy through June 18, 2015. The therapist's discharge notes indicated little progress had been achieved therapy.

Petitioner had the EMG/NCV on April 30, 2015. There was mild irritability with occasional positive sharp waves at the left brachioradialis and left C5-6 paravertebral muscles. In addition, there were prolonged bilateral median digital motor latencies, consistent with bilateral carpal tunnel syndrome, more severe on the left. The findings were consistent with bilateral carpal tunnel syndrome, left greater than right, and mild left C5-6 nerve root irritation.

Petitioner returned to Dr. Koutsky May 6, 2015 to discuss the EMG/NCV results, with evidence of C5-6 nerve root irritation and the MRI showing significant stenosis and spondylosis with modic changes at C4-5. Dr. Koutsky assessed cervical radiculopathy noting that Petitioner had failed one injection as well as therapy. He noted Petitioner had significant stenosis with positive EMG changes. He recommended anterior cervical decompression and fusion with instrumentation at C4-5 and C5-6. He also recommended a neurosurgical evaluation with Dr. Geoffrey Dixon.

Petitioner was seen by Dr. Alpesh Patel at Northwestern Memorial Medical Center June 16, 2015 (PX #7). Petitioner presented with complaints of neck pain as well as left arm pain with tingling in his history of pulling on a frozen door January 5, 2015 and heard a snap. Petitioner recounted her history of an MRI and reported an epidural steroid injection which did not provide relief. She also had trigger point injections. Petitioner complained of numbness and tingling left index finger and weakness her left arm. Petitioner social history included 1–½ packs of cigarettes.

Normal and symmetric motor strength in the upper extremities. Light touch sensation was intact over C3-T1 distributions. Biceps, triceps, and brachioradialis reflexes were equal and symmetric bilaterally. Spurling's, Lhermitte's, and Hoffman's signs were negative bilaterally. There was diminished sensation in the left thumb and index finger, consistent with a C6 distribution. The doctor noted the March 24, 2015 cervical MRI revealed degenerative changes at C45, C56 and C67, with a left-sided disc herniation at C5-6. He also noted that the April 30 EMG revealed evidence of C5-6

nerve root irritation. Dr. Patel reviewed the March 24, 2015 cervical MRI, noting degenerative changes at C4-5, C5-6, and C6-7, with a left-sided disc herniation at C5-6. The April 30, 2015 EMG revealed evidence of C5-6 nerve root irritation.

Dr. Patel assessed neck pain with left arm radiculopathy and numbness and tingling at the C6 disc distribution. He recommended a left C6 selected nerve root block. He also recommended that Petitioner see Dr. Guido Marra for evaluation of her shoulder.

On June 18, 2015 Dr. Koutsky reviewed Petitioner's MRI and EMG findings and treatment options. He again recommended anterior cervical decompression and fusion. Petitioner reported she had seen Dr. Dixon who concurred that her "work-related injury now warrants surgical treatment." Risks of surgery were discussed as well as there were no promises or guarantees regarding the outcome of surgery.

On July 15, 2015 Petitioner was seen by APN Christine Koutsky and Dr. Eugene Bartucci (PX #6). APN Koutsky reviewed Petitioner's history, including neck and left arm pain which was interfering with day-to-day activities and prevented her ability to work. APN Koutsky reiterated Dr. Koutsky's recommendation for surgery. APN Koutsky entered an order for a selective nerve root block recommended by Dr. Ross. Petitioner was to follow with Dr. Bartucci for carpal tunnel and left shoulder pain per recommendations of the IME physician.

On July 15 Petitioner told Dr. Bartucci she had injured her left shoulder and arm at work January 5, 2015 when she tried to open the frozen driver's door of her truck. An MRI showed rotator cuff strain but no tear. She reported that physical therapy had helped but that she had residual pain in the arm. Complaints of hand numbness led to an EMG, which revealed bilateral carpal tunnel syndrome and left-sided C5-6 radiculopathy. Petitioner also recounted an epidural injection and a cortisone injection which did not help.

Dr. Bartucci noted weak hand grip and a positive Tinel's sign. He recommended left carpal tunnel release and injected Petitioner's left subacromial space with Kenalog and Lidocaine. Petitioner returned to Dr. Bartucci August 5, 2015. She reported that the shoulder injection had not helped. She complained that she still could not lift her arm. Dr. Bartucci continued with his recommendation for left carpal tunnel release and added a recommendation for left shoulder arthroscopy.

Petitioner returned to APN Koutsky on August 19, 2015. Her complaints and clinical presentation were unchanged. APN Koutsky again reviewed Petitioner's history of failed conservative care and recommendations for surgery for her work-related

injuries, notably cervical fusion and carpal tunnel release. It was noted that Petitioner had had a pain management consultation with Dr. Patel. As before, Petitioner was kept off work. Petitioner's presentation to Dr. Koutsky on November 1, 2015 was unchanged.

Petitioner saw Dr. Bartucci on September 1 and 21, 2015. On September 1 the doctor noted left shoulder strain, supraspinatus tendinitis, and possible partial tear. He repeated his recommendations for shoulder arthroscopy and carpal tunnel release. On September 21 Dr. Bartucci treated Petitioner a right wrist fracture from a fall the day before.

Petitioner saw Dr. Koutsky October 5, 2015. She had had a C5-6 nerve block which gave her 80% relief from neck and arm initially, but that relief was diminishing. Dr. Koutsky recounted Petitioner's history of complaints and unsuccessful conservative care. He reiterated his recommendation for cervical fusion and kept Petitioner off work.

Petitioner also saw Dr. Bartucci October 5 and 21 and November 2, 2015 in follow-up for her wrist fracture.

Dr. Koutsky wrote a narrative report to Petitioner's counsel November 30, 2015 in which he recounted Petitioner's history of neck and left arm pain since a work-related accident on January 5, 2015. He further recounted Petitioner's unsuccessful conservative care and his own diagnosis of cervical radiculopathy. He repeated his recommendation for anterior cervical decompression and fusion surgery.

Petitioner's condition was unchanged on visits to PA Wudel and Dr. Koutsky December 7, 2015 and January 4, 2016. By January 4 surgery had been approved. Dr. Koutsky, assisted by Dr. Dixon and PA Wudel, performed an anterior cervical discectomy and decompression and C4-5 and C5-6 and anterior fusion at C4-5/C5-6 with instrumentation cages, plates, and screws on January 19, 2016.

Petitioner testified that she was in a collar for 6 weeks after surgery. She then had physical therapy for 4-5 months. She said she felt awesome after surgery. She testified that then her neck and left arm pain was gone and that her left hand was no longer numb.

Petitioner followed with Dr. Koutsky post-operatively on January 27, February 3, March 2, April 6, May 4, June 6, July 6, August 8, September 8, October 17, November 21, December 19, 2016, and January 25, March 1, April 12, and May 25, 2017. Over that period Petitioner had rehabilitative physical therapy, work conditioning and hardening, and FCEs.

Petitioner testified that she requested return to work authorization from Dr. Koutsky even though he wanted to impose restrictions. She testified that she wanted to go back to work. The doctor then released Petitioner to work full duty without restriction on October 17, 2016. On November 21 Dr. Koutsky revised the return to work authorization to adopt the FCE restrictions. On January 25 Dr. Koutsky added a "no driving semi truck" restriction and a "no commercial driving" restriction on March 1. Petitioner had improved through post-operative care until she returned to work in November 2016 when her neck and arm symptoms were aggravated. Thereafter, Petitioner continued to complain of neck pain and radicular symptoms aggravated by driving trucks.

Dr. Koutsky referred Petitioner back to Athletico following surgery for physical therapy and work hardening. An FCE was performed at Athletico August 25, 2016 (PX #5). It was noted that Petitioner exhibited "Consistent Performance/Acceptable Effort (82% or 46/56 Expected Responses)." The FCE was noted as valid. Petitioner demonstrated physical capabilities at the Medium physical demand level, being able to lift 30 lbs. from floor to waist. Petitioner's job description was noted at the Heavy physical demand level, requiring 2-hand occasional lift up to 75 lbs. as reported by Petitioner as necessary to open the engine compartment hood of a truck.

Dr. Koutsky testified by evidence deposition March 2, 2017 (PX #12). PX #12 was missing pages 14, 15, 16, and 17.

Dr. Koutsky refreshed his memory with Petitioner's medical chart notes. He first saw Petitioner March 19, 2015. He reviewed Petitioner's history of left shoulder pain and neck pain with numbness and tingling radiating down the left arm into her thumb, index, and middle fingers. She also reported weakness in the left arm. Petitioner stated her symptoms began January 5, 2015 when she suffered a work injury. Petitioner reported work activities including cranking the dolly of the truck trailer and pulling the pins on her cab. She stated that she had a sharp pain in the shoulder as well as neck pain radiating down the left arm to the elbow.

Petitioner reported that she was seen at the company medical center where she given medication and returned to full duty work as a driver. Petitioner then followed with her primary physician who recommended an MRI and started her on Physical therapy. On examination Dr. Koutsky found weakness in the lefts shoulder abductors. There was also some numbness over lateral border of the left forearm which extended into the thumb and index finger. Petitioner had a positive Spurling's sign on the left which was suspicious for a pinched nerve. There was also a positive impingement sign and weakness in the rotator cuff. Dr. Koutsky reviewed the February 15 shoulder MRI, noting tendonitis but no full thickness tear of the rotator cuff.

Dr. Koutsky diagnosed left shoulder pain and cervical radiculopathy. He ordered a cervical MRI, which was done March 24, 2015. He testified that the MRI showed degenerative changes, stenosis with disc/spur complexes at C4-5, C5-6, and C6-7. Dr. Koutsky recommended continued physical therapy but also recommended an EMG/NCV. The EMG/NVC showed left C5-6 radiculopathy and bilateral carpal tunnel syndrome, which he said was consistent with Petitioner's symptoms. He referred Petitioner for a nerve block injection, which was performed by Dr. Patel.

The Arbitrator assumes Dr. Koutsky's testimony recorded on pages 14 through 17 recounted his decision to perform the January 19, 2016 anterior cervical discectomy and decompression and fusion.

Dr. Koutsky further testified to Petitioner's post-operative care. He opined that the January 5, 2015 work accident cause and was directly related to Petitioner's cervical radiculopathy. He specifically cited Petitioner's work activities of cranking the dolly and pulling pins. He opined that Petitioner's neck condition pre-existed the alleged accident but was aggravated by it. He further opined that the surgery was necessary to treat Petitioner's injuries from her reported workplace accident. He also opined that the surgery would not have been necessary unless Petitioner unless she had some inciting traumatic injury.

Dr. Koutsky testified that the pain cream he prescribed was necessary to lessen the use of narcotic opioids. He prescribed scar cream after surgery to prevent adhesions. Dr. Koutsky stated that some of his patients initially present with shoulder pain when they have neck injuries. He also noted that Petitioner's neck will never be 100% but that she was at MMI.

Dr. Koutsky returned Petitioner to work with FCE restrictions but the jarring when driving a truck was aggravating her chronic neck symptoms. He later restricted her from "commercial driving." He also noted that Petitioner's neck will never be 100% but that she was at MMI.

On cross-examination Dr. Koutsky acknowledged that Petitioner did not mention any neck or upper left extremity problems before January 5, 2015. He also went on to say that the accuracy of his opinion depends on the accuracy of what Petitioner told him about whether she had a prior injury to her neck. Further, he stated that in coming to his conclusion regarding medical causation, he was assuming she had no prior neck or left upper extremity symptoms. Finally, he acknowledged that Petitioner was not taking narcotic medication for pain.

On re-direct examination Dr. Koutsky recited Petitioner's history given to Dr. Bartucci on July 15, 2015 that she was originally injured when she tried to open a frozen truck cab door. Dr. Koutsky also noted Petitioner's care with Dr. Limon and the progression of Petitioner's symptoms while under Dr. Limon's care. Dr. Koutsky opined that attempting to open a frozen truck cab door could aggravate or exacerbate an underlying degenerative cervical spine condition.

Petitioner was evaluated for vocational rehabilitation by Stephen Blumenthal a certified vocational rehabilitation counselor February 21, 2017 and March 29, 2017. His reports were admitted in evidence at his evidence deposition on July 19, 2017 (PX #11).

Mr. Blumenthal extensively reviewed Petitioner's social, educational, and history. In addition, Mr. Blumenthal reviewed various medical records, including those of Dr. Koutsky, the IME report of Dr. Pomerance, the IME report of Dr. Matthew Ross, the IME report of Dr. Selby and the Athletico FCE. Mr. Blumenthal also conducted an interview and vocational testing of Petitioner.

Mr. Blumenthal testified that IME reports and the records of Dr. Koutsky documented Petitioner's C4-5 and C5-6 radiculopathy, status post fusion chronic pain. He noted the FCE findings of Petitioner's maximum lifting capability, floor to waist, 30 pounds and 20 pounds occasionally lifting overhead. Petitioner was limited to carrying 25 pounds for 200 feet. Dr. Koutsky had released petitioner in accord with the FCE restrictions with the added restriction of no commercial driving. Also, Dr. Koutsky had placed Petitioner at MMI.

At the intake interview Petitioner reported that she was able to sit approximately 2 hours and then needed to get it up and move around. She could stand in one position for about 30 minutes but then needed to move around or her neck and shoulder muscles would tighten up. Petitioner was able to bend forward and crouch as well as kneel. She reported that she could lift a gallon of milk but that she could not lift and carry a 40-pound bag of dog food. She said she could operate her personal vehicle for about 30 minutes after which she had a little stiffness and soreness. If she drove about 1 ½ to 2 hours she needed to stop for these 5 to 10 minutes before continuing.

Petitioner reported an extensive history of truck driving, including tractor-trailer trucks. She had previously worked clerical jobs. Petitioner clean completed high school and has held a CDL-A license. On testing Petitioner demonstrated average reading vocabulary but below average reading comprehension. She had moderately below average paper and pencil spelling but moderately above average math computation ability. Petitioner scored above average on nonverbal reasoning. She also demonstrated

strength in spatial relations, numerical ability, word knowledge, perceptual speed and accuracy. She demonstrated a low average ability to complete written information.

Mr. Blumenthal performed a transferable skills analysis, which demonstrated Petitioner's capability as a general office clerk, and appointment clerk, a sales clerk, a sales attendant, security guard, cashier, and gate guard. Wages for these jobs range from $9.49 an hour to $19.36 an hour.

Although Mr. Blumenthal noted Petitioner's transferable skills and aptitudes, he noted those skills did not involve detailed use knowledge of Microsoft Office Word, Excel, or Outlook which is a prerequisite in obtaining employment in the current labor market. He noted that Petitioner has the physical and intellectual abilities to improve her employability and earning capacity, in accord with the *National Tea* case, by completing a certificate program in the 32-hour credit hour Accounting Assistant/Clerk program at Moraine Valley Community College. Mr. Blumenthal opined that Petitioner would be an excellent vocational rehabilitation candidate to complete additional skills training and would benefit from Job Readiness Training and Job Placement Services over a period of 4 to 6 months at a projected cost of $10,000-$15,000.

Mr. Blumenthal further opined that Petitioner had access to the stable labor market, earnings dependent on whether additional formal retraining to improve employability and capacity was obtained. He added that Petitioner will sustain a loss of earning capacity as a truck driver as compared to employability following formal retraining.

After review of additional medical records, Petitioner's employment information, and Illinois Department of Employment Security wage data Mr. Blumenthal prepared an addendum report on July 17, 2017. He noted that petitioner's then current employment at Mid-City Truck Driving Academy involved general office clerk duties and interaction with students was consistent with her current skill set. Petitioner was earning $13.00 an hour for a 40-hour week. Mr. Blumenthal noted that wage data showed that entry-level pay for general office clerks ranged from $11.16 to $11.91 an hour and that median wages or general office clerks ranged from $16.38 $17.60 an hour. Mr. Blumenthal calculated Petitioner's average weekly wage at the time of her injury has $1,009.37, based on the assumption that she earned $25.00 an hour at All Truck. Petitioner had informed him that her base pay was $15 per hour but that there was mandatory overtime of 20 to 30 hours per week. He opined that if Petitioner were able to access a stable labor market as a tractor-trailer truck driver she would be able to earn the range $23.25 to $27.90 per hour.

On cross-examination Mr. Blumenthal acknowledged that he did not perform a labor market survey or a job analysis. He did not develop a specific placement program for petitioner, rather he identified training and placement options. Mr. Blumenthal based his opinions on Dr. Koutsky's restrictions, noting that the FCE restrictions did not restrict commercial truck driving. He also acknowledged that the Dictionary of Occupational Titles listed the physical requirements for a tractor-trailer driver position at the medium demand level. He further acknowledged that the FCE physical therapist's assessment was that Petitioner could perform work at the medium physical demand level.

Mr. Blumenthal did not find Dr. Zelby's July 13, 2016 report persuasive since it was written before the August 25, 2016 FCE. He relied on Dr. Koutsky's work restrictions rather than Dr. Zelby's opinion that Petitioner could return to work. He knew of no restrictions on how many hours Petitioner could work.

On further cross-examination Mr. Blumenthal test that he did test Petitioner's typing skills. He had noted that she took a keyboard class in the 1990s and had not used those skills for last 20 years. Petitioner had earned certificates in high school as an accounting technician and in business management but had not used those skills in the last 20 years. Mr. Blumenthal noted that he relied on that background in forming his opinions. However, he acknowledged that Petitioner probably had limited skills in using Microsoft Office.

Petitioner had been able to obtain all of her prior jobs without professional assistance, including employment obtained following her surgery. Mr. Blumenthal acknowledged that Petitioner's history of driving a truck for Iblaj was not in his records or his reports. The wage data included in his charts was incomplete. Further, he would not normally expect employers to provide on-the-job training in Microsoft Office, Word, Excel, and Outlook.

Petitioner testified she requested a return to work with Respondent, but Respondent would not take her back. She found work as a dump truck driver with J Avenue Development in late October 2016. She was paid $25.00 per hour and worked 40-plus hours per week for (PX #15). Petitioner described the work for J Avenue as "off-roading" in a semi-truck, causing a lot of bouncing, jostling, and jarring. The job at J Avenue caused her severe neck pain and headaches which started at the base of her neck up to the back of her skull. Due to the severe pain caused by driving a dump truck, Petitioner voluntarily quit her position with J Avenue approximately 2 weeks after she was hired.

Petitioner was then hired as a long-haul truck driver for VS Truck Lines on or around November 27, 2016 (PX # 16). She picked up freight and delivered it all over the country. Petitioner's Exhibit #16 comprises DOT logbooks she kept during her employment with VS Truck Lines. The logbooks accurately reflect the hours and mileage she drove for VS Truck Lines from November 27, 2016 until voluntarily resigning on December 22, 2016. The long-haul driving with VS Truck Lines also caused increased neck pain and headaches. The pain forced Petitioner's resignation from VS Truck Lines. Petitioner has not driven a truck since.

Petitioner was examined for her left shoulder pursuant to §12 of the Act by Dr. Jay Pomerance August 6, 2015 (RX #3). Dr. Pomerance reviewed certain imaging of the cervical spine and left shoulder, particularly the shoulder MRI completed February 12, 2015. Petitioner gave a history of injuring her left shoulder at work on January 5, 2015 when she was opening a frozen truck door with her left arm. She reported feeling a pop in the shoulder and pain which radiated down her arm. She also noticed numbness throughout her left hand. Petitioner reported that she was evaluated at a local occupational health clinic where she was diagnosed with a strain, given anti-inflammatories, and returned to work.

Petitioner reported that her symptoms increased with work to the point where she consulted her primary physician who gave her and off work. Petitioner had six weeks of physical therapy with no significant benefit. She also reported taking a long-distance drive to see family during which symptoms significantly increased to a point where she "could not move my arm." Petitioner was then referred to an orthopedic surgeon who informed her she had multiple cervical disc abnormalities. Prescribed therapy then creased. An injection in the shoulder gave minimal relief.

Petitioner reported she had not returned to her prior job as a long-haul truck driver. She reported that in addition to driving she had to load and unload trucks with weights up to 500 pounds. Petitioner's past medical history was significant for a long-standing smoking history. Dr. Pomerantz did not note Petitioner's history of a motor vehicle accident in 2010 or any of the medical care she received related to that accident

Examination Petitioner's neck range of motion was significantly limited. Active range of left shoulder motion was normal, except for diminished flexion. Passive range of motion in the left shoulder was full. Dr. Pomerance could not reproduce the popping Petitioner complained of. There was tenderness to palpation over the coracoid process but no specific tenderness at the greater tuberosity or the anterior lateral. There was some tenderness along the scapula. There was no evidence of muscle atrophy. Rotator cuff strength appeared to be symmetric but with mild left biceps weakness on the left.

Impingement signs were negative. There was a negative cross-over test and no signs of shoulder instability or labral abnormalities.

The examination of the left arm was normal but for reported altered sensation to light touch in the radial aspect of the left hand, including the first dorsal web space. Dr. Pomerance noted that X-rays and the MRI were essentially normal.

Dr. Pomerance opined that Petitioner's left upper extremity complaints appeared to be consistent with cervical radiculopathy. However, noting that he did not treat spine conditions and that spine conditions were outside his expertise, he deferred to a physician who treats spine conditions to confirm whether that diagnosis was correct and if it was related to Petitioner's January 5, 2015 accident. He noted that the April 30, 2015 nerve conduction test was consistent with left cervical radiculopathy in addition to advanced bilateral carpal tunnel syndrome. He further opined that the bilateral carpal was not related to Petitioner's described work accident, nor was it aggravated or exacerbated by the accident.

Dr. Pomerance did not find any specific shoulder or hand abnormalities. He opined that Petitioner has numerous medical history factors associated with the development of bilateral carpal syndrome: age, gender, menopause status, and long-standing 1-2 to pack per day smoking. Finally, Dr. Pomerantz opined that Petitioner did not require any medical treatment for her shoulder but also noted that cervical radiculopathy will often present with primary pain, which he believed was the case with Petitioner. He added that regarding the left shoulder, based on Petitioner's stated job description, she did not need physical restrictions or limitations for work, although he could not vouch for her ability to safely operate a truck.

Although Dr. Pomerance found no specific anatomic upper extremity injury, he could not opine whether Petitioner was at MMI until she had completed medical care and had reached a healing plateau.

Dr. Pomerance prepared an addendum report August 9, 2015 after reviewing additional medical records (RX #4). He reiterated his opinion that Petitioner's symptoms appeared to be consistent with a cervical radiculopathy. He again noted that he did not find the primary problem in the upper extremity. Dr. Pomerance noted cervical nerve problems often present with shoulder/arm discomfort along with numbness in the involved nerve root. He was unclear why treatment continued to be recommended for peripheral arm issues and that the problem appeared be in the neck. However, he again noted that he did not evaluate or treat neck problems and again deferred to someone with expertise in that area.

Petitioner's back was examined by neurosurgeon Dr. Andrew Zelby for a §12 IME on July 13, 2016 (RX #1, DepX #2). In his narrative report Dr. Zelby reviewed Petitioner's history and subjective complaints. He reviewed Petitioner's records from Dr. Limon, Advocate Good Samaritan Hospital from 2010, South Cook County EMS from 2010, Silver Cross Hospital from 2010, Excel Occupational Health Clinic, Dr. Koutsky, Dr. Patel, and Dr. Bartucci. Dr. Zelby also reviewed cervical spine X-rays, a June 6, 2010 cervical CT scan, and a March 24, 2015 cervical MRI. He also reviewed radiology reports from various thoracic and lumbar X-rays and MRIs.

Petitioner reported that she felt a pop in her left shoulder as she tried to open a frozen door on a truck. She had shoulder pain and numbness in the left arm. She continued to work another 5-6 hours, but her pain worsened. A company physician diagnosed a strain. Petitioner reported that she continued to work another 3 weeks but with persistent symptoms.

Petitioner's family physician sent her to physical therapy. She reported that after driving 100 miles on a trip to visit her parents she could not turn her head. Petitioner then saw an orthopedist who told her she had problems with 2 discs in her neck. She had additional physical therapy, multiple spinal injections, and nerve blocks without relief. She had anterior cervical fusion January 19, 2016. She was in a hard collar for 6 weeks followed by additional therapy.

Petitioner reported that her neck pain and hand numbness were better but that her shoulder pain and popping were no better. Petitioner stated that she did not have problems in her right shoulder or arm. Her symptoms were aggravated by driving distances and bending her head to read. Petitioner denied prior episodes of any similar type of symptoms.

On physical exam July 13 Dr. Zelby noted mildly diminished cervical range of motion. Sensation over the entire left arm was diminished.

Dr. Zelby testified by evidence deposition on April 6, 2017 (PX #1). His July 13, 2016 narrative report of the §12 IME was admitted in evidence without objection. He refreshed his memory with his IME report. Dr. Zelby is board-certified in neurosurgery.

Dr. Zelby testified that he examined Petitioner and reviewed her medical records. At the IME Petitioner gave a history of trying to open the frozen driver's door of her semi-tractor on January 5, 2015. She reported that as she pulled she heard and felt a pop in her left shoulder. She had pain in the shoulder and numbness in the entire left hand. Petitioner reported that she worked another 5 or 6 hours but her pain became too

severe to continue. She was initially seen by a company doctor who told her she had a strained shoulder and released her back to work.

Dr. Zelby testified that Petitioner continued to work for 3 weeks but because her symptoms persisted she went to her family physician. The physician took her off work and sent her to physical therapy. Petitioner reported that she drove to Missouri to see her parents but that within 100 miles she was unable to turn her head. Upon return she was seen by an orthopedic specialist who told her she had problems with 2 discs in her neck. Petitioner had physical therapy and multiple spinal injections and nerve blocks, none of which helped. She had an anterior cervical discectomy and fusion on January 19, 2016. Afterward she was in a hard collar for 6 weeks and returned to physical therapy. Petitioner reported that she had been in physical therapy almost constantly since that time and was continuing physical therapy twice a week.

Petitioner still had some neck pain and hand numbness but that her shoulder pain and popping were no better. Her symptoms were exacerbated with fixed postures, driving distances, and bending her head to read. She reported that she was able to drive as well as putting on her shoes and socks. Petitioner denied that she had prior episodes of those or any similar symptoms.

Dr. Zelby recounted Petitioner's history from my motorcycle accident in 2010, she injured her neck, left shoulder, left clavicle, left knee, and had headaches. Dr. Zelby also noted Petitioner had a 30 pack a year smoking history. Smoking accelerates degeneration of the spine.

During the examination Dr. Zelby noted inconsistencies between his objective observations and Petitioner's subjective complaints. He noted that petitioner's ease of movement was not consistent with her reported 7-8/10 pain. Further, Petitioner complained of tremendous pain even on superficial light touch palpation over the lower cervical and upper trapezius regions compared to no complaints of pain to pressure in the same areas when testing of upper extremity strength was done. Spurling's maneuver was positive centrally with non-physiologic pressure, meaning she complained of severe neck pain when pressure was insufficient to actually load the spine. Petitioner complained of diminished sensation that was inconsistent with any spine condition, particularly complaining of loss of sensation in the entire left arm which was non-anatomic. Dr. Zelby added that Petitioner had 4 out of 5 positive Waddell signs, consistent with symptom amplification.

Dr. Zelby noted that the March 24, 2015 cervical MRI showed straightening of the cervical spine and degenerative changes from C4 to C7. The MRI showed a broad-based and left disc steel fight complex at C2-3, a broad-based left osteophyte complex at

C3-4, a broad-based right osteophyte complex at C4-5 with near-complete effacement of the ventral CSF, a broad-based right osteophyte complex at C5-6 with near-complete effacement of the ventral CSF, and a broad-based disc osteophyte complex with hypertrophy at C6-7.

He noted that Petitioner did not complain of neck pain for 2 months after her reported injury at work, and he opined that those complaints were not caused or were unlikely to have occurred because of her work injury. He opined that the reported work injury did not cause her cervical spine spondylosis to become symptomatic. Further, it did not cause, aggravate, exacerbate, or accelerate her underlying degenerative condition. Her MRI from March 2015 showed no acute or post-traumatic abnormalities. The study also showed changes that were consistent with the findings of a June 2010 cervical spine CT scan. He further opined that these things document that there was no change in the condition that was already present in her cervical spine at the time of her shoulder injury and she did not sustain a cervical spine injury.

On cross-examination Dr. Zelby again noted that the 2010 cervical CT scanned was consistent with and materially showed the same things as the 2015 MRI. Dr. Zelby also noted also noted that Petitioner had complained April 13, 2010 4th and 5th digit numbness in the left hand with pressure on the left elbow, which was diagnosed as ulnar neuropathy. This was not related to disk pathology in the cervical spine. He further noted Dr. Limon's diagnosis of left hand carpal tunnel syndrome October 19, 2010. Petitioner was seen in the emergency room of Advocate Good Samaritan June 6, 2010 with complaints of left shoulder, neck, and left clavicle pain. There was no diagnosis cervical sprain/strain. There was also a note from Dr. Limon December 31, 2010 Petitioner's exacerbation of upper neck and lower back pain. Petitioner was also seen in the emergency room of Silver Cross Hospital in December 2010 when she was diagnosed with cervical strain/sprain and whiplash.

On further cross-examination Dr. Zelby that shoulder pain would more likely be related to a C4 radiculopathy rather than a C5 radiculopathy. Petitioner had disc pathology at C4-5, C5-6, and C6-7, with C4-5 the most severe and primarily to the right and C5-6 less severe but to the left. He did note that his patients with C3-4 radiculopathy report neck pain. He also noted that petitioner had no significant problems at C3-4.

Petitioner's counsel examined Dr. Zelby on his familiarity with a cervical radiculopathy review authored by Drs. John Caridi, Matthias Cumberger, and Alexander Hughes at the Hospital for Special Surgery in New York. Dr. Zelby was unfamiliar with the review and could not offer opinions on these published findings.

Dr. Zelby also acknowledged that he has had patients with disc pathology similar to Petitioner who were probably asymptomatic before sustaining some sort of trauma. He agreed, hypothetically, that an asymptomatic condition could become symptomatic due to trauma. In order to relate a trauma to the onset of symptoms the temporal relationship to the trauma would be a factor along with any structural changes and whether symptoms were consistent with radiographic findings. Dr. Zelby specifically testified that he would expect traumatically related symptoms to arise within 24 to 48 hours of the trauma, but certainly no longer than a month.

On further cross-examination Dr. Zelby opined that Petitioner suffered no injury to her neck. She had a degenerative condition which became symptomatic and was diagnosed with radiculopathy more than 2 months after the incident. He did not review the report of the EMG. He did compare the 2010 CT and the 2015 MRI and found the degenerative changes were consistent.

Dr. Zelby would not change any of his opinions regarding the Petitioner's cervical if he knew she had been driving buses and trucks from 2010 up to her January 5, 2015 accident. He believed that nothing in her cervical spine would prevent her from returning to driving. He had no opinion of whether Petitioner's shoulder condition would prevent her from driving.

Dr. Zelby stated that surgery for Petitioner's degenerative cervical spine was not unreasonable but noted that the surgery had nothing to do with anything that happened at work on January 5, 2015.

Petitioner's counsel questioned Dr. Zelby at length about how often he does IMEs, how often he does IMEs for the defense (about 80%), and his relationship with Respondent's counsel, attorney Kevin Luther, and the firm Heyl, Royster. Petitioner's counsel also questioned Dr. Zelby about his billing rates for IMEs.

On further cross-examination Dr. Zelby acknowledged that he had reviewed Petitioner's Excel Occupational Health Clinic records which documented Petitioner's complaint of tingling in the fingers of the left hand. He opined that tingly in the fingers of the left hand was not suggestive of radiculopathy. He noted Petitioner's prior diagnosis of carpal tunnel syndrome and that radiculopathy would follow a nerve root distribution. Dr. Zelby acknowledged that the sharp, knife-like pain radiating down the arm described by Petitioner to Dr. Limon could suggest radiculopathy. He went to state there was no significance to the cervical spine with Petitioner's complaints March 9, 2015 that she was unable to lift a few pounds. Dr. Zelby thought that kind of profound weakness would be related to the shoulder.

On review of Athletico records, specifically a body diagram marked by Petitioner. Dr. Zelby noted that Petitioner had marked the left hand and proximal forearm for numbness and tingling. That presentation with skipping of the distal forearm is not indicative of radiculopathy.

Dr. Zelby also reviewed the IME report by neurosurgeon Dr. Matthew Ross. He acknowledged that Dr. Ross opined that Petitioner's underlying degenerative condition was aggravated in the January 5, 2015 work incident. Dr. Zelby disagreed with that opinion.

Dr. Zelby finally testified that once Petitioner's cervical fusion was healed she could go back to her regular job duties. He did not see any post-surgical X-rays but stated it normally takes 6 months to develop a solid arthrodesis.

Respondent's Exhibit Number 14, an Advocate Good Samaritan Hospital radiology report of cervical spine x-rays on November 6, 2008, was admitted without objection. There were degenerative changes noted at C4-5, C5-6, and C6-7, the worst C6-7.

Respondent's Exhibit Number 6, the clinical notes from Advocate Good Samaritan Hospital on June 6, 2010, was admitted without objection. Those records documented Petitioner's Emergency Department care following her motor vehicle accident on June 6. Petitioner presented to the Emergency Department with a history of loss of consciousness and neck pain and left shoulder pain. Degenerative changes with bulging discs and spurring in the cervical spine were noted on CT scan June 6 (RX #13). Plain x-rays of the left shoulder were negative for fracture or dislocation.

Respondent's Exhibit Number 12, Dr. Limon's clinical note dated 1/26/2015, and Exhibit Number 11, Dr. Limon's clinical note dated 3/16/2015, were admitted without objection. Both exhibits are duplicative of Petitioner's Exhibit Number. The January 26 note documents Petitioner's complaints of left shoulder pain, left arm pain left hand numbness "that started before Christmas at work." The March 16 note documents Petitioner's complaint of aggravating her shoulder when she drove to Missouri over an 8-hour drive. There were no documented complaints of neck pain in either exhibit.

Respondent's Exhibit Number 16, Athletico physical therapy note dated February 13, 2015 documents Petitioner's complaint of left shoulder pain and physical therapy for the affected shoulder. There was no documentation of neck pain therapy applied to the neck.

Respondent's Exhibit Number 15, the report of Petitioner's left shoulder MRI February 12, 2015 at Midwest Imaging and Diagnostic Center, was admitted without objection. The MRI showed supraspinatus tendinosis without evidence of tear or impingement.

Respondent's Exhibit Number 5, Petitioner's medical records from Hedges Clinic (Dr. Limon) from 2007 on, submitted without objection. The records document Petitioner's complaints of tingling in her left-hand fingers October 19, 2010. Dr. Limon diagnosed carpal tunnel syndrome. The records document Petitioner's complaints of neck and low back pain on December 31, 2010 after a motor vehicle accident. The records document Petitioner's continued complaint of neck tenderness on February 1, 2011. Petitioner's Exhibit Number 5 also contains the June 6, 2010 emergency department records of Advocate Good Samaritan Hospital and Dr. Koutsky's March 19, 2015 clinical note.

Respondent's Exhibit Number 2, Dr. Koutsky's notes from October 17, 2016 releasing Petitioner to return to full duty work without restrictions "per her request", was admitted without objection.

Respondent offered its Exhibits Numbers 7, 8, 9, and 10, which were Utilization Reviews dated April 7, April 21, and August 28, 2015, and June 29, 2016 respectively. Petitioner's objection to their admission on hearsay grounds was sustained and the exhibits were not admitted in evidence.

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 that she sustained an injury in an accident that arose out of and in the course of her employment by Respondent.

An accident injury arises out of the employment if the injury's origin has some risk connected with or was incidental to the employee's duties. An injury is in the course of employment if it occurs within period of employment at the place where the employee is expected to be in performance of duties or doing something incidental to job duties.

Here Petitioner proved both elements of a compensable accident. It was undisputed that Petitioner reported to work as a truck driver for Respondent. It was also undisputed that when Petitioner attempted to enter the cab of her assigned truck the cab door was frozen shut because of an ice storm. As she attempted to open the

frozen door she felt a pop in her left shoulder and later developed pain in the shoulder and the left arm.

Clearly, attempting to enter the cab of one's assigned truck is incidental to the duties of a truck driver, a frozen cab door due to weather conditions notwithstanding. In addition, petitioner was injured within the period of time she was assigned to work at the place where she was expected to begin her workday.

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

The Arbitrator finds that Petitioner proved that the condition of ill-being in her left shoulder was causally related to the January 5, 2015 work-related incident. However, the Arbitrator finds that Petitioner failed to prove that the claim condition of ill-being in her neck was causally related to a January 5, 2015 work-related incident.

Petitioner testified that on January 5, 2015 she felt a pop and pain in her left shoulder as she attempted to open the cab door of her assigned truck which had frozen shut due to an ice storm. She was referred that day by her employer to Excel Occupational Health. There she complained of left shoulder and left arm pain with tingling in the left-hand fingers. His diagnosed with shoulder strain and returned to work.

Petitioner continued to work as a truck driver for another 2 to 3 weeks despite claiming continuing left shoulder pain and pain down the left arm. Petitioner consulted her primary physician, Dr. Julie Limon, on January 26, 2015. Dr. Limon also diagnosed left shoulder strain and referred Petitioner for physical therapy and a left shoulder MRI. Petitioner received physical therapy for her left shoulder at Athletico through March 20, 2015.

Petitioner also claims injury to her cervical spine. The Arbitrator finds that this claim is not credible nor is it supported by the medical evidence and competent expert medical opinion. Petitioner testified at the trial of this matter that in addition to the immediate left shoulder pain she developed neck pain which radiated down her left arm and into her hand. When Petitioner consulted with orthopedic surgeon Dr. Kevin Koutsky on March 19, 2015 she gave a history of her neck pain originating from her work-related incident on January 5, 2015. However, there were no documented complaints of neck pain in the records of Excel Occupational Health, or the Hedges Clinic (Dr. Limon), or Athletico physical therapy notes before March 19, 2015. Petitioner continued to give this inaccurate history of date of onset to subsequent healthcare providers.

In addition, Petitioner's credibility is called into question by the history she gave to Dr. Limon that her left shoulder and left arm pain began before Christmas and the

history she gave to therapists at Athletico that she had been having ongoing problems with her shoulder since mid-December, being before the January 5, 2015 incident.

Petitioner's claim for a causal connection to her cervical spine injury is based on opinions of her treating surgeon, Dr. Koutsky. However, Petitioner gave a history of neck pain and pain radiating into the left arm that was not otherwise documented by other healthcare providers. In addition, Petitioner did not provide Dr. Koutsky with a history of her 2010 motorcycle accident when she was worked up for a neck injury which included a CT scan of the cervical spine. Petitioner did not inform Dr. Koutsky of prior neck complaints which led to cervical spine x-rays in 2008. Finally, at her initial encounter with Dr. Koutsky Petitioner did not report that she was originally injured when she attempted to open the cab door of her truck which had frozen shut. Rather, she reported that her complaints came from driving all day and performing activities which included cranking the truck dolly and pulling pins

Dr. Koutsky testified at his evidence deposition that his opinion that Petitioner's cervical spine condition was causally related to the reported January 5, 2015 incident at work was based on the reliability of the history provided by Petitioner.

In addition, the Arbitrator finds Dr. Zelby's opinion that an aggravation of a pre-existing degenerative spinal condition would result in complaints more immediate than those documented in Petitioner's medical records to be reasonable and persuasive. There were no complaints of neck pain in petitioner's medical records prior to March 19, 2015. Considering the thorough nature of recording Petitioner's history and subjective complaints in her medical records before March 19, Petitioner's complaints of neck pain would have been documented had she made them. Further, Petitioner's history of neck and arm symptoms beginning before January 5, 2015, also undercuts her reliability as an accurate reporter of fact and medical history. Lastly, the Arbitrator is also persuaded by Dr. Zelby's observation of apparent symptom magnification.

As stated above, given the unreliable foundation for Dr. Koutsky's causation opinion, the Arbitrator finds that Petitioner failed to prove that she sustained an injury to her cervical spine in the work-related incident on January 5, 2015.

G: <u>What were Petitioner's earnings?</u>

The Arbitrator finds that Petitioner proved her average weekly wage was $1,087.82. Petitioner testified credibly that her hourly rate of pay was $15.00, but also, that she regularly worked overtime. She further testified that overtime was mandatory. Petitioner's Exhibit Number 13, Petitioner's payroll records with respondent was admitted without objection. PX #13 demonstrated that Petitioner never worked a straight 40-hour week. PX #13 provided sufficient circumstantial evidence that overtime work was usual and customary therefore mandatory.

Respondent presented no evidence to rebut Petitioner's claim of average weekly wage of $1,087.82

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, the Arbitrator found that Petitioner failed to prove that she sustained an injury to her cervical spine that was causally related to her work-related incident on January 5, 2015. Petitioner did prove that she sustained a sprain/strain to her left shoulder in the January 5 accident.

Petitioner received immediate care at Excel Occupational Health on the date of her work accident. She saw follow-up care from her primary physician, Dr. Julie Limon, on January 25, 2015, despite having worked at full duty since the accident. Dr. Limon diagnosed shoulder sprain and ordered physical therapy and a left shoulder MRI. All of this care was reasonable and necessary to your or relieve the effects of the shoulder injury Petitioner sustained on January 5, 2015.

2 ½ months after the January 5 work accident Petitioner's presentation shifted to her neck and left arm complaints. There are occasional documented complaints of left shoulder pain after the first documented complaints of neck pain on March 19, 2015. Even so, Petitioner's medical care after March 19 was solely directed to her diagnosed cervical spine condition. Pre-surgical and post-surgical physical therapy did not include therapy to the left shoulder. The Arbitrator found no documentation of medical intervention for Petitioner's left shoulder injury after March 19, 2015.

Given the Arbitrator's finding of no causal connection between the January 5, 2015 work accident and Petitioner's claimed cervical spine injury, the Arbitrator finds that the medical care provided for Petitioner's left shoulder up to March 20, 2015, the last Athletico session after Dr. Limon's March 16 referral for shoulder sprain, was reasonable and necessary, but that, failing to prove a causal connection to the claimed cervical spine injury, the Arbitrator further finds that the medical care provided by Dr. Koutsky and all subsequent care relating to the cervical spine was not reasonable or necessary to cure or relieve the effects of the work accident.

K: What temporary benefits are in dispute? TTD/TPD

The Arbitrator finds that Petitioner's medical records indicate that her left shoulder sprain had stabilized by March 20, 2015. Prior to March 20 petitioner's medical care was focused on her left shoulder complaints. Although there were occasional complaints of left shoulder pain or discomfort after March 20, 2015 there was no documented evidence Petitioner received any medical intervention or left shoulder. The Arbitrator finds that this circumstantial evidence of Petitioner's stabilized

left shoulder condition supports a finding that Petitioner was at MMI are compensable shoulder injury on March 20, 2015.

Therefore, the Arbitrator finds that Petitioner proved that she is entitled to TTD benefits from January 26, 2015, the date Dr. Limon took petitioner off work, through March 20, 2015, the date she achieved MMI for her compensable left shoulder.

L: What is the nature and extent of the injury?

Petitioner's permanent partial disability of her left shoulder injury was assessed in accord with §8.1b of the Act:

(i) No AMA impairment rating was offered in evidence. The arbitrator could not weigh this factor.

(ii) At the time of her injury Petitioner was employed as long-haul truck driver. Petitioner testified that her job involved inspecting and operating tractor-trailer trucks. She testified that driving trucks would jostle and strain her arms. In addition, Petitioner testified that despite a "no touch" job description she was from time to time required push and pull pallets of paint cans in order to unload freight from her truck. The Arbitrator gives moderate weight to this factor.

(iii) Petitioner was 48 years old at the time of her January 5, 2015 accident. Petitioner had a statistical life expectancy of 31.6 years, although the Arbitrator suspects that Petitioner's actual life expectancy will be shorter than the statistical norm due to her extensive heavy smoking habit. The medical records indicate that Petitioner had few, if any, lingering issues with her left shoulder. The arbitrator gives little weight this factor.

(iv) Petitioner has been restricted by her physicians from work as a truck driver since late January 2015. Dr. Limon, who diagnosed left shoulder sprain, restricted petitioner from work January 26, 2015. Petitioner's orthopedic surgeon, Dr. Koutsky, issued varying work restrictions, including no commercial driving, but also had released Petitioner to full duty work in October 2016. However, Dr. Koutsky's work restrictions were related to Petitioner's claimed cervical spine injury and pathology and not her left shoulder injury. There is no clear evidence that as of March 2015 Petitioner's left shoulder injury limited Petitioner's ability to return to work as a truck driver, and, correspondingly, affected her earning capacity. Therefore, the Arbitrator gives little weight to this factor.

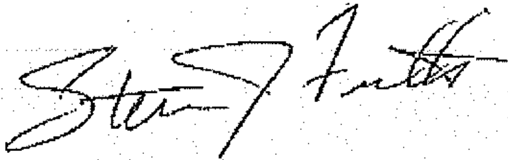
(v) As noted above, Petitioner was initially diagnosed with left shoulder sprain for which she received conservative medical and physical therapy intervention through March 2015. Thereafter, Petitioner's medical care was focused on diagnosing and treating pathology in her cervical spine. The Arbitrator previously found that Petitioner failed to prove that there was a causal connection between her cervical spine condition and

treatment and the January 5, 2015 work accident. Medical records indicate that Petitioner's left shoulder condition had stabilized by March 2015 and required no further medical care. The Arbitrator gives great weight to this factor.

In light of all the evidence, particularly including the above five factors, the arbitrator finds that Petitioner's left shoulder sprain/strain caused a 5% loss of a person-as-a-whole, 25 weeks, permanent partial disability due to the injuries causally related to her workplace accident on January 5, 2015.

O: Is Petitioner entitled to reimbursement for vocational rehabilitation costs?

The vocational services Petitioner received were related to work restrictions due to the condition of her cervical spine. Inasmuch as the Arbitrator found that Petitioner did not sustain a compensable injury to her cervical spine, the Arbitrator finds that vocational rehabilitative services were not reasonable or necessary, given that she had attained MMI with her left shoulder injury.



Steven J. Fruth, Arbitrator

December 26, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie Chapman,

Petitioner,

20IWCC0677

vs.

No. 09 WC 29095

Marion High School,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the appellate court. The sole issue on remand is the calculation of wage differential benefits. The appellate court ruled as follows: "[W]e affirm, in part, the Commission's decision to use the stipulated figure of $68,388 for the upper wage bracket, and reverse, in part, for the Commission to make a factual finding as to the average amount which the claimant was earning or was able to earn at SIU after the accident. Moreover, we order the Commission on remand to utilize a 52-week work year denominator to calculate the weekly installment amount for the claimant's wage differential award." *Marion High School v. Illinois Workers' Compensation Comm'n*, 2019 IL App (5th) 190142WC-U, ¶ 33. The appellate court explained: "The Commission *** failed to make a factual finding whether the claimant's earning capacity was limited to 9 semester hours, equaling $21,600, or 12 hours, at SIU. As such, [Respondent] acknowledges on appeal that this missing finding of fact is necessary to properly calculate the lower wage bracket, and, thus, determine the claimant's wage differential award." *Marion High School*, 2019 IL App (5th) 190142WC-U, ¶ 30.

In accordance with the appellate court's directions, the Commission has considered the pertinent parts of the record *de novo*. Petitioner testified that in August of 2015 she began working as a part-time (8 semester hours), non-tenure track physical education instructor at SIU. Beginning in the spring semester of 2016, Petitioner's teaching load increased to 9 semester hours. Petitioner taught classes five days a week, which she found "[e]xtremely" difficult to do, as her pain increased and her function decreased throughout the week. In the fall semester of

2016, SIU accommodated Petitioner's limitations by having her teach on campus only twice a week. Petitioner's teaching load continued to be 9 semester hours. The following colloquy took place:

> "Q. [Y]ou're contracted for part-time, 75 percent, and now you're satisfying that with either the two classes and the release time for the program directorship or in alternate semesters, three classes, why is it that you believe you are unable physically to work at 100 percent, a four-class schedule?
>
> A. There's no way. *** [T]he amount of time required throughout the day, right now I'm doing three classes, and I'm struggling severely to finish the semester. *** [T]here's too much time throughout a day to even accomplish that. I don't have enough rest time. You couldn't rearrange the classes in enough time. You drive back and forth. It's accumulative. So week after week, *** I may start out okay in August for three weeks, and then after that, it starts going downhill."

Upon further questioning, Petitioner reiterated: "I don't think I could physically do a full contract," "I'm struggling at 75 percent." To control her symptoms, Petitioner regularly takes Baclofen, as well as Valium, Flexeril and Norco as needed.

Juliane Wallace, chair of the Department of Kinesiology, testified that Petitioner is an outstanding, hardworking employee. Dr. Wallace has observed Petitioner's gait change due to pain, especially later in the day. When Petitioner was teaching five days a week on campus, sometimes she physically could not make it to meetings at the end of the week. Dr. Wallace worked with Petitioner to modify her teaching schedule to only twice a week on campus and allow her to perform certain duties remotely. Dr. Wallace did not think Petitioner would be physically able to teach a full-time load. In any event, Dr. Wallace has not been authorized to hire Petitioner full-time.

The Commission concludes that Petitioner is only able to work part-time at SIU and her earning capacity is limited to 9 semester hours, equaling $21,600 annually. The Commission therefore calculates and enters a wage differential award as follows:

66 2/3% x ($68,388 - $21,600) / 52 = $599.85

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $599.85 per week commencing August 17, 2015 for the duration of Petitioner's disability as provided in §8(d)1 of the Act, for the reason that the injuries sustained caused Petitioner to become partially incapacitated from pursuing her usual and customary line of employment.

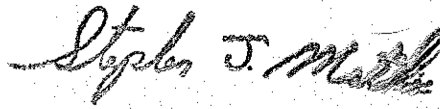
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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.

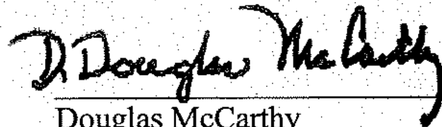
20IWCC0677

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: NOV 19 2020
o-09/15/2020
SM/sk
44



Stephen Mathis



Douglas McCarthy

DISSENT

On February 17, 2015, Arbitrator Lee issued a decision pursuant to Section 19(b) of the Act finding a causal relationship between Petitioner's accident and her lower back condition; the Arbitrator awarded benefits including vocational rehabilitation and maintenance benefits based upon the permanent work restrictions authored by Dr. Gornet. PX8. On November 25, 2015, the Commission affirmed and adopted the Arbitrator's decision in its entirety.

On November 16, 2016, the matter proceeded to hearing before Arbitrator Rowe-Sullivan regarding Petitioner's entitlement to permanency benefits among other benefits requested. On February 6, 2017, Arbitrator Rowe-Sullivan entered a decision awarding *inter alia* benefits pursuant to Section 8(d)1 of the Act of $507.53 per week.

A Petition for Review was filed, and on November 30, 2017, a prior Commission panel modified the Arbitrator's decision by finding Petitioner entitled to Section 8(d)1 benefits of $649.77 per week. In so finding, the Commission utilized a denominator of less than 52 weeks when calculating Petitioner's current earning capacity.

On June 12, 2018, the Circuit Court of Cook County reversed the Commission's calculation of benefits pursuant to Section 8(d)1 finding Petitioner entitled to benefits as follows: "by calculating 66 2/3 of the difference in the average amount Petitioner would be able to earn in full performance of her duties, the stipulated $68,388.00 over the period of 37 weeks ($68,388/37 weeks), and the average amount Petitioner was earning at SIU over the period of 32 weeks ($21,600.00/32 weeks)."

On January 28, 2019, pursuant to the directions of the circuit court, the Commission entered its decision finding Petitioner entitled to Section 8(d)1 benefits in the amount of $782.21 per week.

On subsequent judicial review, the Appellate Court affirmed in part; reversed in part; and remanded the matter with directions. *Marion High School v. Illinois Workers' Compensation*

Commission, 2019 IL App (5th) 190142WC-U. Specifically, as noted by the Majority, the Appellate Court found, "The Commission, however, failed to make a factual finding whether the claimant's *earning capacity* was limited to 9 semester hours, equaling $21,600, or 12 hours, at SIU." (emphasis added). *Id.* at ¶ 30.

I, respectfully, disagree with the Majority as I believe they have failed to adequately address the salient issue, Petitioner's earning capacity. The Majority "concludes that Petitioner is only able to work part-time at SIU and her earning capacity is limited to 9 semester hours, equaling $21,600 annually." *Supra*, ¶ 4. In arriving at this decision, the Majority applies a *de novo* review of "pertinent parts of the record..." *Supra*, ¶ 2. The Appellate Court remanded the matter for the Commission to make factual findings; it did not remand the matter for a new hearing.

In the Commission's decision of November 30, 2017 issued by a prior iteration of the present panel, the Commission specifically found "there are no medical restrictions that limit Petitioner to working a 75% workload at Southern Illinois University. The 75% workload represents the personal choice of Petitioner." Admittedly, the Commission thereafter miscalculated Petitioner's earning capacity, but such miscalculation was due to a misapplication of the law and not the facts. The change in composition of the panel has apparently rendered the Commission's prior finding of Petitioner's earning capacity moot.

As the Commission found in its November 30, 2017 decision, I, too, conclude Petitioner's earning capacity equals 12 semester hours or $28,800.00, annually. Dr. Gornet, Petitioner's treating orthopedic surgeon, released Petitioner to return to work within the parameters of a valid FCE. Dr. Gornet restricted Petitioner to lifting no greater than 10 pounds; alternate between sitting and standing as needed; and no repetitive bending or lifting. PX8. As of the November 15, 2016 trial date, Petitioner testified she had not returned to see Dr. Gornet, although a returned visit was planned for January 2017 at the recommendation of Dr. Parks. T. 53. Nothing in the record evidences these restrictions have been modified in any manner.

Petitioner testified when initially hired by Dr. Vogler in the fall of 2015, she taught a full schedule, five days a week. T. 25. Thereafter, Dr. Vogler was replaced by Dr. Wallace, Petitioner's current supervisor. *Id.* Dr. Wallace allowed Petitioner to teach remotely part of the week with Tuesdays and Thursdays on campus. T. 26. Petitioner testified her request was made due to her increase in pain. *Id.*

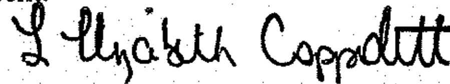
Dr. Wallace testified Petitioner presently works at a reduced capacity *i.e.* 75% of the normal course load. T. 60. Dr. Wallace indicated this accommodation was made to address Petitioner's pain complaints. *Id.* Dr. Wallace verified if Petitioner worked a full-case load, she would earn $3,200.00 monthly. T. 70. Dr. Wallace testified she "would love to have [Petitioner] full time, but the problem is there's not – there's just not the enrollment in the classes, and so getting approval for her to teach more is almost impossible." T. 71.

Calculating the wage differential rate requires the Commission to make two earnings determinations: (1) "the average amount which [she] would be able to earn in the full performance of [her] duties in the occupation in which...[she] was engaged at the time of the accident," and (2) "the average amount which [she]...is able to earn in some suitable employment or business after the accident." *820 ILCS 305/8(d)1*. "The supreme court has held that '[a]lthough wages are indicative or earning capacity, they are not necessarily dispositive.' *Cassens Transp. Co. v. Industrial Commission*, 218 Ill. 2d 519, 531, 844 N.E.2d 414,423, 300 Ill. Dec. 416 (2000). The

test does not focus exclusively on the amount earned, but instead focuses on the capacity to earn. *Id.*'" *Jackson Park Hospital v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 142431WC, ¶ 44.

The parties stipulated Petitioner would be able to earn $1,315.15 per week in the full performance of her prior occupation. I find Petitioner is capable of earning $553.85 per week at her present teaching position. Petitioner chose to reduce her work schedule. Dr. Gornet has not altered her work restrictions, and Petitioner has not returned to Dr. Gornet for further treatment. Moreover, Dr. Wallace confirmed Petitioner's reduced work schedule is due to a lack of current enrollment and not Petitioner's back condition. Petitioner's earning capacity is that of a full-time lecturer. As such, I find Petitioner is entitled to $507.51 per week commencing August 17, 2015 for the duration of her disability pursuant to Section 8(d)1 of the Act.

For the above-stated reasons, I respectfully dissent.



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)
X Correction of scrivener's error	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRUCE PAGE,

Petitioner,

vs. NO: 17 WC 21757

NORTHERN GLASS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, and other-Respondent's credit for TTD overpayment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below, only correcting a scrivener's error, 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, herein, corrects a scrivener's error in the Decision of the Arbitrator, page 24, paragraph 1, last sentence, striking "June 21, 2017" and adding "March 26, 2019",, so the last sentence should read, "...December 2, 2018 through March 26, 2019 equaling 78 & 4/7 weeks at the rate of $1,125.91/week."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 10, 2019 is, otherwise, hereby, affirmed and adopted.

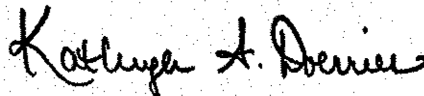
IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written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

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

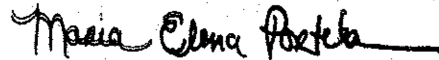
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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.

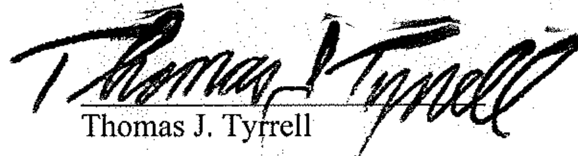
DATED: NOV 2 0 2020
o-11/10/20
KAD/jsf



Kathryn A. Doerries



Maria E. Portela



Thomas J. Tyrrell

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

PAGE, BRUCE
Employee/Petitioner

Case# **17WC021757**

NORTHERN GLASS INC
Employer/Respondent

20IWCC0678

On 10/10/2019, 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 1.69% 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 DONALD FOHRMAN & ASSOC LTD
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

1120 BRADY CONNOLLY & MASUDA PC
IVAN NIEVES
10 S LASALLE ST SUITE 900
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

BRUCE PAGE
Employee/Petitioner
v.

Case # **17 WC 21757**

Consolidated cases: ______

NORTHERN GLASS INC.
Employer/Respondent

20 IWCC0678

An *Application for Adjustment 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 **3/26/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

L. ☒ 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, **6/21/2017**, 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 $**87,821.24**; the average weekly wage was $**1,688.87**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**22,517.60** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,517.60**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $1,125.91/week for 78 & 4/7 weeks, as provided in § 8(b) of the Act. Respondent shall be given a credit of $22,517.60 for TTD.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $1,843.00, as provided in §8(a) of the Act.

Medical benefits

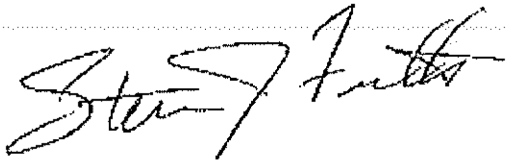
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of ATI Physical Therapy, Bluemound Surgery Center, G&T Orthopedics, Illinois Orthopedic Network, Libertyville Imaging, Metro Anesthesia, Midwest Orthopedic Network, Midwest Specialty Pharmacy and Jeffrey Wingate, M.D. as provided in §8(a) and adjusted in accord with the medical fee schedule provided by 8.2 of the Act.

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

20IWCC0678

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

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



Signature of Arbitrator

October 9, 2019
Date

ICArbDec19(b)

OCT 10 2019

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the accident? ; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** Is Petitioner entitled to prospective medical care?; ***L:*** What temporary benefits are in dispute? TTD/TPD

FINDINGS OF FACT

Petitioner Bruce Page was employed as a union glazier with Respondent Northern Glass, Inc. on June 21, 2017. Petitioner's job entailed the installation of glass, metal, framing, glass railings, doors, and door hardware. His job tasks included setting glass, lifting glass and framing, and unloading trucks. Petitioner often had to lift objects weighing 70+ pounds by himself and double that amount with coworkers. On cross-examination Petitioner identified Respondent's Exhibit #1, a Job Description for "Journeyman/Glazier," and testified that it was "pretty accurate."

Petitioner testified that prior to June 21, 2017 he had no medical issues or symptoms concerning his head, neck, or lower back.

Petitioner related that on June 21, 2017, he and coworkers were performing the glazing work for a newly constructed 11-12 story condominium building. He and a co-worker went up the skip elevator to the fifth floor where his company was staging. He exited the skip elevator and proceeded to where the gang boxes were staged. A plumber standing by the elevator picked up an 8-foot cast iron pipe and swung it over his shoulder and struck Petitioner on the top left side of his head. Petitioner was wearing a hard hat.

Petitioner testified that his knees buckled when he was hit by the pipe but did not fall to the ground. He saw stars and felt a lightening shock from his neck down to his feet. Shortly thereafter he began experiencing headaches. Petitioner reported the incident and finished his workday. That evening, he experienced dizziness, headaches, and pain to his neck.

The next day, Petitioner sought medical care at Aurora Health Care in Kenosha (PX #3). He gave a history of being struck on the top of his hard hat with a steel pipe without loss of consciousness. He stated that overnight he had developed headaches and neck and back pain. Petitioner also reported that he felt a numb spot on his right foot but

that was not documented. It was noted that he denied weakness, numbness, or tingling in the extremities. Petitioner testified that he never experienced a numb spot to the bottom of his foot prior to the accident.

Petitioner underwent a CT scan of the cervical spine which showed multi-level degenerative disc disease, most significant at C5-6 where there was mild left-sided neural foraminal narrowing and loss of disc height loss. A CT of the brain was negative for abnormalities. Petitioner was diagnosed with a head trauma and cervical muscle strain. He was discharged to home/self-care. Petitioner testified that he was not given any work restrictions by the emergency room physician.

Petitioner testified that he returned to work. He consulted with his family physician, Monica Singhvi, M.D, with continuing symptoms. Dr. Singhvi advised him to follow-up with the Aurora Health Occupational. Petitioner returned to Aurora Health on July 6, 2017. His intake sheet chart indicating symptom of dizziness of head, neck and back pain, and right foot numbness but otherwise denied, low back pain or weakness or paresthesias in the extremities (PX #3). The examining physician recommended frequent stretching, use of analgesic medications, and a neurological evaluation.

Petitioner sought medical care at Illinois Bone & Joint Institute (IBJ) on July 17, 2017, on referral from Dr. Singhvi (PX #4). Petitioner was examined by Dr. Rhutav Parikh, a physical medicine and rehabilitation physician. Petitioner reported symptoms of neck and upper back pain and persistent headaches. Dr. Parikh examined Petitioner and had x-rays performed of the cervical and thoracic spine. Dr. Parikh diagnosed cervical and thoracic strains and a concussion with persistent headaches. Petitioner was prescribed a Medrol Dosepak, physical therapy and vestibular rehabilitation, and amitriptyline for his headaches and sleep issues. Petitioner was also given an off work note until his next evaluation.

Petitioner began physical therapy (PT) with IBJ Rehabilitation on July 25, 2017 (PX #5). The PT diagnoses were cervicalgia, thoracic spine pain, and low back pain. Petitioner gave a history of being hit on the top of the head and his knee buckled and he felt a shock wave through his whole body. He also reported intermittent numbness on the ball of his right foot as if he were stepping on a penny; neck stiffness and soreness, back pain if he stands longer than 30 minutes, and deep aching from midback to his neck when lying down in bed more than 2 hours. He also reported feeling foggy and slow thinking.

Petitioner returned for a follow-up with Dr. Parikh on August 1, 2017. He reported some improvement with his neck symptoms with physical therapy, but his midback was no better. Petitioner was advised to continue with physical therapy and to remain off work. Petitioner returned to Dr. Parikh on August 15, 2017 with no improvement to his neck and midback symptoms. He reported persistent pain at the base of his neck that was aggravated with any type of rotational movements. The midback pain was aggravated by

bending and twisting. Dr. Parikh recommended MRIs of both the cervical and thoracic spine. Physical therapy with vestibular rehabilitation was continued.

The MRIs were performed on August 21, 2017. Radiologist Dr. Corinne Atty noted the cervical MRI revealed mild multi-level cervical spondylosis without any focal central disc protrusions or central canal stenosis. The radiologist noted mild arthropathy causing mild right neural foraminal stenosis at C3–C4 and disc osteophyte complexes which partially effaced the ventral CSF without causing spinal canal stenosis at C4–5 and C6–7. There was also facet arthropathy at these levels. Dr. Parikh noted the thoracic MRI showed mild multi-level spondylosis without any focal disc protrusion or herniation. The radiologist noted mild disc space narrowing at a few levels in the thoracic spine. There was a mild disc bulge and arthropathy of the left facet joint with mild left neural foraminal stenosis at T3–4. There was also a small disc bulge at T7–8. Petitioner reported that he still had persistent pain and stiffness along the neck and upper back.

On August 24, 2017 Dr. Parikh gave Petitioner a referral for chiropractic treatment and gave work restrictions of no lifting, pushing/pulling greater than 10 lbs., and no repetitive bending or twisting. Petitioner testified that he never sought the chiropractic treatment recommended. He further testified that Respondent did not accommodate the restrictions set forth.

On August 29, 2017, Petitioner had a neurology consultation with Dr. Mohan Ayyaswamy at Aurora Health. Petitioner was evaluated and diagnosed with post-concussion syndrome. Dr. Ayyaswamy recommended an EEG due to Petitioner's left eyelid twitching and the medication meclizine for his dizziness.

On September 6, 2017, Petitioner saw orthopedic surgeon Dr. Thomas Poepping at G&T Orthopaedics and affiliated with Illinois Orthopedic Network [ION] (PX #6). Petitioner gave a history of being hit on the head at work. He complained of neck and upper back pain and numbness in the right plantar foot. Petitioner complained that he felt he was getting worse.

Dr. Poepping performed a clinical examination and reviewed the thoracic and cervical MRIs. It was his impression that Petitioner had cervical and thoracic spondylosis which had been exacerbated by the injury. Based on his failure to respond to physical therapy, Dr. Poepping opined that Petitioner would be a candidate for cervical injections.

Petitioner was seen by pain management physician Sajjad Murtaza, M.D. at ION October 10, 2017 (PX #7). Petitioner gave a history of the accident including a description that the when he was hit by the pipe, he felt an electric shock going down from his head through his entire spine. Petitioner reported cervical and thoracic pain ranging from 8-10/10. He also reported that he initially had numbness and tingling to the plantar right foot near the big toe and arch, but that the numbness and tingling had spread up his leg and that his symptoms were worsening.

Dr. Murtaza assessed Petitioner with a work-related injury resulting in significant severe cervical and thoracic spine pain as well as intermittent numbness and tingling to the legs and feet, right greater than left. Dr. Murtaza recommended a C6-7 epidural steroid injection (ESI) to target Petitioner's neck pain. He further prescribed the topical gel diclofenac.

On November 1, 2017, Petitioner returned to Dr. Poepping with a new complaint of right lateral thigh numbness when standing in the shower and continued pain in the bottom of his right foot, neck and midback. Given that Petitioner had an IME scheduled, Dr. Poepping took a wait and see approach.

Petitioner received the PT at IBJ through August 29, 2017 and was discharged November 20, 2017.

At the request of Respondent, Petitioner was examined by Steven Mather, M.D. on November 16, 2017 pursuant to §12 of the Act. Dr. Mather's narrative report was admitted as Exhibit #2 at his deposition on February 21, 2019 (RX #3).

Dr. Mather noted Petitioner's complaints of headaches 3-4/week, neck pain, midback pain, numbness of his right lateral thigh, and a sensation in the bottom of his right foot like there was something underneath the bottom of his foot. Petitioner further related that he could only sit for 40 minutes at a time. Dr. Mather performed an examination of the neck and midback, reviewed the cervical and thoracic MRIs of the cervical and thoracic spine, and a record review, but no review of radiologic imaging. Dr. Mather noted that Petitioner marked a pain diagram indicating neck pain, widespread thoracic pain, numbness in the right lateral fine, and numbness in the right plantar foot.

On examination Dr. Mather noted Petitioner was 6'4" tall and 312 pounds. Petitioner had normal rotation of the cervical spine and that Spurling's maneuver did not elicit arm symptoms were radiation of pain. He noted Petitioner was diffusely tender from C2 to L2 without spasm. Thoracic spine range of motion exercises reproduced diffuse thoracic pain. Dr. Mather diagnosed a cervical strain and a possible thoracic strain. He also diagnosed psychogenic pain/functional overlay. Dr. Mather found that Petitioner's subjective symptoms were not corroborated by his physical examination or objective findings. He opined that Petitioner did not meet the criteria for cervical or thoracic injections. Dr. Mather concluded that Petitioner could return to work without restrictions.

Petitioner testified that after his examination with Dr. Mather, he learned that Dr. Mather determined that he could return to work full duty. Respondent stopped Petitioner's TTD and medical benefits after Dr. Mather's examination.

Petitioner followed-up with Dr. Ayyaswamy on November 29, 2017 concerning his headaches, eye twitching, and vertigo. Petitioner reported retro-orbital headaches 3-4

times per month. Petitioner also complained of right leg numbness lasting 15-20 minutes with standing and decreased with sitting and resting. He also complained that he had persistent numbness on the ball of his foot that never went away. Dr. Ayyaswamy recommended an MRI of the brain and EEG and suggested that Petitioner follow-up with an orthopedic specialist concerning his back and neck pain.

Petitioner testified that after the termination of his benefits, he returned to work for Respondent on December 12, 2017. His job duties aggravated his neck, back, and foot. He stopped working due to his pain on December 17, 2017.

On December 19, 2017, Petitioner was seen by Dr. Murtaza and his Physician Assistant, Jessica Gregg. Petitioner reported his attempt to return to work and the aggravation of his pain. Petitioner informed Dr. Murtaza that when he was not at work, he was lying in bed. His pain was described as 8/10 to the neck with constant stiffness with headaches and dizziness on an intermittent basis. After work, his pain was a 10/10.

Dr. Murtaza noted Dr. Mather's November 16, 2017 IME report. Per the IME Petitioner was to return to work at MMI. Dr. Mather had diagnosed cervical and thoracic strain. However, Dr. Murtaza noted Petitioner's continued significant pain without a history of pain prior to the injury where he was struck on the head and suffering a concussion. Petitioner reported attempts to return to heavy construction work significantly aggravated pain in the neck and upper back. Petitioner reported 8/10 neck pain with intermittent headache and dizziness. He reported that at work his pain was 10/10. Petitioner also reported continued numbness and tingling near the right big toe.

Dr. Murtaza opined that Petitioner was not at MMI. He stated that although Petitioner's objective findings were not severe, he does continue to experience significant pain which limited his functionality and affected his ability to work. Dr. Murtaza recommended injections to the cervical and thoracic spine and a surgical consultation. He further imposed work restrictions of carrying and lifting no more than 10 lbs., pushing/pulling no more than 30 lbs., no lifting above the shoulder, no bending, squatting, climbing ladders, kneeling, or crawling.

Petitioner was seen again by Dr. Ayyaswamy at Aurora Health Care on December 3, 2017. Dr. Ayyaswamy diagnosed post-concussion syndrome and right leg numbness.

Petitioner continued to treat with Dr. Singhvi at Aurora Health Care throughout 2018 for hypertension obesity, and hypothyroidism. However, Dr. Singhvi also diagnosed Petitioner's history of cervical radiculopathy and intervertebral lumbar disc disorder with myelopathy, lumbar region.

On January 8, 2018, Petitioner saw neurosurgeon Dr. Geoffrey Dixon at ION for a consultation regarding his neck and midback pain. Dr. Dixon noted the cervical MRI demonstrated small disc protrusions at C4-5 and C6-7, neither of which caused obvious

nerve root compression. The thoracic MRI demonstrated disc protrusions to the left a T10-11 or T11-12. Based on his examination and review of the MRI findings, Dr. Dixon did not believe that Petitioner was a surgical candidate. He recommended that Petitioner consider resuming physical therapy and consider an evaluation from pain management for possible injections. Petitioner was instructed to remain off work.

Petitioner saw Dr. Krishna Chunduri of ION on January 23, 2018. Petitioner complained of neck pain that radiated down his right side into his midback. Ongoing neck pain was 8/10 He also reported permanent numbness in the bottom of his right foot and occasional numbness and tingling in the right side of his thigh. He did not have any significant lower back pain at that time.

After examining Petitioner and reviewed the diagnostic findings, Dr. Chunduri diagnosed cervical spondylosis and right lower extremity paresthesias, possible radiculopathy. He opined that based on the mechanism of injury and the symptoms Petitioner's symptoms were either due to a facet injury on the right side or, if, taken into account with the separate numbness in the right leg, a possible spinal cord injury. Dr. Chunduri recommended a right C5-6, and C6-7 diagnostic medial branch block and a lumbar MRI.

The MRI was performed January 29, 2018 at Libertyville Imaging Center. There was a 2 mm broad-based posterior disc protrusion at L4-5 without central canal or neural foraminal stenosis and a 4 mm broad-based left paracentral and foraminal disc protrusion at L5-S1 with facet joint hypertrophy abutting the left traversing S1 and left exiting L5 nerve roots.

On February 8, 2018, Dr. Chunduri performed the recommended medial branch blocks at C5-6 and C6-7, on the right. Petitioner followed up with Dr. Chunduri on February 20, 2018 and stated that the injections provided no relief. He continued to complain of pain in his neck and midback. He also reported pain of his lower back with numbness and tingling radiating down to the right foot.

Dr. Chunduri's physical examination revealed positive lumbar tenderness to palpation, a positive straight-leg raise on the right at 60°, and a positive Spurling compression test of the neck to the right shoulder. After reviewing the lumbar MRI, Dr. Chunduri concluded that Petitioner's right leg symptoms were due to the nerve compression at L5-S1. He diagnosed cervical spondylosis with right radiculitis and lumbar disc herniation with right radiculitis. Petitioner was negative for cervical facet mediated pain. Dr. Chunduri recommended an epidural steroid injection (ESI) at C6-7, which was administered on March 6, 2018.

On March 20, 2018 Petitioner reported mild improvement from the injection for one week. He continued to have neck pain radiating into the shoulders, pain in his upper midback, and pain of lower back radiating to this right leg. Because the diagnostic block

and the epidural injection provided no relief, Dr. Chunduri felt that that no further interventional treatment of the neck would be of a benefit. Dr. Chunduri recommended an EMG to evaluate for possible cervical radiculopathy. Dr. Chunduri also recommended an ESI at L5-S1 on the right.

An EMG of the upper extremities muscles was performed March 30, 2018. The only significant finding was mild irritability in the right C6-7 paravertebral muscles.

Dr. Chunduri performed an L5-S1 ESI on April 17, 2018. At his May 1, 2018 follow-up with Dr. Chunduri, Petitioner stated that he had significant improvement for one week, but then all his symptoms then returned. Dr. Chunduri recommended that Petitioner's symptoms be controlled by medications and a possible surgical evaluation if the medicines did not provide him better pain control. The diagnoses remain the same.

An EMG of the upper extremities muscles was performed March 30, 2018. The only significant finding was mild irritability in the right C6-7 paravertebral muscles.

Petitioner returned to Dr. Chunduri May 15, 2018. Petitioner reported that the prescribed gabapentin did provide better pain control. Petitioner reported that he had significant difficulties at work trying to lift heavy objects and that his lumbar pain continued to be a problem. Petitioner stated that he wished to look at further options concerning his lower back symptoms. Dr. Chunduri recommended a spinal consultation.

On May 25, 2018, Petitioner consulted with orthopedic surgeon Dr. Jeffrey Wingate at ION. Petitioner gave the history of his accident, including feeling a shock down his entire spine and into his arms and legs. He had neck and bilateral arm symptoms, as well as right foot numbness. Petitioner reported that over the past 6 months his entire right posterolateral thigh had gone numb in combination with the posterior calf and all the way to the plantar aspect of his right foot. Petitioner related that he tried to work for 6-7 weeks but could not do it because of severe spinal pain to all 4 extremities.

Dr. Wingate reviewed Petitioner's records from Dr. Chundari, the March 30, 2018 EMG, the August 21, 2017 cervical and thoracic MRIs, and the January 29, 2018 lumbar MRI. Dr. Wingate noted osteophyte complexes at C4-5 and C6-7 without significant stenosis. The lumbar MRI showed several small disc herniations, most notably a 4 mm broad-based left paracentral and foraminal disc protrusion at L5-S1 with abutment of the left traversing S1 and left exiting L5 nerve roots with moderately severe neuroforaminal stenosis. There was a 2 mm broad-based posterior disc protrusion at L4-5. Dr. Wingate interpreted the scan as showing an annular tear at L5-S1 with foraminal protrusion of disc material. It was his opinion that the MRI revealed moderately severe to severe neuroforaminal stenosis involving the left L5 segment of the spine, most notably the L5 nerve root itself.

Dr. Wingate reviewed Dr. Mather's November 16, 2017 IME report. He disagreed with Dr. Mather's opinions. He noted that that the MRI ordered by Dr. Chunduri was appropriate and that the MRI demonstrated pathology which underlay the basis for Petitioner's ongoing lumbosacral radiculopathy to both lower extremities, right greater than left. He further noted this seemed to be related to the right SI nerve root as well as the left L5 nerve root. Dr. Wingate specifically noted that Petitioner had legitimate injuries as a result of the work accident and that there was a significant discogenic component to the L5–S1 low back pain syndrome.

Dr. Wingate diagnosed Petitioner with severe axial low back pain with right S1 radiculitis, left L5 radiculitis, right greater than left clinical symptoms, cervical H&P with right sided radiculopathy. Dr. Wingate felt that the lumbar MRI scan clearly showed pathology that corroborated Petitioner's symptoms. He felt that Petitioner had legitimate injuries as a result of the described work injury. Dr. Wingate noted that it was difficult for him to recommend any type of lumbosacral reconstruction at the time given he was less than one-year post injury. He recommended a lumbar EMG study and felt Petitioner was a good candidate for a lumbar discography. He further stated that Petitioner was not capable of returning to normal occupation.

On June 12, 2018, Petitioner returned to Dr. Chunduri for a follow up. He continued to complain of lower back pain radiating down his right leg, neck pain, and thoracic pain. Petitioner noted his consultation with Dr. Wingate and Dr. Wingate's recommendation of surgery. He told Dr. Chunduri that he did not want to undergo lumbar surgery. Dr. Chunduri noted that if that was the case then he was likely at MMI and recommended an FCE. Petitioner was to continue with gabapentin and Diclofenac topical gel.

Petitioner had the recommended EMG on June 22, 2018. There was mild irritability in the right L5-S1 paravertebral muscle but no right lumbosacral nerve root pattern. There was possible irritation to smaller sensory nerve branches in areas had been subject to trauma but due to their smaller size that could not be measured. On July 6, 2018, Petitioner participated in an FCE at ATI Physical Therapy. The FCE was determined to be valid and that Petitioner's capabilities demonstrated at a LIGHT physical demand level. Petitioner was found in capable of meeting the HEAVY demand level of his job as a union glazier.

On July 10, 2018, Petitioner followed with Dr. Chunduri. Based on Petitioner's clinical presentation and the FCE results. Dr. Chunduri noted that Petitioner was "likely at MMI" and imposed permanent restrictions of 15 lbs. lifting, 30 lbs. pushing/pulling, and occasional bending, climbing, and kneeling. He was advised to continue with gabapentin for nerve pain and use ibuprofen and naproxen as needed.

At the request of Respondent, Petitioner returned to Dr. Mather for a second §12 examination on October 4, 2018. Dr. Mather's narrative report was admitted as Exhibit #3 at his deposition on February 21, 2019 (RX #3). In addition to the clinical examination Dr. Mather reviewed Petitioner's records from Drs. Chunduri, Murtaza, Dixon, and Wingate. He also reviewed the March 30, 2018 and June 22, 2018 EMGs, The FCE, the January 29, 2018 lumbar MRI, the August 21, 2017 thoracic and cervical MRIs, and pain X-rays taken at the IME.

Petitioner's complaints consisted of neck pain, headaches, intermittent dizziness, mid thoracic pain and low back pain with sensation of numbness in the right foot and right lateral thigh. Examination of the cervical spine revealed pain with flexion at 40°. The lumbar spine exam of range of motion was essentially normal but was painful. Straight-leg raising was normal. There was normal strength and sensation. Dr. Mather diagnosed cervical strain and psychogenic pain/functional overlay.

Dr. Mather's impression of the lumbar MRI was that Petitioner had mild, age appropriate and degenerative disc disease at L5-S1 without herniation or nerve root compression. Dr. Mather noted that Petitioner's low back complaints arose after the first IME and were not related to the work accident. He further stated that Petitioner's current symptoms were not related to the accident. He disagreed with the diagnoses of Drs. Murtaza, Chunduri, Dixon, and Wingate, particularly noting that they disagreed with each other.

Dr. Mather opined that Petitioner had "several bizarre symptoms" such as the lower back complaints that started in October 2017 and that could not be confirmed by physical examination, EMG, or MRI. He further opined that Petitioner did not require injections. He again concluded that Petitioner was at MMI and could return to full duty work.

On December 28, 2018, Petitioner returned to Dr. Wingate for a follow-up. Petitioner reported no significant change to his overall condition. Dr. Wingate noted that he had reviewed some prior records closer to the date of accident in which Petitioner reported numbness to the ball of his foot. He also reviewed the IME reports of Dr. Mather.

Dr. Wingate performed a physical examination and found a positive straight-leg raise and an abnormal sensation along the right outer posterolateral thigh. Petitioner continued to complain of abnormal sensation to the bottom of the foot. Dr. Wingate's impression was right S1 radiculitis, left L5 radiculitis, right greater than left sensory abnormality, and right C6 and C7 radiculitis with positive EMG study. Dr. Wingate maintained that Petitioner presented with discogenically mediated lumbar radiculopathy involving both extremities, isolatable to the L5-S1 motion segment. He noted that his opinions differed remarkably than those of Dr. Mather.

Petitioner testified that he made several efforts to try to work. Between February 5, 2017 and March 27, 201, he worked as a glazier for Rock Valley. Petitioner state that he had to work because he had no income and had to eat. Petitioner stopped working for Rock Valley because he was in too much agony. He also attempted to work as a valet with a company called Progressive. Climbing in and out of cars and the walking at a fast pace back and forth through the parking lot were too difficult for him so he did not return. Petitioner made one last attempt to work for AutoZone, the car parts company, on November 19, 2018. He ended up standing up behind the counter most of his workday which caused too much pain to his back and neck. Petitioner stopped working on December 1, 2018.

At hearing Petitioner testified to pain from his neck and head down to his foot. He stated that he has difficulty sleeping more than 2 hours, after that he is tossing and turning. The pain in his neck is constant and sometimes he has shooting pain. His midback feels as though something is stuck in it and hurts when he walks or sneezes. He has aching and numbness into right thigh and the bottom of his foot which seems to be getting worse with time. Petitioner testified that he wishes to undergo whatever treatment that will make him better.

<u>Evidence Deposition Dr. Jeffrey Wingate, January 25, 2019 (PX #8)</u>

Dr. Wingate is a board-certified orthopedic surgeon, specializing in degenerative and traumatic conditions of the spine. His practice in Michigan and Illinois consisted of spinal surgical reconstructions focused on people with traumatic injuries, fractures of bones, and or soft tissue injuries of the spine. He refreshed his memory with his records and reports.

Dr. Wingate discussed the finding of the January 28, 2018 lumbar MRI in detail, explaining that MRI demonstrated at the L5-S1 disc lost one-third of its height and was black, demonstrating that it was dried out. In addition to the darkness of the disc, there was a discreet herniation on the left side affecting the central part of the canal involving the lower nerve roots, both centrally and specifically to the left. He felt there was moderately severe to severe level of neuroforaminal stenosis involving the left L5 segment of the spine. He opined that the Petitioner's symptoms correlated with the MRI findings because both the L5 and S1 nerve roots were involved.

Dr. Wingate discussed his physical examination on May 25, 2018. He elaborated that Petitioner had weakness in the right S1 nerve root evidenced by difficulty performing single limb toe raising. Petitioner has symmetric grip strength and some paresthesias of the right radial forearm and dorsal aspect of the wrist and hand. These sensory abnormalities were related to more to the C6 nerve root. Dr. Wingate noted spasm throughout the lower midportion of the thoracic spine, fair range of motion, and pain with

backward bending. Dr. Wingate thought that Petitioner had some facet derived pain in the right part of his thoracic spine.

Dr. Wingate did not find any inconsistencies between Petitioner's subjective complaints and his objective findings, both diagnostically and by clinical exam. He further added that he did not find any inorganic findings that would indicate some type of psychological pathology. It was his opinion that Petitioner had several things going on, facetogenic back pain related to an arthritic facet joint and narrowing around the T11 facet on the right side of the spine. He further felt that the MRI findings of the lumbar spine provided an objective basis for both the right S1 and left L5 radicular leg pain and/or weakness symptoms.

Dr. Wingate addressed Petitioner's report of numbness of the bottom of the foot at his first emergency visit and subsequent medical visits after the injury. Dr. Wingate noted that this sensation started following the injury and that it was seemingly from nerves of the low back to his right leg.

Dr. Wingate further discussed his second visit with Petitioner on December 28, 2018. He noted that Petitioner continued to have positive straight-leg raise and abnormal sensation into the right posterior lateral thigh. Overall the clinical examination was similar to his first examination.

Dr. Wingate testified that the compressive force of being hit on the head by the steel pipe elicited his symptoms to the cervical spine that is seen on the cervical MRI. He opined that the same compressive force created the clinical scenario with his right midback. He further testified that the mechanism of injury caused Petitioner's resulting spinal condition.

On cross-examination Dr. Wingate explained that non-contiguous spinal injuries are very common as the whole spine is connected. The force of the collision between the pipe and head and neck created the electrical abnormal sensory sensation immediately which led to the development of inflammation around the nerves which never died down. He added that Petitioner likely had pre-existing degeneration at L5-S and that the force of the impact to the head caused that segment to be provoked. Dr. Wingate stated that the mechanism of injury caused a transfer of stresses.

On re-direct examination, Dr. Wingate noted that Petitioner's claim of feeling an electric shock down his head through his entire spine is consistent with the construction of the spinal cord and electrical pathways to all of the extremities. A significant injury to the head or neck can easily manifest as a neurologic injury or create neurologic complaints anywhere in the body.

Evidence Deposition of Steven Mather, M.D., February 21, 2019 (RX #3)

Dr. Mather testified from his November 16, 2017 and October 4, 2018 IME reports. He recited the records he had reviewed, adding that he had reviewed Dr. Wingate's evidence deposition.

Dr. Mather stated that he typically performs around 200 to 215 IMEs per year, all for the defense. He charges $1,200 per IME and $1,200.00 per hour for deposition time.

On direct examination, Dr. Mather recounted the IME he performed on November 16, 2017. He recited Petitioner's complaints headaches, neck pain, back pain, and a sensation of something on the bottom of his right foot. On examination Petitioner had a full range of motion in the cervical spine but with right-sided pain with Spurling's. There was diffuse tenderness from the head to the lumbar area. Petitioner had normal sensation in the upper and lower extremities. Dr. Mather especially noted Petitioner's strong hand grip. Petitioner had a full range of motion in the lumbar spine. Petitioner had degenerative changes in his cervical spine which were normal for his age.

Dr. Mather diagnosed cervical strain, possible thoracic strain, and psychogenic pain and functional overlay. He explained that psychogenic pain and functional overlay meant that Petitioner had a non-organic source of pain. Dr. Mather felt that the mechanism of injury caused a transfer of force to the neck and upper thoracic area. On cross-examination Dr. Mather noted that Petitioner had no radicular complaints at the November 2017 IME, particularly noting numbness in the lateral thigh is not lower lumbar radiculopathy. Due to the lack of radicular complaints, Dr. Mather did not conduct a lumbar examination.

Dr. Mather described Petitioner's report of numbness on the bottom of his right foot as an "odd sensation."

Dr. Mather reiterated his November 17 opinion that Petitioner did not require any further treatment because the cervical spine was stable. Petitioner did not have any signs of impingement or impairment relative to the cervical and thoracic spine. He added that the complaint of numbness on the bottom of the right foot was an isolated odd sensation which could not be attributed to a specific diagnosis. It was his opinion then that Petitioner could return to work without restrictions.

Dr. Mather then discussed his re-examination on October 4, 2018. Dr. Mather reviewed Dr. Chunduri's records, Dr. Mutaza's notes, the FCE report of July 6, 2018 (which noted Petitioner's job was HEAVY demand), Dr. Dixon's January 8, 2018 note, Dr. Wingate's April 25, 2018 note, and the lumbar MRI imaging.

Dr. Mather noted that Dr. Murtaza focused on Petitioner's subjective pain but did not use generally accepted validation of radiculopathy before performing injections Dr. Mather cited the American Pain Society Guidelines of 2009, which indicate validation of radiculopathy or offering an epidural. Dr. Mather also took issue with Dr. Chunduri's

opinion that the work accident caused Petitioner's lower back injury. Dr. Mather noted that at the first IME Petitioner did not circle the lower back on the pain diagram. He also noted that it shouldn't take more than 6 months for the onset of low back symptoms to appear after a trauma. He also disputed that the accident described by Petitioner was not likely to transfer compressive force to the lumbar spine.

Petitioner reported that he had had an EMG and 2 cervical spine injections. The examination revealed some mild tenderness in the cervical spine, good range of motion, and pain with flexion. Petitioner reported low back pain with flat maneuver but pain with lateral bending. Straight-leg raise was normal. Dr. Mather found the lumbar MRI showed mild aging changes at L5-S1 with no nerve root compression or herniation.

Dr. Mather noted that the neck exam was benign. He disagreed with Dr. Wingate's findings that there were small herniations on the lumbar MRI. He stated his conclusion agreed with the radiologist. Dr. Mather also noted that Dr. Chunduri had found Petitioner at MMI when Petitioner declined surgery. He found no radiculopathy. He also noted that there were no abnormalities in the EMGs.

Dr. Mather further testified regarding Dr. Wingate's notes and deposition. Contrary to Dr. Wingate, he maintained that there was no finding that the L5-S1 segment was unstable. (Id. at 29)

On continued direct examination Dr. Mather again opined that Petitioner was at MMI by the time of the first IME examination November 16, 2017. He further opined that medical care after that date was not necessary.

On cross-examination, Dr. Mather repeated that he did 200 – 215 IMEs a year. He charges $1,200 for an IME and $1,200/hour for a deposition. He refuted that he earns about $250,00/year for IMEs, stating that DuPage Medical Group receives his fees for IMEs.

Mr. Mather acknowledged in his medical record review for the November 16, 2017 IME he did not make note that Petitioner reported symptoms of numbness and tingling to the plantar right foot that spread up the leg to Dr. Murtaza on October 11, 2017. He admitted that such symptoms could be associated with lumbar spine pathology. Dr. Mather could not answer a hypothetical of whether being hit on the top of the head by a 100-pound pipe could cause a structural compromise to the lower spine because there were too many unknown variables. Dr. Mather clarified that his finding of psychogenic pain/functional overlay should not be interpreted as malingering or seeking secondary gain.

Dr. Mather was asked if he looked over the MRI of the lumbar spine again after reviewing Dr. Wingate's testimony. He responded that he did not, noting, "you can't get radiculopathy when there's no nerve root compression. Rather, he maintained his opinions from his initial viewing. Dr. Mather again noted that the broad-based disc bulge

at L5–S1 was age appropriate degeneration. He repeated his disagreement with Dr. Wingate's interpretation that L5–S1 was collapsed by 1/3. He specifically noted that he saw L4–5 as completely normal.

Dr. Mather acknowledged that the symptoms of numbness reported in the foot could be associated with impingement of the L5 or S1 nerve roots. However, he added that Petitioner did not have lumbar symptoms because of Petitioner's markings on the pain diagram.

Dr. Mather also added that a discogram would be dangerous. He added redirect examination puncturing a normal disc can cause that disk to degenerate.

On further cross-examination Dr. Mather elaborated his note that petitioner presented with "bizarre" symptoms, namely numbness the lateral aspect of the right thigh, which did not make any sense. He noted that he related to an upper lumbar condition which was completely by MRI. Petitioner straight leg raise was negative. He noted that Petitioner had reported to other physicians that the right foot numbness was constant; whereas, Petitioner reported to Dr. Mather that the symptom come and go.

CONCLUSIONS OF LAW

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

This issue was not genuinely disputed. Petitioner testified credibly that he was at a worksite installing windows when he was struck in the head by a pipe estimated at 100 pounds, wielded by plumber also at the worksite. No evidence was offered petitioner's testimony.

Accordingly, the Arbitrator finds that Petitioner proved that he was injured in an accident that arose out of and in the course of his employment.

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

This issue was not genuinely disputed as to Petitioner's cervical and thoracic injuries. Petitioner testified credibly and without contradiction that he was struck in the head by a length of waste pipe wielded by a plumber working on the work-site. He had immediate pain in his neck and mid-back. Petitioner sought and received medical care for those complaints in a timely manner.

Various of Petitioner's treating physicians noted a causal connection between the work accident and Petitioner's neck and mid back complaints. In fact, Respondent's retained IME examiner, Dr. Mather, diagnosed Petitioner with work-related cervical and thoracic strains at the initial IME November 16, 2017. Dr. Mather again diagnosed cervical strain at his second IME on October 4, 2018. The Arbitrator notes that Dr.

Mather did not specify then whether the previously diagnosed thoracic strain had resolved or whether his initial diagnosis was erroneous.

The disputed issue is whether Petitioner sustained a lumbar injury which resulted in pain and radicular symptoms that were work causally related to the work accident.

Petitioner's history of subjective neurological complaints with lateral right thigh numbness and right plantar numbness were documented early on after the June 21, 2017 work accident. In addition, Petitioner's complaints of low back pain were documented in the IBJ PT evaluation on July 25, 2017. Lumbar spine imaging demonstrated objective abnormalities, the extent of which was disputed. Physicians treating physicians Drs. Chunduri and Wingate opined that Petitioner's lumbar pathology and symptomatology were causally related to the work accident on June 21, 2017. On the other hand, Respondent's retained IME examiner, Dr. Mather, opined that Petitioner's lumbar pathology was age-related degeneration and not causally related to the work accident.

The number of witnesses testifying to a particular fact or issue may not be convincing if a lesser number of witnesses is more convincing when testifying to that fact or issue. Here however, the Arbitrator finds the opinions on the greater number out a way the opinions of the one. In particular, the Arbitrator does not find Dr. Mather's persuasive. Petitioner had a well-documented history of early subjective complaints with his right leg and foot.

Petitioner's complaint of numbness on the sole his right was first documented at Aurora Health Care the day following the work accident, June 22, 2017. This complaint was also documented at IBJ PT on July 25, 2017. In addition, petitioner's complaint of low back pain was first documented at IBJ PT on July 25. Dr. Mather mistakenly based his lack of causation opinion on the belief that Petitioner's low back complaints arose much later. In addition, Dr. Mather was dismissive of Petitioner's well-documented complaints of right plantar numbness so that he did not conduct a genuinely objective evaluation of that complaint.

In addition, Dr. Mather's credibility is questioned when in cross-examination he attempted to raise the inference that he did not personally benefit from fees be charged for IMEs or depositions. The Arbitrator finds Dr. Mather's testimony regarding his remuneration incredible.

Further, Dr. Mather's response cross-examination was from time to time an exercise in in wordplay and evasion. From time to time he did not respond with straight answers to straight questions.

Dr. Mather's diagnosis of psychogenic pain/functional overlay was equally unpersuasive given his opinion that Petitioner was neither malingering nor seeking secondary gain. Dr. Mather opined that that Petitioner's subjective complaints of pain

were not based on objective clinical findings but did not dispute or explain why petitioner did exhibit pain following his work accident.

Accordingly, the Arbitrator does not accept the lack of causation opinions of Dr. Mather and adopts the causation opinions of Drs. Chunduri and Wingate. Therefore, the arbitrator finds that Petitioner proved that his current condition of ill-being in his lumbar spine was causally related to the work accident on June 21, 2017.

J: Were the medical services that were provided to Petitioner reasonable and necessary?

In light of the Arbitrator's previous finding that Petitioner proved that his conditions of ill being in his cervical, thoracic, and lumbar spines were causally related to his work accident on June 25, 2017, the Arbitrator also finds that petitioner proved that the medical services provided for treatment of those injuries was reasonable and necessary. Specifically, the arbitrator finds Dr. Mather's opinions that petitioner's medical care is not necessary to be unpersuasive.

Petitioner submitted multiple medical bills pertaining to medical treatment received for his work-related injury:

a) ATI Physical Therapy - $2,581.04

Petitioner submitted a medical bill from ATI pertaining to the FCE performed on July 6, 2018 at the request of Dr. Chunduri (PX #7). The Arbitrator has reviewed the medical bill and the corresponding medical records and finds the FCE was reasonable and necessary to evaluate Petitioner's physical capabilities. The Arbitrator awards the medical bill of ATI Physical Therapy to Petitioner subject to adjustment in accord with the medical fee schedule.

b) Bluemound Surgery Center - $11,800.00

The medical bill of Bluemound Surgery Center pertains to the surgical center charges for the cervical epidural injection performed on March 6, 2018 and the lumbar epidural injection performed on April 17, 2018 (PX #7). The Arbitrator finds that the injections prescribed by Dr. Chunduri were reasonable and necessary to alleviate Petitioner's pain. The Arbitrator awards the medical bill of Bluemound Surgery Center to Petitioner subject to adjustment in accord with the medical fee schedule.

c) G & T Orthopedics - $825.00

The medical bill of G & T Orthopedics pertains to 2 orthopedic office visits petitioner had with Dr. Poepping on September 6 and November 1, 2017 (PX #6). The Arbitrator has reviewed the medical bill and the corresponding medical records and finds that the medical charges of Dr. Poepping were reasonable and necessary. The Arbitrator awards the medical bill of G & T Orthopedics to Petitioner subject to adjustment in accord with the medical fee schedule.

d) Illinois Orthopedic Network - $7,342.65

The medical bill of Illinois Orthopedic Network corresponds to medical treatment rendered by Drs. Murtaza, Chunduri, Dixon, and Wingate for dates of service between December 19, 2017 through May 25, 2018 (PX #7). The Arbitrator has reviewed the medical bill and the corresponding medical records and finds that the medical charges of Illinois Orthopedic Network were reasonable and necessary. The Arbitrator awards the medical bill of Illinois Orthopedic Network to Petitioner subject to adjustment in accord with the medical fee schedule.

e) Libertyville Imaging - $1,690.00

The medical bill of Libertyville Imaging pertains to the lumbar MRI performed January 29, 2018 (PX #7). The Arbitrator has reviewed the medical bill and the corresponding medical records and finds that the medical charges of Libertyville Imaging were reasonable and necessary. The Arbitrator awards the medical bill of Libertyville Imaging to Petitioner subject to adjustment in accord with the medical fee schedule.

f) Metro Anesthesia – $2,030.15

The medical bill of Metro Anesthesia pertains to the cervical medial branch blocks performed by Dr. Chunduri (PX #7). The Arbitrator has reviewed the medical bill and the corresponding medical records and finds that the medical charges of Metro Anesthesia were reasonable and necessary. The Arbitrator awards the medical bill of Metro Anesthesia to Petitioner subject to adjustment in accord with the medical fee schedule.

g) Midwest Orthopedic Network – $6,171.64

The medical bill of Midwest Orthopedic Network pertains to medical services provided by Dr. Chunduri for services dates between January 23 and July 10, 2018 (PX #7). The Arbitrator has reviewed the medical bill and the corresponding medical records and finds that the medical charges of Midwest Orthopedic Network were reasonable and necessary. The Arbitrator awards the medical bill of Midwest Orthopedic Network to Petitioner subject to adjustment in accord with the medical fee schedule.

h) Midwest Specialty Pharmacy - $10,775.09 Total Bills; $7,863.03 Outstanding

The medical bill of Midwest Specialty Pharmacy pertains to medications prescribed by Drs. Murtaza and Dr. Chunduri. The Arbitrator has reviewed the medical bill and the corresponding medical records and finds that the medical charges of Midwest Specialty Pharmacy were reasonable and necessary. The Arbitrator awards the medical bill of Midwest Specialty Pharmacy to Petitioner subject to the medical fee schedule. Respondent made payments of $1,183.64 for the charge of November 15, 2017 and $1,728.42 for the charge of December 22, 2017, leaving an outstanding balance of $7,863.03.

i) Jeffrey Wingate, M.D. - $1,050.00

The medical bill of Jeffrey Wingate, M.D. pertains to an office visit on December 28, 2018 (PX #8). The Arbitrator has reviewed the medical bill and the corresponding medical record and finds that the medical charge of Jeffrey Wingate, M.D. was reasonable and necessary. The Arbitrator awards the medical bill of Jeffrey Wingate, M.D. to Petitioner subject to adjustment in accord with the medical fee schedule.

K: Is Petitioner entitled to any prospective medical care?

Dr. Wingate has opined that Petitioner will likely require some type of surgical reconstruction with fusion, instrumentation and bone graft. He further opined that he would like petitioner evaluated with lumbar discography to obtain a better understanding of Petitioner's discogenic pain. Petitioner expressed to Dr. Chunduri on June 12, 2018 that he was not interested in lumbar surgery, but at hearing he expressed that he was interested in any medical treatment that would make him feel better.

Respondent's IME examiner, Dr. Mather, opined that discography was not medically necessary and in fact presented risks of causing degeneration of healthy discs. Even so, in light of the Arbitrator's previous findings, the Arbitrator finds this opinion Dr. Mather equally unpersuasive.

Based on the foregoing, the Arbitrator finds that petitioner proved that he is entitled to the reasonable and necessary prospective medical care and treatment recommended by Dr. Wingate.

L: What temporary benefits are in dispute? TTD/TPD

Petitioner claims multiple periods for which he believes he is entitled to TTD benefits. He further claims TPD for periods of time he worked at Progressive and AutoZone.

TTD

a) July 17, 2017 through December 11, 2017 (21 & 1/7 weeks)

The medical records of Dr. Parikh of IBJ indicate that Petitioner was provided an off work note on July 17, 2017. Petitioner testified that he went off work as of that date. The Request for Hearing, ArbX #1, states that Petitioner claimed he was off work beginning September 17, 2017. Both the medical records and the testimony of Petitioner confirm that July 17, 2017 was the date that Petitioner first was taken off work by his physician. Consequently, the Arbitrator finds that an error was made on ArbX #1 and that July 17, 2017 was the initial date Petitioner was off work.

Petitioner's TTD benefits were terminated as of November 16, 2017 per the IME of Dr. Mather. Treating physicians had not released Petitioner to return to work. Due to the termination of benefits, Petitioner went back to work for Respondent on December 12, 2017. Petitioner stated that he experienced excruciating pain while

performing his job duties. Petitioner testified that he worked until December 17, 2017 but stopped because his pain was so severe.

The Arbitrator finds that Petitioner proved that he was not capable of returning to work full duty as a union glazier at the time his benefits were terminated by Respondent. Petitioner is entitled to TTD benefits from July 17, 2017 through December 11, 2017.

b) December 18, 2017 through February 4, 2018 (7 weeks)

Petitioner returned to Dr. Murtaza on December 19, 2017. After examining Petitioner, Dr. Murtaza released Petitioner to return work with restrictions of lifting no more than 10 lbs., pushing and pulling no more than 30 lbs., no overhead lifting and no bending, squatting, climbing, kneeling or crawling. Petitioner testified that he presented the restrictions to the respondent and they could not accommodate him.

c) March 28, 2017 through September 17, 2018 (24 & 6/7 weeks)

Petitioner testified that due to the lack of income he made another attempt to return to work as a union glazier with Rock Valley. Petitioner worked for Rock Valley from February 5, 2018 through March 27, 2018. Petitioner testified that he stopped work as of March 27, 2018 because he was in agony every day.

Petitioner remained off work through September 17, 2018. On September 18, 2018, Petitioner testified that he attempted to work as a car valet for a company called progressive. Petitioner stated that he lasted one day, but of pain he incurred climbing in and out of cars and walking at a fast pace through the parking lot. Petitioner earned one day of wages equaling $81.00.

d) September 19, 2018 through November 18, 2018 (8 &5/7 weeks)

Following his attempt to work as a car valet, petitioner remained off work until through November 18, 2018. On November 19, 2018, petitioner took a job for AutoZone, auto parts company. Petitioner was employed there from November 19, 2018 through December 1, 2018. Petitioner voluntarily left that job because he could not handle the excessive standing required. Petitioner earned $532.23 for the time he worked there.

e) December 2, 2018 through March 26, 2019 (16 & 3/7 weeks)

Petitioner testified that he has not work for any other employer since his employment with AutoZone. He has remained off work from December 2, 2018 through March 26, 2019.

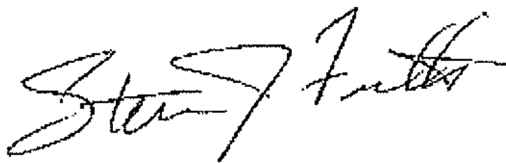
The Arbitrator notes that Petitioner attempted to work despite his medical condition. Based on the foregoing, the Arbitrator awards TTD for the periods of: July 17, 2017 through December 11, 2017; December 18, 2017 through February 4, 2018; March 28, 2017 through September 17, 2018; September 19, 2018 through November 18, 2018; and December 2, 2018 through June 21, 2017 equaling 78 & 4/7 weeks at the rate of $1,125.91/week.

Respondent is entitled to a credit of $22,517.60 for TTD benefits paid.

TPD

The Arbitrator further awards Petitioner temporary partial disability benefits (TPD) for the one day he was employed at Progressive and the days he worked at AutoZone. Per §8(a) of the Act, TPD shall be equal to 2/3 of the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of accident and that the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working. There was no evidence presented as to what Petitioner could be earning in the full performance of his duties as a union glazier, therefore the Arbitrator uses the average weekly wage.

Accordingly, the Arbitrator awards TPD for date of September 18, 2018 equal to [($1,688.87 x 1/7 week) - $81.00] x 66-2/3% or $106.84. The Arbitrator further awards TPD for the dates of November 19, 2018 through December 1, 2018 equal to [($1,688.87 x 13/7 week) - $532.23] x 66-2/3% or $1,736.16. Consequently, the Arbitrator awards Petitioner TPD for both the Progressive and the AutoZone jobs equal to $1,843.00.



Steven J. Fruth, Arbitrator

October 9, 2019
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RODNEY WILLIAMS,

Petitioner,

vs. NO: 18 WC 32133

STATE OF ILLINOIS
CENTRAL MANAGEMENT SERVICES,

Respondent.

20 I W C C 0 6 7 9

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of permanent disability 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.

During the pendency of this review, Petitioner filed a Motion for Penalties and Fees. Petitioner was afforded an opportunity to present his argument in support of his Motion during the oral arguments of November 10, 2020. After considering both Petitioner's written submission and oral argument, the Commission denies Petitioner's Motion for Penalties and Fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 10, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Motion for Penalties and Fees filed on July 28, 2020 is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical expenses as detailed in Petitioner's Group Exhibit 2, pursuant to §8(a) and subject to §8.2 of the Act. Respondent shall receive credit for payments made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $793.65 per week for a period of 25 3/7 weeks, representing April 18, 2018 through May 21, 2018 and September 7, 2018 through January 28, 2019, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of $16,140.71 for TTD benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $714.29 per week for a period of 66.8 weeks, as provided in §8(e)11 of the Act, for the reason that the injuries sustained caused a 40% loss of use of the left foot.

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: NOV 2 0 2020

LEC/cak

O: 11/10/2020

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS JR, RODNEY L Case# **18WC032133**
Employee/Petitioner

SOI-CENTRAL MANAGEMENT SERVICES 20IWCC0679
Employer/Respondent

On 12/10/2019, 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 1.52% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

5002 ASSISTANT ATTY GENERAL
JOSEPH BLEWITT
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 10 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF **LASALLE**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rodney L. Williams, Jr.
Employee/Petitioner

Case # **18** WC **32133**

v.

Consolidated cases:

State of Illinois – Central Management Services
Employer/Respondent

20IWCC0679

An *Application for Adjustment 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 **Ottawa, Illinois**, on **September 26, 2019**. 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 for the right shoulder 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 ______

20IWCC0679

FINDINGS

On **3/29/18**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

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

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

In the year preceding the injury, Petitioner's average weekly wage was $**1,190.48**.

On the date of accident, Petitioner was **41** years of age, ***single*** with 1 dependent children.

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

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

Respondent shall be given a credit of $**16,140.71** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**16,140.71**.

ORDER

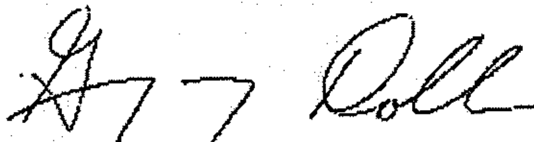
Respondent shall pay Petitioner reasonable and necessary medical services as provided in Petitioner's Group Exhibit 2, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for payments made.

Respondent shall pay Petitioner temporary total disability benefits of $793.65/week for 25-3/7weeks ($20,181.39), commencing 4/18/18 through 5/21/18 and 9/7/18 through 1/28/19, as provided in Section 8(b) of the Act. Respondent shall receive a credit of $16,140.71 and pay Petitioner the remaining balance of $4,040.68.

Respondent shall pay Petitioner permanent partial disability benefits of $714.29/week for 66.8 weeks, because the injuries sustained caused 40% loss of use 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

12/6/19
Date

DEC 10 2019

FINDINGS OF FACT

Petitioner testified that on 3/28/19 he was working for Respondent, State of Illinois, Central Management Services. He was 41 years of age and single with one dependent child. Petitioner has worked for the State of Illinois for eighteen years. Petitioner testified that he worked as a Janitor/maintenance person and his responsibilities included maintenance and cleaning of the building where he worked, as well as securing the building at the end of the day. The building is a two-story building with a lower basement level. Petitioner's duties require him to use stairs on a regular basis, use ladders and requires squatting and kneeling to perform his job. Petitioner is on his feet throughout his work day. Petitioner testified that on 3/29/18 he was securing a gate when the curb he was standing on crumbled, causing his left ankle to roll. He testified that he noticed immediate pain and notified his supervisor. He continued to work and hoped that it would become better but it did not.

Petitioner testified and the medical records reflect that he presented to Dr. Iyad Jundi at the CGH Medical Center on 4/18/18. (PX 1.1) Petitioner reported that he had injured his left ankle at work. Since then, he had showed little improvement. He was slightly limping with walking and his ankle was swollen laterally with tenderness under the lateral malleolus. Eversion of the foot caused pain also laterally. He had minimal tenderness over the medial aspect without swelling or warmth. Walking on the arch was associated with significant pain. Otherwise, he was able to walk on his toes and heels with minimal difficulties. X-rays showed no acute fracture. The assessment was a left ankle sprain. Petitioner was given an ankle brace to use for a week or two and 800 mg ibuprofen 3 times daily with food for about 5-7 days. He was given work restrictions and told to follow up. Petitioner continued his treatment at CGH Medical Center and was eventually referred to Dr. Riley after a MRI of the left ankle was obtained. The MRI when completed on 6/26/18, revealed: 1) the anterior talofibular ligament was completely torn; 2) sprains of the posterior talofibular ligament and calcaneofibular ligament; 3) tendinosis and a small interstitial tear of the peroneus brevis tendon along its retro-malleolar course; 4) tendinosis of the peroneus longus tendon along its retro-malleolar course; 5) a small amount of fluid in the tendon sheaths of the distal tibialis posterior and flexor digitorum longus tendons, likely tenosynovitis; and 6) achilles tendinosis and mild peritendinitis. (PX 1.2)

On 9/7/18, Dr. Riley performed a left ankle lateral stabilization with internal brace and a left peroneus brevis repair. (PX 1.3). Dr. Riley noted that Petitioner had left lateral ankle instability and peroneus brevis rent and tear from a work-related injury. Dr. Riley's description of the procedures indicates that upon immediate entrance to the peroneus brevis he noted hemorrhagic synovium, which was debrided and a rent at the level of the fibula was then encountered. Dr. Riley then removed the scarred and redundant tissue within the peroneus brevis and was then able to re-tubularize the peroneus brevis with 2.0 FiberWire. Placement back in the retrofibular groove and the peroneus brevis and longus were noted. Dr. Riley then directed his attention to the ATFL (anterior talo-fibular ligament), which was incised sharply and a fibular periosteal cuff was made. The distal fibula was identified and the extensor retinaculum was obtained for use as the Gould modification. The tissue was noted quite attenuated and Dr. Riley felt it was necessary for stabilization with an internal brace. The lateral process of the talus was then dissected and the lateral aspect of the talus was identified. Dr. Riley then drilled and placed a 3.5 anchor with the internal brace attached. This was then fed through a 4.75 anchor and the 4.75 anchor was placed in the fibula. There was remaining redundant tissue from the fibular cuff and Dr. Riley then utilized 0 Vicryl and oversewed this within the repair in a vest over pants fashion. Dr. Riley then proceeded to close the subcutaneous tissue and complete the surgical procedure. Petitioner was discharged to home as an outpatient and to followup with Dr. Riley in five to seven days. Norco was prescribed for pain management and Xarelto as a deep venous thrombosis prophylaxis. Petitioner was also instructed to be strictly adherent to non-wightbearing and was placed in a pneumatic cast boot.

Petitioner continued his post-operative treatment with Dr. Riley and formal physical therapy through CGH Medical Center. On 1/10/19, Petitioner had his last therapy visit and reported to his physical therapist that walking around Walmart for about an hour caused his left ankle to feel achy. He also reported that he will occasionally feel a "sting" in his left lateral ankle when walking without a shoe or on uneven surfaces. The therapist noted significant tenderness along the incision and during STM, that Petitioner felt tingling in his lateral toes during scar massage and that tightness persisted in the gastroc, despite the Petitioner doing his home stretching program.

Petitioner testified and the medical records reflect that Petitioner was last seen by Dr. Riley on 2/25/19. Petitioner reported that he would still get some pain when going up or down stairs or when changing directions. Petitioner was released to work with no restrictions and to use regular shoe gear.

Petitioner testified that there are still unpaid medical expenses with CGH Medical Clinic in the amount of $7,183.09. Petitioner presented into evidence copies of the unpaid medical expenses. (PX 5) The Arbitrator notes that PX-5 is specifically listed as an exhibit for identification purposes of the unpaid medical expenses. The billing for these unpaid medical expenses is also contained within Petitioner's Group Exhibit 2, which contains all of the medical expenses incurred by Petitioner for the treatment that was rendered.

On 3/14/19, Petitioner was examined by Dr. Stephen F. Weiss, at the request of Respondent, per Section 12 of the Act. Dr. Weiss prepared a report, dated 3/20/19. (PX-4) Dr. Weiss noted that on 3/29/18 Petitioner suffered tears of the lateral ligaments and peroneus brevis at work and that he underwent lateral stabilization and peroneus brevis repair. Dr. Weiss noted that Petitioner estimated his ankle to be about two-thirds of normal and that he would wear high-top shoes or boots in lieu of an external ankle brace. Also noted was that Petitioner does have some problems with stair climbing, ladder climbing, kneeling and squatting. On physical examination, Dr. Weiss noted restricted motion, antalgic gait on the left, swelling and calf atrophy. Dr. Weiss also indicated that neurocirculatory status of the feet was normal with the exception of almost absent sensation in the dorsolateral aspect of the left foot involving the outer two toes. Dr. Weiss' diagnosis indicated lateral stabilization and peroneus brevis repair of the left ankle secondary to the work incident in question. Finally, Dr. Weiss noted that Petitioner denied any prior difficulties with his left ankle, objective findings included ankle swelling and calf atrophy, there was no evidence of symptom magnification, Petitioner's restricted motion and antalgic gait were consistent with his objective findings, Petitioner's current objective findings are secondary to the work incident in question, all the medical treatment has been reasonable and necessary, that Petitioner has reached MMI, and that his current objective findings represent permanent residuals of his injury.

Petitioner testified that he continues to work for Respondent in the same capacity and his duties include maintenance of the building, cleaning, and securing the building and gates. He testified that he is making the same amount of money that he was at the time of his work accident. He testified as to what he currently notices about his left ankle/foot while at work. He testified that the building has a second floor and a basement and that he does a lot of walking and using of stairs, which causes a lot pain and swelling. He uses ice on a daily basis and also uses Aleve, ibuprofen or Tylenol at least three times a week. Petitioner testified that he does not use a brace at work because it is uncomfortable and bulky with his foot wear, but he wears high-ankle shoes or boots to help for support because they are more comfortable on his left ankle/foot. He also testified that his job duties require him to push recycling bins, which is difficult and causes pain to his left ankle/foot. The surgical hardware has not been removed and remains in Petitioner's left foot/ankle.

Petitioner also testified as to what he currently notices about his left ankle/foot when he is at home. Petitioner testified that he has difficulty with uneven surfaces and he had to purchase a riding-mower because he has too much pain trying to use a push-mower. He likes to work on his car, but getting up and down off the ground is difficult with his left ankle/foot. Also, that he is no longer able to run, play softball or play tennis, which he did prior to this work accident.

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

The Arbitrator adopts and incorporates all the above findings of fact into these findings.

The Petitioner's work accident occurred after September 1, 2011. Therefore, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

- The reported level of impairment based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment;
- The occupation of the injured employee;
- The age of the employee at the time of injury;
- The employee's future earning capacity; and
- Evidence of disability corroborated by the treating medical records.

With regard to the reported level of impairment pursuant to Section 8.1(b), the Arbitrator notes that no impairment rating was obtained. Therefore, the Arbitrator gives no weight to this factor.

With regard to the occupation of the Petitioner, the Arbitrator notes that Petitioner is employed as a janitor/maintenance person with Central Management Services. The Arbitrator notes that Petitioner's occupation does involve extensive time on his feet, the use of stairs in a three-level building, the use of ladders, as well as squatting and kneeling. Petitioner's job is strenuous and demanding as it relates to Petitioner's left foot/ankle. Therefore, the Arbitrator gives more weight to this factor.

With regard to the age of the employee at the time of injury, the Arbitrator notes that Petitioner was 41 years of age at the time of the accident. The Arbitrator notes that Petitioner is young and will have to endure this injury longer than someone more advanced in years and that Petitioner has more than twenty years of work-life remaining. The Arbitrator therefore gives significant weight to this factor.

With regards to the Petitioner's future earning capacity, the Arbitrator notes that no evidence was presented that shows Petitioner's future earning capacity has been diminished. The Arbitrator therefore gives no weight to this factor.

With regard to the evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner suffered a complete anterior talofibular ligament tear, sprains of the posterior talofibular ligament and calcaneofibular ligament, and a small interstitial tear of the peroneus brevis tendon along its retro-malleolar course. Also diagnosed was tendinosis of the peroneus brevis tendon along its retro-malleolar course, tendinosis of the peroneus longus tendon along its retro-malleolar course, fluid in the tendon sheaths of the distal tibialis posterior and flexor digitorum longus tendons, likely tenosynovitis, and achilles tendinosis and mild peritendinitis. Petitioner was taken to surgery and underwent a left ankle lateral stabilization with internal brace and a left peroneus brevis repair. Petitioner's surgery required hardware and that hardware remains in Petitioner's left foot/ankle. Petitioner continues to experience pain and swelling with the use of stairs, walking on uneven ground, getting up from the floor, squatting and kneeling, and walking for extended periods of time. Respondent's Section 12 examiner, Dr. Stephen Weiss, confirmed restricted motion, antalgic gait on the left, swelling and calf atrophy. The Arbitrator therefore gives greater weight to this factor.

The Arbitrator notes that determination of permanent partial disability is not simply a calculation but an evaluation of all 5 factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, having considered

the factors enumerated in Section 8.1(b) of the Act, 820 ILCS 305/8.1(b), the Arbitrator finds that as a result of her accidental injuries the Petitioner has sustained 40% loss of use of the left foot, pursuant to Section 8(e) of the Act.

20IWCC0679

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERIKA JEFFREY,

Petitioner,

vs. NO: 17 WC 11324

SUGAR CREEK ALZHEIMER CARE,

Respondent.

20IWCC0680

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

The Commission strikes the first full sentence in the first paragraph on page 11 of the Arbitrator's decision.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 9, 2019 as modified above is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is not causally related to the December 24, 2016 accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent is not liable for medical expenses incurred by Petitioner after December 27, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay to the Petitioner the sum of $816.43 per week for a period of 33 2/7 weeks, representing April 14, 2017 through December 3, 2017, that being the period of temporary total incapacity for work under §8(b) of the Act, and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

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

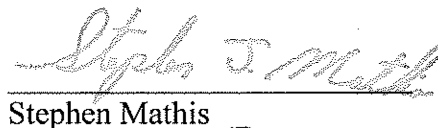
IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or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

The bond requirement in 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.

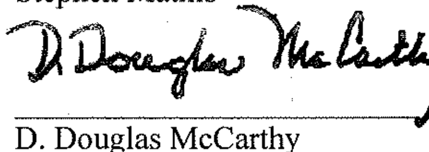
DATED: NOV 2 0 2020

L. Elizabeth Coppoletti

LEC/cak


Stephen Mathis

D: 10/20/2020


D. Douglas McCarthy

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

JEFFERY, ERIKA
Employee/Petitioner

Case# **17WC011324**

SUGAR CREEK ALZHEIMER CARE
Employer/Respondent

20IWCC0680

On 3/9/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0210 GANAN & SHAPIRO PC
AMY L TURNBAUGH
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602

FINDINGS

On the date of accident, **12/24/2016**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**63,720.28**; the average weekly wage was $1,225.39

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

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

Respondent shall be given a credit of $**26,960.01** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**26,960.01**.

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

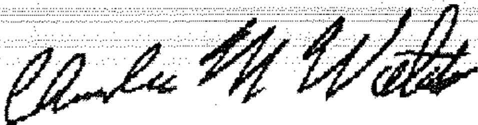
ORDER

PETITIONER'S CURRENT CONDITION OF ILL-BEING IS NOT CAUSALLY RELATED TO THE ORIGINAL INJURY.
PETITIONER IS NOT ENTITLED TO PROSPECTIVE MEDICAL CARE UNDER SECTION 8(A) OF THE ACT.
PETITIONER IS NOT ENTITLED TO TPD AND/OR MAINTENANCE BENEFITS.
RESPONDENT IS NOT LIABLE FOR MEDICAL EXPENSES INCURRED BY PETITIONER AFTER 12/27/17.

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

March 6, 2020
Date

ICArbDec19(b)

MAR 9 - 2020

STATEMENT OF FACTS

Erika Jeffrey (hereinafter "Petitioner") testified she was hired to work for Sugar Creek Alzheimer care (hereinafter "Respondent") in May 2016. The position she was hired for was Health Services Director. The job entailed managing staff and caregivers. She indicated her job duties included preparing schedules, managing patient records/admissions. She managed the records of individual CNAs as their supervisor. She further testified she would occasionally be required to handle direct contact with patient care. She testified initially her contact with direct patient care at Respondent's location would be approximately one shift per week or 5 to 10 times over the course of her initial employment. She then testified a new administer was hired in October 2016. Her responsibility to cover nursing shifts increased directly in response to the hiring of the new administrator.

Petitioner stated that overnight shifts were not completely covered and that managers such as herself would have to cover those shifts routinely. She further testified at the time of injury on December 24, 2016, her direct supervisor was Crystal Biddle. When the supervisor/administrator was not in the building, the Health Services Director would assume responsibilities of the administrator during those times. Petitioner testified that surrounding the timeframe of the accident on December 24, 2016, she was required to have direct patient care 3 to 4 times per week during shifts.

With respect to the accident on December 24, 2016, she testified a nurse had called in and she was charged with covering that nurse's shift over the evening hours on December 24. She was filling in as the charge nurse covering the staffing floor. That required her to have direct patient care with managing all patients' medications and illnesses. She was the immediate on-site supervisor for all of the CNAs on staff that evening. In describing the incident that occurred on December 24, Petitioner testified a resident had recently been admitted who was an inappropriate admission based on the level of care needed. The patient had fallen and it took all of the on duty caregivers to attempt to help get the resident up off the floor. This included Petitioner. Petitioner testified they were using a gait belt in order to lift the patient and she was combative. There were three caregivers and Petitioner trying to lift the patient off the floor. Petitioner testified the patient was very heavy, the belt came off, the other caregivers let go and Petitioner still had a hold on the belt and her arm flew over her head.

After the incident, Petitioner testified she felt immediate onset of pain. However, the patient needed additional medical treatment for a wound as a result of the incident and an ambulance was called for that purpose. Petitioner then testified she reported it to the administrator, Crystal. She testified she asked the administrator help and was ignored. She also asked for another nurse to come in to relieve her but no one would come in because it was the Christmas holiday. As such, she stated she finished out her shift overnight and chose not to seek medical treatment until December 26 so as not to spend her entire holiday in an emergency room or urgent care facility. She testified during that time she iced her shoulder and monitored the facility as best she could. She could not continue to perform the functions of an RN/charge nurse at that time.

Petitioner testified/corroborated and the medical records reflect she appeared for medical treatment at McLean County Orthopedics, initially with Dr. Armstrong. Petitioner admitted she had been a prior patient at that facility for an unrelated hip conditions in 2014 and she chose to treat at this facility. She provided a consistent history and mechanism of injury. Dr. Armstrong diagnosed Petitioner with impingement syndrome of the shoulder. X-rays taken were negative for fracture. Petitioner also had AC degenerative joint disease but had an intact glenoid. There were prescriptions provided including physical therapy. She was told to follow-up as needed. (PX 2) She began a course of physical therapy on January 19, 2017 at Athletico. (PX 4) She participated in physical therapy until ultimately undergoing surgery.

In order to rule out cervical pathology, Petitioner underwent an MRI of the cervical spine on February 23, 2017 which was read to show a very low-grade cervical spondylosis without any sizable disc herniation or cervical neural impingement. She returned to McLean County Orthopedics on February 28th 2017. She elected to undergo an injection of the right shoulder at that time. She was told to avoid strenuous activity for two days. Further, she was told if there was no relief from the injection to call for an MRI of the shoulder. She was returned to work light duty with no lifting greater than 5 pounds. (PX 2) Petitioner testified she continued working during this time under the light duty restriction.

She underwent an MRI of the right shoulder for continued complaints on March 15, 2017. This was read to show no full thickness tear of the rotator cuff or labral visualized. It showed tendinopathy of the supraspinatus tendon. Thereafter, Dr. Armstrong referred Petitioner to Dr. Norris within McLean County Orthopedics. She saw Dr. Norris on April 5, 2017. He performed an evaluation of the right shoulder. A right biceps injection was performed. Dr. Norris recommended an additional 2-4 weeks of physical therapy. He opined if she did not improve at that time, he would then discuss surgical possibilities. He provided a light duty restriction which continued no lifting greater than 5 pounds with the right arm. (PX 2)

Petitioner testified Respondent did not continue to honor her work restrictions and ultimately, Petitioner's employment with Respondent ended approximately April 13, 2017. She later admitted she filed separate employment claims against Respondent which were later settled. Petitioner confirmed she began receiving TTD benefits beginning April 14, 2017. She returned to Dr. Norris on April 26, 2017 and indicated the injections did not help. Dr. Norris then recommended surgery.

At Respondent's request, Petitioner was examined by Dr. Kefalas on June 14, 2017 pursuant to Section 12 of the Act. Dr. Kefalas took a history from Petitioner, performed an examination, reviewed the relevant medical records including Petitioner's MRI and ultimately diagnosed Petitioner suffered an acute right shoulder injury during the mechanism on December 24, 2016. He opined she had symptoms consistent with right shoulder AC joint synovitis and right shoulder impingement syndrome. He confirmed her current objective findings at that time were pain at the right AC joint as well as pain with cross abduction of the right shoulder. There was a positive impingement sign. These correlated with Petitioner's subjective complaints. He agreed that no additional diagnostic testing was warranted. He then further agreed Petitioner was a candidate for the arthroscopic shoulder surgery Dr. Norris had recommended. He indicated

Petitioner was capable of working with light duty restrictions which would limit her to no overhead lifting or activity with the right arm until after recovery from surgery. (RX 1)

Thereafter, Petitioner underwent surgery on July 21, 2017 with Dr. Norris. The procedure was a subacromial decompression, distal clavicle excision and biceps tenodesis. (PX 3) In her first follow-up appointment after surgery, Dr. Norris continued to restrict Petitioner for four weeks. Upon her return to Dr. Norris on August 28, 2017, Petitioner was doing "outstanding" according to Dr. Norris with very few complaints of pain. She had returned to full functional motion. He recommended she proceed to the strengthening phase of physical therapy and return for follow-up in four weeks. He provided her with a light duty restriction of no lifting greater than 5 pounds. (PX 2) Petitioner continued in physical therapy. (PX 4)

By September 27, 2017, Dr. Norris noted Petitioner continued to improve and had pain only intermittently with specific activities. It did not affect her activities of daily living consistently. He recommended she start the work conditioning phase in an effort to get her back to the same level she was preinjury and to follow-up in four weeks. He completely restricted her from work in order to complete work conditioning. (PX 2)

Petitioner returned to Dr. Norris on November 9, 2017. Dr. Norris noted Petitioner had been doing really well until she started work conditioning. She had some complaints of increased pain which he felt were just inflammation aggravated by increasing her activity. He provided a glenohumeral and bicipital groove injection as well as providing a Medrol Dose Pak to calm down any acute inflammation. He recommended she finish out her last two weeks of work conditioning and then return to him for follow-up where he anticipated a release back to work at that time. He deferred discussing MMI until after a trial of returning to work. (PX 2)

She returned to Dr. Norris November 29, 2017. At that visit he noted Petitioner had been working hard in her work conditioning program. She felt she had some pain with overhead activities but overall felt she could perform the duties of her job and would like to go back to work without restrictions. Dr. Norris's report stated he felt comfortable letting her go back to work without restrictions but would not declare her at MMI until one follow up with her in approximately 3 to 4 weeks. She was released to return to full duty work as of December 4, 2017. (PX2)

Petitioner testified she then chose to seek out a second opinion with a physician her attorney recommended she see, Dr. Rhode. She appeared for an appointment with Dr. Rhode on December 14, 2017. After obtaining a history and examining Petitioner, Dr. Rhode felt Petitioner had plateaued in her treatment. He felt because she was allegedly moderately symptomatic with subjective complaints of lateral shoulder pain, and claimed she was unable to return to work full duty, he restricted her temporarily to modified, light - medium duty and prescribed she undergo a functional capacity evaluation. (PX 5)

Petitioner underwent a functional capacity evaluation with a therapist employed by Dr. Rhode on December 14, 2017. The therapist performing the functional capacity evaluation with Petitioner's own description of her job title as Health Services Director, utilized a DOT job description for nurse supervisor. At the conclusion of testing, the therapist felt there were no

major limitations with Petitioner's ability to return to work found. The therapist specifically opined Petitioner's objective functioning was higher than Petitioner's perceived abilities. (PX 6)

Petitioner then returned to Dr. Norris on December 27, 2017. Dr. Norris noted she was returning after being released without restrictions as of the last visit. He stated she had not challenged her shoulder in exactly the same way but does not have any significant limitations. Dr. Norris did not feel there was any more medical treatment needed and he released her at maximum medical improvement. He did not believe her own recitation to him she has any long-term restrictions. He noted she underwent an FCE since her last visit as ordered by another physician she was instructed to see at the recommendation from her lawyer. Dr. Norris admitted he knew nothing of any treatment plan and stated she could continue with whatever care that physician felt necessary. He released her at maximum medical improvement to return on an as needed basis, capable of full duty, without restrictions. (PX 2)

Petitioner returned to Dr. Rhode on January 10, 2018. She claimed to have been moderately symptomatic at that time. Despite Dr. Rhode's own therapist indicating the results of the FCE showed no major limitation with any type of return to work to her preinjury capabilities, Dr. Rhode imposed permanent restrictions of modified medium duty with overhead restrictions of 10 to 20 pounds. He placed her at maximum medical improvement, stated no additional treatment was needed or necessary and told her to follow-up as needed. (PX 5) Thereafter, he completed and AMA impairment rating which resulted in an assessment of 10% disability to the extremity or 6% of the person. (PX 7)

Petitioner admitted there was then a break in time after Dr. Rhode's examination where she did not seek any additional medical treatment. Between the visit with Dr. Rhode on January 10, 2018 and her ultimate return to Dr. Norris on July 10, 2018, she obtained a new job at Unity Point Methodist Hospital in Peoria. She admitted she works in a neonatal or intensive care unit for newborns. She stated her position at this location does not require her to lift as extensively as the patients she cares for weigh anywhere up to 12 pounds. Her new position in the specialty care nursery began approximately May 3, 2018. Petitioner testified she was hired in her new position for three, twelve hour shifts per week and stated her base pay was $28.76/hour. She admitted there is additional compensation for overnight shifts and additional weekend differential compensation. As evidence, Petitioner submitted copies of her first two paychecks at Unity Point which the arbitrator notes only demonstrates evidence of her pay during orientation. (PX 13)

Petitioner testified that between the release from Dr. Rhode and her obtaining the job at Unity Point Methodist, she looked for work and submitted applications to nursing homes and/or assisted living facilities where her prior experience had been. She did not have any written documentation to substantiate any locations or facilities where she may have submitted an application or any documentary evidence beyond her testimony that she actively looked for work between January 10, 2018 and her eventual recruitment by Unity Point in May 2018. The arbitrator notes Petitioner did not testify or name any specific potential employers/facilities where she applied for work.

Petitioner returned to Dr. Norris on July 10, 2018. Dr. Norris noted she returned at that time complaining of right shoulder pain. He stated at that time her examination of complaints were consistent with impingement syndrome with bicipital tendinitis. He recommended an injection with instructions to call back if she did not get better in the coming weeks. He stated he would then recommend an MRI of her cervical spine and referral to Dr. Naour if she had persistent complaints of scapular pain and numbness in her hand which could indicate a possible cervical spine etiology as well. Dr. Norris's notes indicate Petitioner called requesting that July 10, 2018 appointment occurred based on a voice message she left on July 3, 2018 complaining she was having right shoulder pain that goes across the "top of her shoulder" and over her biceps. (PX 2)

Petitioner's explanation for why she did not seek any medical treatment between January 2018 and her eventual return to Dr. Norris on July 10, 2018 is that her symptoms increased due to an increased level of activity. Upon further questioning, she stated she decided to seek additional care because the level of pain increased. She specifically stated she was "pretty matriculated" into her role at the hospital and had begun actual patient care working on her own. She stated the level of activity had increased and therefore an increase in pain and symptoms occurred.

On cross examination Petitioner admitted she had appeared with her attorney in court on June 21, 2018 for purposes of a pretrial hearing at which point the case was discussed and recommendations were made regarding permanency by the assigned arbitrator. After that appearance for hearing on June 21, Petitioner contacted Dr. Norris's office on July 3, 2018.

Petitioner then chose to seek out another opinion with Dr. Lawrence Li on August 15, 2018. Petitioner admitted this was again another choice of physician she chose to seek out. Dr. Li obtained a history, reviewed her pre-surgical MRI and obtained a new MRI of her shoulder on August 15, 2018 to compare. It was read to show a suggestive moderate to high grade articular surface partial thickness tear of the distal supraspinatus tendon, along with mild supraspinatus muscle atrophy and postoperative changes. Dr. Lei interpreted after reviewing the two MRIs that Petitioner has additional pathology and needs new surgery for the rotator cuff with revision and distal clavicle excision. Petitioner testified and the records reflect she continue treating with Dr. Li as most recently as March 1, 2019. Dr. Li has continued to prescribe her medications with a recommendation for ongoing shoulder revision surgery. (PX 8) Petitioner admitted she has continued working at her current job the entire time and has not missed any work since beginning her employment at Unity Point Methodist.

Dr. Norris testified on November 27, 2018 he is a board-certified orthopedic surgeon with a subspecialty in sports medicine. His practice consists mostly of arthroscopic repair in joints with minimally invasive procedures of the shoulders, knees and hips. He testified and summarized his care of Petitioner. He reviewed the MRI of Petitioner's shoulder from March 15, 2017 at his first visit. Upon presentation, Dr. Norris noted Petitioner had a positive O'Brien's and Speed's test. He noted she had pain within the labrum along the long head biceps tendon. He further testified that with respect to the surgical procedure he performed, there was one minor finding of some fraying of the under surface of the lead edge of the supraspinatus tendon on the articular side which was only slightly different to his anticipated findings from the MRI. He also

noted a type II superior labrum tear. Due to the minimal amount of fraying, he felt no repair of that was necessary. (PX 11)

Thereafter, he summarized Petitioner participated in physical therapy and then he ultimately discharged her at maximum medical improvement with no restrictions as of the visit on December 27, 2017. He testified when she returned to him on July 10, 2018, she returned complaining of right shoulder pain. He performed a physical examination at that visit and stated the pertinent findings consisted of tenderness over the bicipital groove and medial border of the scapula as well as having a positive Hawkin's test. He then stated her presentation in July 2018 was different than her presentation to him in November and December 2017. He felt her presentation in July 2018 was consistent with impingement syndrome and pain within the bicipital groove and the long head of the biceps tendon. He then further stated his diagnosis of Petitioner leading up to the July 2017 surgery and at the time of surgery was superior labral pathology as well as AC joint pain and that her presentation to him in July 2018 was different with a different set of positive findings and history. (PX 11)

Upon questioning, Dr. Norris admitted he never reviewed any medical notes from Dr. Li. He never reviewed any medical reports from Dr. Rhode. He had no opinion as of the time of his testimony in November 2018 that Petitioner needed any additional treatment for the right shoulder. Dr. Norris limited his testimony to establish the treatment he rendered to her in his opinion was reasonable and appropriate and causally related to the original work injury. Dr. Norris admitted was never provided any subsequent medical to review from either Dr. Rhode or Dr. Li and therefore did not review or compare the MRI of Petitioner's shoulder after presenting to Dr. Li to the MRI in his possession from 2017. Dr. Norris limited his testimony to his treatment only of Petitioner and simply noted that when she returned to him in July 2018, her complaints and presentation as well as his objective findings were different than the original injury. (PX 11)

Dr. Rhode testified on November 14, 2018 he is an orthopedic surgeon with a subspecialty in sports medicine. He testified he is board certified in orthopedic surgery and board-certified in sports medicine. He testified he saw Petitioner the first time on December 14, 2017. He testified she came in for a second opinion evaluation of her right shoulder injury from December 24, 2016. He testified he did not have access to Petitioner's original MRI study from March 15, 2017. He performed a physical examination and found she had some mild loss of motion. She could forward elevate two 165°. She had good strength. He indicated she had positive impingement findings suggestive of residual rotator cuff pathology. (PX 12)

He testified Petitioner told him she was unable to return to full duty work secondary to her residual symptomology and therefore he ordered an FCE. He admitted the therapist performing the FCE was within his own office and his employee. Petitioner returned on January 10, 2018. Dr. Rhode testified he reviewed the FCE and deemed it valid. He placed her at medium duty with an overhead restriction of 10 pounds frequent, 20 pounds maximum. He opined that as of January 10, 2018, Petitioner had plateaued and required restrictions limiting the overhead work. He authored the nature and extent disability report on January 13, 2018. (PX 12)

Dr. Rhode testified that prior to providing his testimony in November 2018, he was provided a copy of the MRI films Dr. Li obtained in August 2018. His opinion was that the MRI demonstrated a high grade partial thickness tear of the supraspinatus tendon. He opined it was consistent with her original injury despite having no prior records to review. He testified that despite reviewing the MRI from Dr. Li it was his opinion that Petitioner would be at MMI. He further admitted that when Petitioner came to him, he provided her treatment rather than performing an independent evaluation. She underwent medical treatment in the form of a functional capacity evaluation which he prescribed and which was performed at his facility. He further admitted he had no record Petitioner was referred to him by any other physician. (PX 12)

Upon cross-examination, Dr. Rhode was asked whether he reviewed the individual findings within the FCE. He was specifically asked whether he reviewed the findings in terms of noting what his own therapist's opinions were in regard to Petitioner's perception of her abilities versus what she could objectively perform from testing. Dr. Rhode could not recall whether he truly reviewed the findings contained within the body of the FCE. He then admitted that within the body of the FCE, the therapist specifically noted Petitioner could perform better than what she perceived she could perform. He admitted the therapist documented there were inconsistencies between what Petitioner could objectively and physically perform versus what Petitioner perceived she could perform. He also admitted the therapist concluded there was no major limitation with Petitioner's return to work. The therapist referred to the actual job based on what she relayed to the therapist which a nursing supervisor. (PX 12)

Dr. Rhode further admitted the basis of his opinions as to why he placed her with permanent restrictions was because of his generalized sense of the duties of a nurse. He admitted he was unaware of what her actual pre-injury job requirements were with her employer. Dr. Rhode then admitted he never reviewed any of Dr. Norris's records as the treating surgeon. He further admitted he did not know what beyond what Petitioner told him the extent of the surgery that was performed as he never reviewed a surgical report. He also admitted he had no knowledge of Petitioner's activities between his treatment of her in December 2017/January 2018 and her presentation to Dr. Li in August 2018. He further admitted he had no idea of when or how or what type of job she may have obtained in between. He limited his opinions to the information he had in front of him in terms of opinions rendered based on Petitioner's statements to him, rather than obtaining the medical records of the treating surgeon to review. (PX 12)

Dr. Lawrence Li testified on October 22, 2018. He testified he is an orthopedic surgeon and his focus of practice is on shoulders, hands and knees. Dr. Li testified upon Petitioner's initial presentation, he examined her and found she had normal range of motion and good strength. She had tenderness over the AC joint and over the bicipital groove. He felt she had a positive O'Brien's test and positive cross arm abduction test. He stated those suggested biceps problems and also AC joint problems. Dr. Li testified he reviewed both the preoperative MRI from 2017 and the MRI he prescribed and she obtained in August 2018. His testimony was that it appeared the rotator cuff tear Dr. Norris saw on the previous MRI and debrided during surgery was significantly larger. He testified it was at that point in 2018 a moderate to high grade tear of the rotator cuff tendon which resulted in some atrophy of her muscles. Dr. Li's opinion was that the current findings on the 2018 MRI were a result of the debridement of the original care. His

recommendation was for Petitioner to undergo repair of the rotator cuff since there was at that point a high-grade tear and also remove more of the distal clavicle. (PX 10)

Regarding additional medical records, Dr. Li testified he had Dr. Norris's records as well as physical therapy records and work conditioning records to review. He was asked whether he had a chance to review the FCE from December 14, 2017 and did not admit he reviewed it but simply stated he received it. Dr. Li testified that in his opinion, Petitioner's current status as she presented to him in August 2018 is causally related to the original work injury simply because, according to him, she had residual symptoms that never resolved. (PX 10)

On cross-examination Dr. Li admitted that he does not recall the timeline or the timeframe of what he memorialized in his initial evaluation and history on August 15, 2018, that she had imaging, physical therapy, surgery, then therapy and work conditioning, released to full duty and returned to work in May 2018. He was unaware of the timeline of Petitioner's care with Dr. Norris and Dr. Rhode and had no information regarding Petitioner's change in employment or the gap in time between treatment with Dr. Norris and Dr. Rhode, when she obtained new employment and her appearance with him for complaints. (PX 10)

Petitioner testified she wants to undergo surgery with Dr. Li and continues to see him for that purpose.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

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). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc. Co. V. Industrial Board,* 284 Ill. 378 (1918).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission,* 44 Ill. 2d 214 (1969).

Credibility is the quality of a witness which renders his evidence worthy of belief. The arbitrator, whose province it is to evaluate witness credibility, evaluates the demeanor of the witness and any external inconsistencies with his testimony. Where a claimant's testimony is inconsistent with his actual behavior and conduct, the Commission has held that an award cannot stand. *McDonald v. Industrial Commission,* 39 Ill. 2d 396 (1968); *Swift v. Industrial Commission,* 52 Ill. 2d 490 (1972). While it is true that an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d 213 (1980). Internal inconsistencies in a claimant's testimony, as well as conflicts between the claimant's testimony and medical records, may be taken to indicate unreliability. *Gilbert v. Martin & Bayley/Hucks,* 08 ILWC 004187 (2010).

Overall, the Arbitrator has doubts about the credibility of Petitioner. Petitioner's demeanor changed dramatically between direct examination and cross examination. Answers to questions on direct were easily and completely answered and Petitioner's recall appeared complete. On cross examination, however, there were so many answers given by Petitioner in which she stated that she did not remember or did not recall events that were clearly in the medical records. Almost all of the instances where Petitioner did not remember of recall an event favored her case.

With respect to (F), whether Petitioner's current condition of ill being is causally related to the injury, the arbitrator finds the following:

There is no question and the parties stipulated Petitioner had a compensable injury on December 24, 2016. Petitioner sought medical care with Dr. Norris at McLean County Orthopedics. Her course of care included surgery in July 2017, physical therapy and eventual work conditioning. Thereafter, she was released by her treating surgeon, Dr. Norris, capable of full duty in December 2017. At the urging of her attorney and at her own decision, she chose to seek a second opinion with Dr. Rhode in December 2017. Dr. Rhode admitted he did not have access to any of Dr. Norris's records, including the pre-surgery MRI and/or the surgical report. He also did not review or have access to any of Petitioner's physical therapy or work conditioning records. He simply took Petitioner's statement to him that she could not return to work in a full duty capacity due to residual complaints and therefore ordered a functional capacity evaluation.

Furthermore, the arbitrator finds Dr. Rhode's opinions not supported by a review of the entirety of the record and limited to his knowledge of petitioner's care which was only through her recitation to him. He also did not rely on or utilize the internal findings within the report of the FCE, performed by a therapist in his office that he employs. He had no specific knowledge of Petitioner's preinjury job requirements. He simply took the results of the FCE as valid, without determining or reviewing his therapist's opinions Petitioner's capabilities objectively were greater than her perceived limitations. He did not utilize his own employee's opinions to document Petitioner had no barrier to returning to her pre-injury job as a nursing supervisor/Health Services Director for Respondent.

He simply chose to place permanent restrictions on her based on her subjective complaints. Furthermore, he was not aware, even at the time of his testimony in November 2018, of the subsequent change in employment, duration between her release at MMI from Dr. Norris and obtaining a new position, and her ultimate presentation to Dr. Li in August 2018. As such, the arbitrator finds Dr. Rhode's opinions limited and not the best evidence to establish whether Petitioner's condition and need for permanent restrictions credible.

Likewise, with respect to Dr. Li's opinions regarding causal connection, he admitted that while he had Dr. Norris's chart in his chart, he made no mention of the discrepancies which Dr. Norris noted upon Petitioner's return presentation to him in July 2018. Specifically, Dr. Li simply rendered a blanket opinion that his belief was Petitioner's current condition of ill being upon her presentation to him in August 2018, eight months after being discharged by the treating surgeon, three months after obtaining a new job, a seven-month gap between Petitioner's discharge from care and return to Dr. Norris with new complaints he noted were "different" than what he treated her for originally, simply rendered the opinion her current condition was causally related to the original injury. The arbitrator simply finds that not to be credible based on his lack of understanding and lack of knowledge of the course of Petitioner's care and original timeline of the injury.

The arbitrator finds the opinions of Dr. Norris, Petitioner's treating surgeon to be most credible. Within that, Dr. Norris released Petitioner capable of full duty work and placed her at maximum medical improvement from the resulting care of the original injury in December 2017. Dr. Rhode also placed Petitioner at maximum medical improvement based upon his examination and treatment of her in December 2017/January 2018. Neither physician recommended nor proposed Petitioner would need any future or additional medical care.

The record and Petitioner's testimony reflect Petitioner sought no medical care between her last presentation to Dr. Rhode on January 10, 2018 and a phone call and one time return visit to Dr. Norris in July 2018. The arbitrator further notes that during that seven month gap, Petitioner obtained new employment and began working at Unity Point Methodist Hospital in a completely different capacity as pre-injury. Also significant during this timeframe, Petitioner admitted she had a court appearance for her worker's compensation case in June 2018 with her attorney, a pre-trial was conducted regarding permanency value which resulted in the matter not resolving. Within two weeks thereafter, Petitioner called Dr. Norris and complained of an increase in pain and requested to be evaluated. Thereafter, upon her presentation to Dr. Norris on July 10, 2018, he specifically noted her complaints as she presented to him on July 10, 2018, seven months after being discharged at maximum medical improvement, were "different" than her complaints during the course of his original treatment.

The arbitrator finds this significant and there was clearly a change in Petitioner's condition at some point after being discharged by the treating surgeon and a second opinion physician. The arbitrator finds the opinions rendered by Dr. Li attempting to causally relate her current condition in August 2018 to the original injury in December 2016 simply not supported by the record. Petitioner's testimony that her symptoms never resolved after being discharged by Dr. Norris in December 2017 is simply not supported by the record as there is a lack of any

additional follow-up by Petitioner to Dr. Norris or even to Dr. Rhode. The arbitrator further finds the timing of Petitioner's sudden decision to contact Dr. Norris complaining of shoulder pain on July 3, 2018, approximately within two weeks after a court appearance for a pretrial hearing and discussion of permanency for her claim also suspicious and evidence of potential secondary gain. Based on the totality of the above, the arbitrator finds Petitioner's current condition not causally related to the original injury.

With respect to (O), whether Petitioner has exceeded her choice of treating physician, the arbitrator finds the following:

All three physicians' testimony was abundantly clear in conjunction with Petitioner's own testimony she specifically chose to seek out Dr. Norris as her treating physician through McLean County Orthopedics. Petitioner admitted she had been a prior patient of that facility and chose to return there for care after the original injury. As such, McLean County Orthopedics with Dr. Armstrong and Dr. Norris constitute Petitioner's first choice of treating physician.

The arbitrator further finds based on Dr. Rhode's testimony in conjunction with Petitioner's testimony that while her attorney's intent may have been for Petitioner to undergo a Petitioner's IME with Dr. Rhode, he performed actual treatment to Petitioner in the form of having a functional capacity evaluation performed by an employee in his own facility. As such, that constitutes medical treatment and therefore as Dr. Rhode admitted in conjunction with Petitioner that no other physician referred Petitioner to Dr. Rhode, Dr. Rhode became Petitioner's second choice treating physician.

Lastly, with respect to Dr. Li, Petitioner admitted at trial she chose to seek out that opinion with Dr. Li and that she was not referred to Dr. Li by either Dr. Norris or Dr. Rhode. Dr. Li even admitted in testimony Petitioner was not referred to him by any other physician. As such, the arbitrator finds Dr. Li is Petitioner's third choice of treating physician and regardless of the causal connection determination rendered above, Respondent is not liable for any of the medical care Petitioner has received with Dr. Li. Dr. Li is the only physician who has recommended Petitioner undergo additional medical care and if Petitioner chooses to obtain that medical care, Respondent is not liable for the charges.

With respect to (L), what temporary benefits are in dispute, the arbitrator finds the following:

As the arbitrator has found the opinions rendered by Dr. Norris to be the most credible, he released Petitioner capable of full duty work in December 2017. The parties stipulated Petitioner was entitled to TTD benefits from April 14, 2017 through December 3, 2017, a period of 33 2/7 weeks. Petitioner alleges an additional entitlement to TTD benefits from December 13, 2017 through January 10, 2018. This is the period of time Dr. Rhode restricted Petitioner while undergoing his evaluation, functional capacity evaluation and return for the findings and placement of alleged permanent restrictions. With respect to lost time, the arbitrator finds restrictions Dr. Rhode placed on Petitioner without support in the medical records. Dr. Rhode's admission and his lack of reliance on his own employee/own therapist's opinions regarding Petitioner's capabilities and her ability to return to her pre-injury level of employment in the

specific position she had with Respondent is simply not credible and does not hold weight with this arbitrator. As such, the arbitrator finds Petitioner was capable of full duty employment as of her discharge from care from Dr. Norris and any claim for additional TTD benefits is denied.

With respect to Petitioner's allegation of entitlement to maintenance benefits from January 11, 2018 through May 2, 2018, the arbitrator finds Petitioner's limited testimony claiming she sought employment and submitted applications at an unknown number of facilities and no written documentation to substantiate any location is not credible evidence to establish entitlement to maintenance benefits. As the arbitrator has found Petitioner capable of full duty work status in reliance on Dr. Norris's opinions, a claim for any maintenance benefits is denied.

Lastly, with respect to Petitioner's allegation for TPD benefits based on her claim she is making less money in her current position due to permanent restrictions, the arbitrator finds that without merit as well. Regardless of the fact the arbitrator already found Petitioner capable of full duty based on Dr. Norris's opinions, the arbitrator could not find Petitioner would be entitled to any TPD benefits as the only documentation Petitioner submitted into evidence constituted two paychecks worth of earnings just after Petitioner was hired during an orientation phase of employment. As Petitioner admitted there were additional compensation opportunities for working night shifts and weekends, and Petitioner failed to supply evidentiary evidence to establish she was making less money, such as providing a tax return or copies of pay stubs, the arbitrator finds that telling in that there is no documentation to support Petitioner is actually earning less money that would entitle her to TPD benefits, assuming arguendo, the arbitrator believed Petitioner had a job change due to permanent restrictions. As such, the arbitrator find Petitioner is not entitled to any TPD benefits.

With respect to (J), whether the medical services provided to Petitioner were reasonable and necessary, the arbitrator finds the following:

As the arbitrator has found the testimony and opinions of the treating surgeon to be most credible, and in light of Dr. Norris's discharge at maximum medical improvement on December 27, 2017, the arbitrator finds that medical care rendered to Petitioner after December 27, 2017 is not causally related nor is Respondent liable for any of the charges Petitioner incurred thereafter. The arbitrator already found Dr. Li and his care is beyond Petitioner's choice of treating physician and as such, all of Dr. Li's charges are not Respondent's liability.

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

PATRICK MULDOWNEY,

Petitioner,

vs. NO: 17 WC 19602

ACTIVE VISIONS, INC.,

Respondent.

20IWCC0681

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 9, 2019 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the claimed charges from Orthopedic and Rehabilitation Centers, subject to the fee schedule, except for the charges relating to the office visits of March 4, 2019 ($180.00) and May 6, 2019 ($180.00). Of the medication-related Rx Development Associates charges of $6,355.87, Respondent shall only pay for charges relating to Meloxicam and Tramadol.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $1,634.00 for medical benefits that have been paid, and Respondent shall hold Petitioner

harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $300.00 per week for a period of 27 6/7 weeks, representing January 25, 2018 through August 7, 2018, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b), this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any. Respondent shall have a credit of $7,390.50 for TTD benefits already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall provide and pay for the right reverse total shoulder replacement surgery recommended by Dr. Gabriel Levi as provided in §8(a) of the Act.

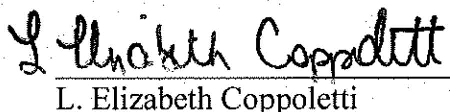
IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 20 2020


L. Elizabeth Coppoletti

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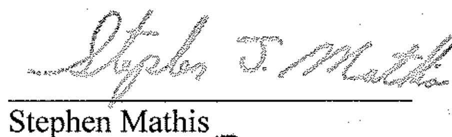
Stephen Mathis

O: 10/20/2020

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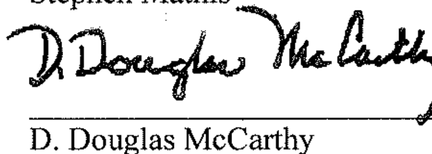

D. Douglas McCarthy

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

MULDOWNEY, PATRICK Case# **17WC019602**
Employee/Petitioner

ACTIVE VISIONS INC
Employer/Respondent

20IWCC0681

On 7/9/2019, 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 2.07% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
CHARLES M MARING II
10 S LASALLE ST SUITE 900
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Patrick Muldowney
Employee/Petitioner

v.

Active Visions, Inc.
Employer/Respondent

Case # **17** WC **19602**

Consolidated cases: **D/N/A**

20IWCC0681

An *Application for Adjustment 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 13, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **5/11/2017**, 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 $**23,400.00**; the average weekly wage was $**450.00**.

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 $**7,390.50** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**7,390.50**.

Respondent is entitled to a credit of $**1,634.00** under Section 8(j) of the Act.

ORDER

Medical benefits

Petitioner claims the bills in PX 1. The Arbitrator declines to award the claimed balance of $30.42 for Emergency Room care rendered at Swedish Covenant Hospital on May 18, 2019. Petitioner did not testify to undergoing care on that date. The Swedish Covenant Hospital records offered by Petitioner (PX 2) do not contain any records dated May 18, 2019. The Arbitrator awards Petitioner the claimed charges from Orthopedic & Rehabilitation Centers, subject to the fee schedule, except for the charges relating to the office visits of March 4, 2019 ($180.00) and May 6, 2019 ($180.00). No records concerning these office visits are in evidence. PX 3. Of the medication-related Rx Development Associates charges of $6,355.87 claimed by Petitioner, the Arbitrator awards only those charges relating to Meloxicam and Tramadol. The Arbitrator declines to award the claimed charge of $69.34 from Infinite Strategic Innovation. This charge appears to relate to an office or therapy visit of June 27, 2017. The previously awarded charges from Orthopedic & Rehabilitation Centers include charges for this service date.

Respondent shall be given a credit of $1,634.00 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Arb Exh 1.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $300.00/week for 27 6/7 weeks, commencing 1/25/2018 through 8/7/2018, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 1/25/2018 through 8/7/2018, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $7,390.50 for temporary total disability benefits that have been paid. Arb Exh 1.

20IWCC0681

Prospective Medical Care

Respondent shall authorize and pay for the right reverse total shoulder replacement recommended by Dr. Gabriel Levi.

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

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

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

Signature of Arbitrator

7/9/19
Date

ICArbDec19(b)

JUL 9 - 2019

Patrick A. Muldowney v. Active Visions, Inc.
17 WC 19602

20 I W C C 0 6 8 1

Summary of Disputed Issues

Petitioner, a caregiver for disabled adults, claims he injured his right shoulder on May 11, 2017, near the end of his evening shift. He sought Emergency Room treatment the following morning, began seeing Dr. Levi in early June and underwent a right shoulder arthroscopy on January 25, 2018, following some intervening treatment for general health conditions. By February 2018, Dr. Levi was recommending a shoulder replacement to restore Petitioner's right arm function. Dr. Atluri conducted a Section 12 examination on March 8, 2018, on behalf of Respondent. In his report of March 27, 2018, Dr. Atluri found causal connection, via an aggravation theory, noting that Petitioner denied any pre-accident right shoulder treatment. He recommended therapy and indicated Petitioner might require a shoulder replacement if he remained symptomatic. After reviewing additional records, including hospital records dating back to 2007, Dr. Atluri changed his mind and concluded that the work accident only temporarily aggravated an underlying arthritic condition, with that condition returning to baseline by August 2017.

Petitioner resumed light duty for Respondent in August 2018 and continued seeing Dr. Levi thereafter. He was still performing light duty as of the hearing.

The disputed issues include accident, causal connection, medical expenses, temporary total disability from January 25, 2018 through August 7, 2018 and prospective care with Petitioner seeking a reverse right shoulder replacement. Arb Exh 1.

Arbitrator's Findings of Fact

Because Petitioner's pre-accident medical history is at issue, the parties offered into evidence extensive records dating back to approximately 2006. The Arbitrator has reviewed these records. The Arbitrator notes that a number of records in the last section of PX 4 relate to individuals other than Petitioner. The Arbitrator gives no consideration to these records.

Records from Stroger Hospital dated March 20, 2007 (more than ten years before the claimed work accident) relate to a follow-up visit for hypertension and diabetes, with Petitioner having discontinued a certain diabetes medication six weeks earlier. The examining physician also noted a two-week history of occasional right arm/shoulder pain occurring with movement. The physician described this pain as "achy though sometimes sharp" and "worst with lifting." The physician indicated that Petitioner denied any trauma and reported relief from Tylenol/Advil. He diagnosed "arm pain musculoskeletal" and recommended that Petitioner take Ibuprofen PRN. Levi Dep Exh 3. PX 4.

A handwritten Stroger Hospital progress note that appears to date back to 2007 relates primarily to diabetes-related eye problems but also mentions a complaint of occasional right shoulder pain, with Petitioner reporting benefit from Ibuprofen or Aleve. The examining provider, whose name is not legible, described the right shoulder examination as "unremarkable." He or she diagnosed "bursitis?" and recommended Motrin as needed. PX 4. Records from Stroger Hospital dated May 13, 2008 reflect Petitioner complained of cold and cough symptoms. The records list five diagnoses, with the fifth being "R should pain, chronic; Ibuprofen PRN helps." Records from the same facility dated September 9, 2008 reflect Petitioner was seen in follow-up for cold symptoms and a cough of three

weeks' duration. The records list seven diagnoses, the sixth of which is "R shoulder pain, chronic; no pain currently; Ibuprofen PRN." PX 4.

Records in RX 2 reflect that, on December 16, 2012, Petitioner underwent Emergency Room care at Swedish Covenant Hospital for a cough, congestion and "sweats." Petitioner gave a history of asthma, pneumonia, diabetes, hypertension and trigger finger. He denied arm pain. BCM0446. Records in RX 3 reflect that Petitioner underwent chest X-rays on February 5, 2013 due to "pain and numbness right arm." RX 3, 2-3. Records in RX 2 reflect that, in 2015 and 2016, Petitioner underwent treatment for indigestion/chest pain, left-sided chest pain and a left hand burn. He underwent a right knee meniscal repair by Dr. Levi in December 2016. None of the 2016 records reflect complaints relative to the right arm or shoulder. Records in the same exhibit reflect that Petitioner underwent a CT/CTA scan of his right upper extremity on May 2, 2017, nine days before his claimed work accident. The scan report reflects the testing was performed due to "right upper extremity claudication symptoms" and "asymmetric blood pressure measurements." The scan showed focal calcified stenosis of the proximal right subclavian artery. It also showed "moderate arthritic changes of the right shoulder." BCM0195-6. RX 4, 10-11.

Petitioner testified he is 55 years old. T. 11. He has worked as a caregiver for Respondent for seven years. He takes care of disabled adults. His tasks include cooking, cleaning and dispensing medication. T. 11-12. He is currently based at one specific house but goes to other locations as needed. T. 12. He was injured on May 11, 2017, near the end of his shift. He was working at Respondent's main location, a house Respondent owns. T. 13. He was headed upstairs to check on clients when he heard a loud bang. A client named Greg Beruka had fallen in a bathtub. Petitioner went to Greg's aid. He told Greg he was going to lift him and warned him not to twist his body or wiggle. He started lifting Greg but midway, despite his warning, Greg suddenly twisted to the right while putting all his weight on Petitioner's right arm. Petitioner kept supporting Greg's weight so that Greg would not sit back and injure his leg. Petitioner testified he felt a pop and slight pain in his right arm, up in the shoulder area. T. 14-15. He finished his shift and reported the accident to Respondent. T. 15.

Petitioner testified he sought treatment at the Emergency Room at Swedish Covenant Hospital the following day. He provided a history of the accident. T. 15. The Emergency Room triage screening (PX 2) reflects Petitioner arrived at 5:22 AM and complained of 10/10 right arm pain "since 0100 this morning." Petitioner reported lifting a patient at work earlier in the day and starting to experience pain after he got home. The examining triage nurse noted a full range of motion of the right arm. A physician's assistant, Megan Lee, PA-C, noted that Petitioner complained of right shoulder pain of four hours' duration:

> "Yesterday at work one of his patients fell in the bathtub during which he caught his patient. No pain initially after the accident but roughly 3 hours after the incident he began to notice pain in the right shoulder."

Lee also noted that Petitioner denied any previous injuries. On right shoulder examination, she noted limited abduction due to pain, crepitus with abduction, positive "empty can" testing and pain with Hawkins testing. She ordered right shoulder X-rays which showed no fracture and severe degenerative changes. RX 4, pp. 8-9. She diagnosed a rotator cuff strain and administered a Toradol injection. At the time of discharge, she provided Petitioner with a sling. She recommended he rest, take Naproxen as

needed, keep his arm elevated and follow up with employee health and Dr. Levi, an orthopedist, before returning to work. PX 2.

Petitioner first saw Dr. Levi on June 2, 2017. T. 16. Petitioner testified he was familiar with Dr. Levi because the doctor had operated on his knee a year earlier. T. 16. RX 2. He denied having previously seen the doctor for his shoulder. T. 16.

Dr. Levi's note of June 2, 2017 sets forth a consistent history of the work accident and subsequent care. He indicated that, while Petitioner was trying to help a client who had fallen in a bathtub on May 11, 2017, the client "turned his entire body, making [Petitioner] put all his strength on his right shoulder to avoid his client falling again." He noted that Petitioner denied having any right shoulder pain before this incident. He indicated that Petitioner rated his current pain at 2/10 but indicated this pain could intensify to 7-8/10 when he lifted his arm or at night. He also indicated that Petitioner was taking Naproxen and denied being unable to lift his arm to the side at all.

On right shoulder examination, Dr. Levi noted active abduction to 30 degrees and then compensation with the scapula to 60 degrees, pain and crepitus with passive abduction, an inability to externally rotate due to pain, passive internal rotation to 40 degrees, limited by pain, and 3/5 supraspinatus strength. He also noted a positive impingement maneuver with adduction and internal rotation. He described Petitioner as having a "very obvious horn blower sign indicating rotator cuff insufficiency." He obtained right shoulder X-rays. He interpreted the films as showing arthritis of the right glenohumeral joint with a large inferior osteophyte "that looks like it might now be fractured from the humerus." He opined that the injury caused an exacerbation of Petitioner's previous arthritis. He administered an injection and placed Petitioner in a sling. He prescribed an MRI, physical therapy and medication, including Norco. He directed Petitioner to remain off work and return in four weeks. PX 3. T. 16-17. Petitioner testified the doctor subsequently allowed him to resume light duty. T. 17.

The right shoulder MRI, performed on June 6, 2017, showed rotator cuff tendinopathy, with the radiologist suspecting "at least a partial-thickness tear of the articulating undersurface of the distal supraspinatus tendon," glenohumeral osteoarthritic changes, a small glenohumeral effusion and acromioclavicular inferior hypertrophic spurring with some impingement. PX 3.

Petitioner underwent an initial physical therapy evaluation at Orthopaedic and Rehabilitation Centers on June 7, 2017. T. 17. The evaluating therapist recorded a consistent history of the work accident. She noted a past history of a stent procedure in 2013 and knee surgery. She also noted pain ratings of 5-7/10 and difficulty sleeping. PX 3.

Petitioner continued attending therapy thereafter, while performing light duty. T. 18.

Records in PX 2 reflect that Petitioner underwent an EKG and an echocardiogram at Swedish Covenant Hospital on June 16, 2017.

Petitioner returned to Dr. Levi on June 27, 2017. T. 18. The doctor noted that Petitioner was still experiencing right shoulder pain and limited motion. He also noted that Petitioner reported benefit from therapy, sling usage and Norco. The doctor's examination findings were essentially unchanged. He interpreted the MRI as showing an "obvious rotator cuff tear." He recommended a right shoulder arthroscopy and directed Petitioner to continue attending therapy while awaiting approval for this surgery. He released Petitioner to light duty with no lifting. PX 3.

On July 25, 2017, Dr. Levi noted that Petitioner remained symptomatic and was still taking Norco for pain. He also noted that Petitioner rated his current pain as 0/10 but indicated it could rise to 5/10 while trying to sleep. He indicated that Petitioner reported waking up every two hours due to pain. The doctor's examination findings were unchanged. He noted that, despite having sent appeal letters and leaving messages for adjusters, the recommended arthroscopy had not been approved. He directed Petitioner to stay off work and continue therapy while awaiting approval. He prescribed medication, including Mobic and Norco. PX 3.

Petitioner testified he underwent treatment for non-work-related health conditions in August and September 2017. T. 19. He underwent a hernia repair and, on September 10, 2017, was admitted to a hospital due to chest pain. He ended up having four stents inserted. T. 19-20.

Records in PX 2 reflect that Petitioner went to the Emergency Room at Swedish Covenant Hospital on August 8, 2017 due to a persistent cough. He underwent a chest X-ray, which showed no acute cardiopulmonary findings. The examining physician noted wheezing bilaterally with some mild rhonchi. After noting the negative chest X-ray, the physician prescribed Albuterol, Prednisone and a Z pack.

A therapy note dated August 11, 2017 reflects that Petitioner reported having undergone care at a hospital for acute bronchitis. Petitioner left the therapy session early "due to coughing and shortness of breath." Subsequent therapy notes through August 23, 2017 reflect that Petitioner complained of shoulder stiffness and difficulty lifting his arm. PX 3.

Petitioner saw Dr. Levi again on August 25, 2017. In his note of that date, the doctor described the surgery as "being needlessly denied." He directed Petitioner to continue therapy. He released him to work with no use of the right arm. PX 3.

A therapy note dated August 29, 2017 reflects a complaint of constant 5/10 right shoulder pain. A note dated September 1, 2017 reflects that Petitioner was still performing light duty and was waking every two hours due to right shoulder pain. A note dated September 5, 2017 reflects that Petitioner was unable to perform certain maneuvers "due to possible abdominal hernia." PX 3.

Records in PX 2 reflect Petitioner went to the Emergency Room at Swedish Covenant Hospital on September 7, 2017 due to "bleeding around his hernia since Saturday" and associated abdominal pain. The examining physician noted a reducible umbilical hernia with an open wound. Petitioner underwent a CT scan of the abdomen to make sure the hernia was not incarcerated. He was discharged home on topical and oral antibiotics and with directions to see his surgeon, Dr. Kim, in follow-up. PX 2.

A therapy note dated September 6, 2017 reflects a complaint of 4-5/10 pain over the preceding weekend and a current complaint of 1/10 pain. On September 12, 2017, the therapist noted that Petitioner reported wearing his sling all the time, including while performing light duty. The therapist also noted that Petitioner reported experiencing symptoms while trying to write while wearing the sling. PX 3.

On September 26, 2017, Dr. Levi again described the recommended surgery as "being needlessly denied." PX 3. The following day, Petitioner's therapist noted that Petitioner was scheduled to undergo a hernia repair on October 9, 2017. PX 3.

Petitioner underwent a physical therapy re-evaluation on October 31, 2017. The therapist noted ongoing right shoulder complaints, pain ratings ranging from 3-5/10 and difficulty sleeping. The therapist also noted that Petitioner had been away from therapy for almost a month due to hernia surgery, with his primary care physician allowing him to resume subject to a weight restriction of 15 pounds. PX 3.

On November 28, 2017, Dr. Levi noted that Petitioner rated his current pain at 4/10 and indicated this could increase to 9/10, with associated "locking up" of the shoulder and difficulty sleeping. He also noted that the adjuster had approved the surgery, that he was awaiting written authorization and that the surgery was tentatively scheduled for December 14, 2017. He took Petitioner off work. PX 3.

Petitioner testified the shoulder surgery was delayed because his hernia-related wound was still open. T. 21. On December 12, 2017, Dr. Levi noted that, although the shoulder surgery was scheduled for that Thursday, Petitioner could not undergo it "because he still has drainage from his umbilical hernia repair." He also noted that the wound was still draining a bit and that it would thus not be safe to proceed with the arthroscopy. He recommended that Petitioner stay off work and return in three weeks. PX 3.

Dr. Levi operated on January 25, 2018, performed a right shoulder arthroscopy with extensive debridement and synovectomy, a subacromial decompression with bursectomy and acromioplasty, a distal clavicle excision and a plasma injection. Petitioner testified that Respondent or its carrier approved this surgery. T. 22. In his operative report, Dr. Levi indicated that "[Petitioner] understands that he may need a joint replacement in the future but the attempt was going to be made to do a debridement and rotator cuff repair and see if we can prevent or postpone a joint replacement." He also noted he obtained workers' compensation approval for the arthroscopy. Dr. Levi documented "severe arthritis with almost no cartilage remaining on the humeral head and significant arthrofibrosis, multiple loose bodies."

Petitioner testified that Dr. Levi took him off work following the surgery. At this point, he began receiving workers' compensation checks. T. 23.

Petitioner underwent a physical therapy evaluation on January 26, 2018, the day after the arthroscopy. The therapist noted that Petitioner had been informed he might need a shoulder replacement in the future. The therapist also noted that Petitioner was off work and receiving help from his sister with dressing and routine chores. PX 4.

On February 6, 2018, Dr. Levi noted that Petitioner rated his current pain at 4/10 and his maximum pain at 8/10. He indicated that Petitioner remained symptomatic despite the surgery and "will need a reverse total shoulder surgery." He noted that Petitioner was scheduled to attend an independent medical examination on March 8, 2018. He directed Petitioner to remain off work, continue therapy and return in six weeks. He refilled the Norco prescription. PX 3.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Atluri on March 8, 2018. T. 23. In his report of March 27, 2018, Dr. Atluri noted that Petitioner described trying to lift a client out of a bathtub in May 2017 when the client "twisted in a manner which suddenly loaded [Petitioner's] right arm." Dr. Atluri also noted that Petitioner denied feeling anything at the time of the

incident but began feeling right shoulder and arm pain later the same day. He indicated that Petitioner complained of current right shoulder soreness but described having significant pain at night, with that pain interfering with his sleep. He noted that Petitioner denied any pre-accident shoulder problems. He described Petitioner's medical history as significant for various ailments including hypertension, arthritis, asthma, a heart attack and diabetes.

On right shoulder examination, Dr. Atluri noted tenderness over the acromioclavicular joint and subacromial space, well-healed arthroscopy scars, crepitus and snapping with gentle motion and pain reported with any range of motion. Dr. Atluri indicated he could not perform provocative testing due to guarding and reported pain with any attempts at strength testing.

Dr. Atluri described Petitioner as cooperative throughout the examination. He noted no inconsistencies.

Dr. Atluri interpreted X-rays from 2017 as showing severe arthritic changes. He interpreted the CT angiogram performed on May 2, 2017 as showing narrowing of the right side of the subclavian artery and arthritic changes. He described the June 6, 2017 MRI as a "poor quality study" revealing arthritic changes, superior migration of the proximal humerus, a large full-thickness rotator cuff tear, cystic changes in the greater tuberosity and some edema of the acromioclavicular joint.

Dr. Atluri indicated he reviewed the Emergency Room records, Dr. Levi's records and operative report, records from Presence St. Francis Hospital and physical therapy notes.

Dr. Atluri concluded that Petitioner "has severe chronic arthritis in his right shoulder." He indicated the "severity of [the] arthritic changes and degree of deformity in the right shoulder required years to develop." He saw no evidence of right shoulder complaints or treatment in the pre-accident records. He opined that, "based upon the available information, [Petitioner's] right shoulder condition would be considered work-related." He went on to state: "specifically, the work injury may have aggravated this patient's pre-existing chronic right shoulder arthritis." He indicated his opinion could change if he saw additional records reflecting pre-accident symptoms.

Dr. Atluri opined that, with the exception of the arthroscopy, the treatment to date was reasonable and necessary. He described the arthroscopy as "not medically necessary," indicating it would not predictably improve Petitioner's symptoms, given the severity of the arthritic changes in the right shoulder.

Dr. Atluri indicated that further treatment was reasonable. He found one to two months of additional therapy to be appropriate, with evaluation by a reconstructive shoulder specialist to follow if Petitioner's symptoms persisted. He causally linked the need for this care to the work accident. He stated that Petitioner's condition was likely to progress even if his symptoms plateaued, given the natural course of shoulder arthritis. He anticipated that Petitioner would reach maximum medical improvement within six to eight months of the reconstructive surgery. He found Petitioner currently capable of performing light duty, with no overhead use of the right arm and no lifting over 5 pounds with the right arm. He causally linked the need for these restrictions to the work accident. He indicated he could not perform an impairment rating since Petitioner was not yet at maximum medical improvement. Atluri Dep Exh 2, RX 1, pp. 65-74.

Petitioner returned to Dr. Levi on March 13, 2018. The doctor described Petitioner as "still having severe pain," especially when trying to sleep. He indicated that Petitioner previously took Norco but was "now taking Naprosyn and Tylenol." On right shoulder re-examination, he noted "pseudoparalysis," indicating Petitioner was not able to forward flex or abduct. He described the passive range of motion as also very limited. He again recommended a shoulder replacement. He recommended the continued use of topical medication.

On April 27, 2018, Dr. Levi issued an addendum, indicating he reviewed urine test results and noted no inconsistencies. PX 3.

On July 10, 2018, Dr. Levi described Petitioner as "not doing well." He indicated Petitioner was taking Norco and Naproxen and using topical gels for pain control. He noted that Petitioner's symptoms were worse at night. On re-examination, he noted active forward flexion to 85 degrees, active abduction to 60 degrees, pain with supraspinatus testing and a very painful and limited range of motion. He reviewed Dr. Atluri's report, noting the doctor's statement that it would be appropriate for Petitioner to see a shoulder reconstruction specialist if his symptoms persisted. He indicated Petitioner would benefit from a reverse total shoulder arthroplasty "given he has no rotator cuff function." He continued to keep Petitioner off work. He recommended continued therapy. He indicated he held a twenty-minute conference with the nurse case manager. PX 3.

On July 24, 2018, Dr. Atluri issued an addendum, after reviewing therapy notes and records from Dr. Levi and Stroger Hospital. Dr. Atluri noted that, while Petitioner told him he did not have pre-accident right shoulder problems, the 2007 records from Stroger showed that he did. Those records also showed a diagnosis of chronic shoulder pain. Dr. Atluri described the 2007 records as directly contradicting the history Petitioner gave him. Additionally, people who have degenerative arthritis typically exhibit a pattern of waxing and waning symptoms. The post-accident therapy notes show this pattern. By July or August 2017, Petitioner's symptoms were generally mild in severity. This fits with a diagnosis of chronic shoulder pain.

Dr. Atluri stated that the new records prompted him to change his causation opinion. He now believes that the work accident "may have caused a temporary exacerbation" but that Petitioner reached baseline by August 2017. Any treatment rendered after September 2017, including the arthroscopy, is not related to the work accident. Levi Dep Exh 4. Atluri Dep Exh 3.

On August 7, 2018, Dr. Levi described Petitioner as much better, pain-wise, but still unable to lift his arm. He indicated Petitioner wanted to go back to work on a light duty basis.

Dr. Levi indicated he reviewed Dr. Atluri's addendum. He described this document as "remarkable for a change in his opinion." He found it illogical that Dr. Atluri would find an aggravation yet no causation. He again recommended shoulder replacement surgery. He released Petitioner to work with no lifting. PX 3.

Petitioner testified he began performing light duty for Respondent after Dr. Levi released him. T. 26. He is receiving his regular salary. He still interacts with clients but performs no lifting, pushing or overhead work. He is no longer assigned to work with clients who are in wheelchairs. T. 34-35. He is continuing to see Dr. Levi on a regular basis. If the Arbitrator were to award the replacement surgery that Dr. Levi is recommending, he would undergo this surgery. T. 27.

In an addendum issued on September 18, 2018, Dr. Levi noted that urine testing was inconsistent and that he planned to discuss this with Petitioner at the next visit. PX 3.

On October 9, 2018 and November 6, 2018, Dr. Levi noted that Petitioner rated his pain at 0/10 but was unable to lift his arm or move it very well. He indicated that Petitioner's right arm weakness was affecting his daily activities. He noted that Petitioner was performing light duty. He described Petitioner as stating "he cannot lift people because he just does not have any strength to the right shoulder." On re-examination, he noted active forward flexion to 100/90 degrees, active abduction to 45 degrees, limited active external rotation, 3/5 supraspinatus strength and pseudoparalysis. On October 9, he prescribed six weeks of therapy but indicated Petitioner still needed surgery. He imposed restrictions of no lifting and no pushing. On November 6, 2018, he indicated he was waiting for surgery to be approved "as this is the only way to improve [Petitioner's] function." PX 4.

On December 11, 2018, Petitioner saw Dr. Levi again. The doctor noted a pain rating of 0/10. He indicated that Petitioner "has some limitation with motion" but has no pain. He noted that Petitioner had stopped attending therapy four months earlier. On re-examination, he noted active forward flexion of 115 degrees, active abduction of 45 degrees, limited active external rotation, 3/5 supraspinatus strength and pseudoparalysis. He noted that, while the surgery had provided good pain control, Petitioner "has no strength to the shoulder abduction and FF." He again recommended a reverse total shoulder replacement "as the only possible way to improve his function." He imposed restrictions of no lifting, pushing or pulling and no overhead activities. PX 4.

On January 21, 2019, Petitioner returned to Dr. Levi. Petitioner rated his current pain at 0/10 The doctor prescribed six weeks of therapy three times per week. PX 3.

Dr. Levi testified via an evidence deposition taken on February 11, 2019. Dr. Levi testified he is a board certified orthopedic surgeon. He is currently licensed in Illinois and Wisconsin. He specializes in knee, hip and shoulder problems. PX 5, p. 5. Levi Dep Exh 1. He sees approximately 500 patients per month. He performs 400 to 500 surgeries per year. PX 5, p. 7.

Dr. Levi testified he does not independently recall Petitioner. He reviewed Petitioner's chart prior to the deposition. He first saw Petitioner on June 2, 2017. Petitioner reported injuring his right shoulder while trying to help a client who had fallen in a bathtub. The client turned as Petitioner was lifting him. Petitioner described having to put all his strength into his right shoulder to avoid having the client fall again. PX 5, pp. 8-9. Petitioner denied having any prior right shoulder problems. PX 5, p. 9. The doctor testified he has no reason to doubt the accuracy of Petitioner's history. PX 5, p. 9. After examining Petitioner, he diagnosed a rotator cuff tear and exacerbation of previous arthritis. PX 5, p. 13. Petitioner was able to actively abduct only to 30 degrees, "which is very little." He was able to move Petitioner's arm much further than that, which meant that Petitioner had weakness to the rotator cuff. Petitioner also exhibited a "horn blower sign." This term is used when a person compensates for a torn rotator cuff by moving the shoulder up to the ear when trying to lift his arm. PX 5, pp. 10-11. Petitioner had a "very obvious rotator cuff deficient shoulder." PX 5, p. 11.

Dr. Levi testified that, at the initial visit, he obtained X-rays, administered an injection, placed Petitioner in a sling and prescribed therapy. PX 5, p. 12.

Dr. Levi testified that, to his knowledge, Petitioner was performing full duty before the May 11, 2017 accident. Petitioner denied having right shoulder pain before the accident. PX 5, p. 12. There was no indication that Petitioner was malingering. PX 5, p. 13.

Dr. Levi testified it is common for someone to have arthritis in a joint yet be asymptomatic. It is possible for someone with arthritis to be working full duty, particularly if the arthritis is in the shoulder. PX 5, p. 13. The history Petitioner provided was consistent with the injury he presented. PX 5, p. 13. At the first visit, he felt the prognosis was not good since Petitioner had obvious rotator cuff insufficiency and weakness. PX 5, p. 14.

Dr. Levi testified he next saw Petitioner on June 27, 2017. He reviewed the MRI images as well as the report. Petitioner had what appeared to be "at least a high grade partial thickness tear of the rotator cuff." He recommended an arthroscopy. He prescribed Meloxicam, an anti-inflammatory, along with Prilosec, a stomach protector, Norco for pain and topical Terocin. PX 5, pp. 15-16.

Dr. Levi testified he operated on Petitioner on January 25, 2018, performing a right shoulder arthroscopy with extensive debridement and synovectomy, a subacromial decompression and a distal clavicle excision. His operative findings corroborated his initial diagnosis. The only difference was that Petitioner had developed a lot of arthrofibrosis. He found a lot of inflammation of the rotator cuff but not necessarily a large reparable tear. PX 5, p. 17. Petitioner's pain improved after the surgery. His motion also improved but remained very limited. PX 5, p. 17. He would consider the surgery a success. At the first post-operative visit, on February 6, 2018, Petitioner was doing better but "not as well as [he] would like him to ultimately be." PX 5, p. 18. In his opinion, the work accident brought about the need for the arthroscopy. PX 5, p. 18. He prescribed therapy and placed Petitioner off work. PX 5, p. 18.

Dr. Levi testified that, at the next visit, on March 13, 2018, Petitioner was experiencing a lot of pain which he attributed to lifting people out of wheelchairs and placing them on toilets. PX 5, p. 19. Petitioner said he was having trouble sleeping again and his shoulder was "locking up." PX 5, p. 19. At this point, it did not seem as if the arthroscopy provided much benefit. PX 5, p. 19. He recommended a shoulder replacement to alleviate the pain and improve Petitioner's function. PX 5, p. 19. He continued to keep Petitioner off work. PX 5, p. 20.

Dr. Levi testified that a shoulder replacement is an open procedure. The surgeon is thus able to remove a lot of scar tissue and excess bone formation. He then replaces the worn surfaces with metal and plastic. Metal and plastic do not experience pain but exposed bone does. PX 5, p. 20. Following a replacement, Petitioner should regain more motion. The work accident brought about the need for the replacement. There is no question that Petitioner has arthritis that developed over time but people with arthritis can be fully functional. It was after the injury that Petitioner became unable to lift his arm. PX 5, p. 21. The arthroscopy was the "logical first step" but it proved to be insufficient. PX 5, p. 21.

Dr. Levi testified he saw Petitioner again on July 10, 2018, at which point he received and reviewed Dr. Atluri's report. He agreed with Dr. Atluri's recommendation that Petitioner see an adult reconstructive shoulder specialist. He is such a specialist. PX 5, p. 24. As of this date, he recommended a reverse total arthroplasty. PX 5, p. 24.

Dr. Levi testified he continued seeing Petitioner after July 10, 2018. At Petitioner's request, he allowed Petitioner to resume light duty, with no lifting, as of September 4, 2018. PX 5, p. 26. As of December 11, 2018, Petitioner was doing a lot better pain-wise but he had "no strength to forward

flexion or abduction." PX 5, p. 25. He continued to recommend a reverse total shoulder replacement. PX 5, p. 25.

Dr. Levi opined that, barring the recommended surgery, Petitioner will not regain strength in his shoulder. PX 5, pp. 26-27.

At this point in the deposition, Dr. Levi reviewed records from Cook County/Stroger dated March 20, 2007. Those records show Petitioner was admitted due to diabetes and otherwise complained of two weeks of occasional right arm or shoulder pain, alleviated by Tylenol and Advil. There was no history of trauma. Dr. Levi testified there is no indication in these records that Petitioner had severe pain or limitations, rendering him unable to work. PX 5, p. 28. These records do not prompt him to change his causation opinion because they mention only occasional pain and no weakness. The doctors who saw Petitioner at that time did not recommend imaging or treatment other than some Ibuprofen. PX 5, pp. 28-29.

Dr. Levi testified he reviewed an additional report from Dr. Atluri. The report was "remarkable for a change in [Dr. Atluri's] opinion." Dr. Atluri acknowledged that an aggravation occurred but went on to state there was no work injury. Dr. Levi testified this was "not logical." Dr. Atluri relied on the 2007 records in concluding that Petitioner had a chronic shoulder problem before the work accident but those records were generated ten years before the accident. Dr. Levi testified that, to his knowledge, the 2007 records were the only pre-accident records that mentioned any kind of shoulder care. PX 5, pp. 30-31. The records do not even set forth a shoulder diagnosis. PX 5, p. 32.

Dr. Levi testified he still recommends a total shoulder replacement for Petitioner. The need for this surgery stems from the work accident. PX 5, p. 32. Petitioner is currently capable of working but he would have difficulty lifting any weight or reaching above shoulder level. PX 5, p. 33. Petitioner's pain would likely increase as soon as he uses his shoulder more and the replacement would help with that. PX 5, p. 33. Petitioner will need therapy and medication after the replacement. He will need to be off work for six months to a year. The care he has rendered and the surgery he is recommending are reasonable and necessary. PX 5, p. 34.

Under cross-examination, Dr. Levi testified he reviewed Petitioner's chart before the deposition. He charges $1250 per hour for deposition time. The party requesting the deposition pays his fee. PX 5, p. 35. Petitioner was over 50 as of the initial visit. Petitioner's age was not a risk factor in the development of his arthritis, independent of any accident. PX 5, p. 36. Petitioner is obese. Obesity is not necessarily a risk factor for developing arthritis, independent of any accident. PX 5, p. 36. Petitioner's denial of pre-accident shoulder problems was material to his causation opinion. PX 5, p. 36. If Petitioner described the size of his patient to him at the initial visit, he did not record this information. PX 5, p. 37. Petitioner did attempt to describe his positioning during the accident. PX 5, p. 37. Petitioner had right shoulder arthritis at the time of the accident. At one point, he described the arthritic changes as severe. These changes developed over a period of time. PX 5, pp. 37-38. At the initial visit, Petitioner rated his pain at 2/10 when he was stationary. PX 5, p. 38. On July 25, 2017, Petitioner rated his pain at 0/10 when he was stationary. PX 5, p. 38. During the surgery, he observed the condition of Petitioner's shoulder joint. The arthritic changes were significant. PX 5, p. 38. As of August 2018, Petitioner rated his maximum pain at 0/10. Petitioner was just using topical medication at that time. PX 5, p. 39. He diagnosed "pseudoparalysis" of the shoulder at that time. This term is used to describe the appearance of a patient who has severe shoulder weakness, usually due to a rotator cuff tear. Petitioner has rotator cuff dysfunction and severe arthritis. PX 5, p. 40. Petitioner would not need

a replacement independent of the accident. He would not recommend replacement to someone just because he has arthritis. It is when a patient is symptomatic and weak that he can be improved via a replacement. PX 5, p. 41. Petitioner's rotator cuff may not be torn and displaced but it is not functioning. PX 5, pp. 41-42. An anatomic, as opposed to reverse, replacement would improve Petitioner's pain but he is recommending a reverse because that brings the shoulder up to a certain length to improve the rotator cuff and deltoid function. PX 5, p. 42.

On redirect, Dr. Levi testified he has seen patients whose arthritis is as severe as Petitioner's yet they are functional. The arthroscopy likely relieved Petitioner's pain because it was "delayed unnecessarily." During that delay, Petitioner developed more scar tissue. During the arthroscopy, he was able to remove some of that scar tissue. PX 5, pp. 43-44.

Dr. Atluri testified via an evidence deposition taken on May 10, 2019. RX 1. Dr. Atluri testified he has practiced medicine for fifteen years. RX 1, p. 4. He did his residency at the University of Illinois. He then underwent fellowship training in upper extremity and microvascular surgery at the Philadelphia Hand Center. RX 1, p. 5. He subsequently joined a group practice now known as Hand to Shoulder Associates. He devotes his entire practice to treating problems from the hand to the shoulder. RX 1, p. 6. He is board certified in orthopedic surgery and has subspecialty certification in hand surgery. RX 1, p. 6. He performs about 350 surgeries per year, about 100 of which involve the shoulder. He performs shoulder replacements only in trauma cases. He does not do any elective shoulder replacements. RX 1, pp. 6-7. He devotes about 10% of his time to medical-legal work, most of which involves performing IMEs in workers' compensation claims. RX 1, p. 7.

Dr. Atluri testified he examined Petitioner on March 8, 2018, at Respondent's request. RX 1, p. 7. He identified Atluri Dep Exh 2 as the report he prepared after the examination. RX 1, p. 8. He does not independently recall the examination. RX 1, p. 8. Petitioner was 54 years old as of the examination. Petitioner described himself as right-handed. RX 1, p. 9. He reported injuring himself in May 2017, while trying to lift a client out of a bathtub. He indicated the client twisted in such a way as to suddenly load his right arm. He denied experiencing anything at that particular moment. He indicated he felt pain in his right arm and shoulder later on. RX 1, p. 9. He went to an Emergency Room the next day. RX 1, p. 9. He described the treatment he had undergone to date. He complained of ongoing right shoulder soreness and night pain affecting his ability to sleep. RX 1, p. 10. He described wearing a sling when out of his house but was not wearing a sling at the time of the examination. He said he had forgotten to wear it. RX 1, pp. 10-11. He denied having any pre-accident right shoulder problems or treatment. RX 1, p. 11. Dr. Atluri testified he had no reason to doubt this denial as of the examination. RX 1, p. 11. The type of pathology Petitioner had usually causes symptoms but he has seen patients who are asymptomatic despite having severe abnormalities on X-ray. RX 1, p. 11.

Dr. Atluri testified his examination technique changes somewhat when he conducts an IME. He usually incorporates more validity testing, such as distraction testing. He also examines both upper extremities. He does not always do this when examining typical patients. RX 1, p. 12. He examined both of Petitioner's shoulders. He noted no scapular winging in either shoulder. The left shoulder revealed some snapping but no crepitus. The range of motion was normal, as was provocative testing. When he examined Petitioner's right shoulder, he noted some tenderness over the AC joint and the subacromial space. He noted well-healed arthroscopy scars as well as crepitus, snapping and pain with range of motion. He only assessed Petitioner's active range of motion because Petitioner told him his surgeon had advised him it was safe to do active range of motion. RX 1, p. 13. Petitioner had minimal external and internal rotation. Active flexion was 60 degrees. Active abduction was 35 degrees. Active

extension was 40 degrees. All of these parameters are abnormal. RX 1, p. 14. Strength testing was "too painful" so he did not perform it, especially in light of the recent arthroscopy. RX 1, p. 14. The examination findings were consistent with Petitioner's complaints. X-rays taken on May 12, 2017 showed severe arthritic changes and superior migration of the humeral head. In his opinion, the arthritis was present for years. RX 1, p. 15. He reviewed a CT angiogram from May 2, 2017 which showed some right shoulder joint arthritis. RX 1, p. 15. He also reviewed the June 6, 2017 right shoulder MRI images. In his opinion, the MRI was of poor quality but it did reveal arthritis at the glenohumeral joint with superior migration of the proximal humerus along with a large full-thickness rotator cuff tear, cystic changes in the greater tuberosity and some edema at the AC joint. RX 1, p. 16.

Dr. Atluri testified his impression as of the examination was right shoulder arthritis. He reviewed a number of treatment records, including Dr. Levi's operative report. He opined that the work accident aggravated Petitioner's chronic degenerative arthritis. He did not believe the arthroscopy was medically necessary given the severity of the arthritis. RX 1, pp. 17-18. An arthroscopy is very effective at treating soft tissue problems, such as a rotator cuff tear, but it cannot correct the type of severe arthritis Petitioner has. RX 1, p. 18. The medical literature shows that, once a patient has a rotator cuffr arthropathy, i.e., severe arthritis with a large rotator cuff tear, an arthroscopy is no longer effective. RX 1, pp. 18-19. He viewed Petitioner as needing therapy twice weekly for one to two months followed by a transition to a home exercise program. He also believed Petitioner could potentially require evaluation by a reconstructive shoulder specialist if his symptoms warranted it. RX 1, p. 19. He believed that the accident brought about the need for ongoing care. RX 1, p. 20. He based this opinion on Petitioner's denial of pre-accident symptoms and the fact he developed symptoms "fairly rapidly within twenty-four hours" of the accident. RX 1, p. 20.

Dr. Atluri testified he issued an addendum on July 24, 2018, after reviewing over 300 pages of additional records, including records from Stroger Hospital. RX 1, pp. 22-23. He noted that Petitioner's denial of pre-accident right shoulder symptoms was inconsistent with March 2007 and September 2008 records from Stroger, which showed "longstanding right shoulder complaints." RX 1, p. 24. He also reviewed post-accident therapy notes which showed that Petitioner's symptoms were mild by July or August 2017. The additional records changed his impression of Petitioner's overall clinical picture. Before, he felt that, despite having severe arthritis, Petitioner was asymptomatic as of the accident. The new records suggested he actually had chronic right shoulder pain. RX 1, p. 25. Such chronic pain has a typical waxing and waning pattern. That pattern shows up in the therapy records. Those records showed increased symptoms after the accident that subsided by August. He was not able to reconcile the additional records he reviewed with the history Petitioner provided to him in March 2018. RX 1, p. 31. He no longer believes the work accident aggravated the arthritis. He would not use the word "aggravation" because that implies a more permanent change in the condition. He believes there was "plausibly a temporary exacerbation of the condition." He felt that Petitioner's ongoing symptoms "represented a natural progression of his chronic degenerative arthritis." RX 1, p. 32. He also believed Petitioner had returned to baseline by August 2017. RX 1, p. 32. With respect to the work accident, Petitioner reached maximum medical improvement by August 2017. He noted that all the imaging studies were suggestive of a chronic rather than acute condition. RX 1, p. 33. He would expect "significant progression" of the mechanical changes in the shoulder on X-ray during the ten years between 2007 and the work accident. RX 1, p. 35.

Dr. Atluri testified that, in the absence of trauma, age and activity are not so relevant as far as the development of arthritis is concerned. However, age and activity are very relevant in terms of the progression of arthritis. In an older, less active person, arthritis is generally better tolerated and

progresses more slowly. RX 1, p. 36. As of the examination and the addendum, he believed a replacement might be a reasonable treatment option for Petitioner. As of the addendum, he no longer believed the need for a replacement stemmed from the work accident. RX 1, p. 38.

Under cross-examination, Dr. Atluri reiterated he performs shoulder replacements only in the context of traumatic injuries. RX 1, pp. 40-41. The X-rays he reviewed were from March 2018, not March 2017. RX 1, p. 41. Petitioner had treatment at Stroger on many other dates besides the 2007 and 2008 dates he highlighted. RX 1, pp. 41-42. Of the 456 pages of Stroger records he reviewed, the three dates he referenced relate to the shoulder. RX 1, p. 43. He acknowledged that, on September 9, 2008, Petitioner denied having any current right shoulder pain. Back in March and September 2007, Petitioner described having "occasional" right shoulder pain. RX 1, p. 44. He cannot recall whether he saw any records documenting right shoulder pain after September 4, 2007. RX 1, p. 45. When he testified earlier that he would have expected significant progression of Petitioner's arthritis after 2007, based on the complaints Petitioner had at that time, that progression would have manifested in deterioration in function as well as pain and reduced motion. RX 1, p. 45. Based on Petitioner's description of his job duties, he would expect Petitioner's job to be physical in nature. As far as he knows, there is no indication Petitioner had difficulty performing full duty during the years he worked for Respondent before the accident. RX 1, p. 46. Petitioner had some difficulty with certain duties after the accident. He did not see records showing Petitioner had difficulty performing his job before the accident. RX 1, p. 47. He does not recall whether Petitioner was seen for his knee or his shoulder on March 24, 2017. He saw no indication of any shoulder complaints between March 24, 2017 and the work accident. RX 1, pp. 48-49. He believes Petitioner was under active care during that time. RX 1, p. 49. His definition of "baseline" would be Petitioner's condition before the work accident. To his knowledge, Petitioner was not under active right shoulder care up to the time of the accident. RX 1, p. 49.

Petitioner identified the documents in PX 1 as certain of his medical bills. He is not receiving bills at home but does not know whether the insurance company paid all of his medical expenses. T. 33-34.

Under cross-examination, Petitioner acknowledged that he denied any past history of right shoulder pain at the Emergency Room on May 12, 2017 and when he saw Dr. Levi on June 2, 2017. T. 35-36. He also told Dr. Atluri he had no history of right shoulder problems before the work accident. T. 37. He denied telling Dr. Atluri he felt no pain at the time of the accident. T. 37. When he went to Stroger Hospital on March 20, 2007, he complained of muscular right arm pain, not right shoulder pain. T. 38. He started experiencing this pain two weeks earlier, after he underwent shots at a hospital. He was told to take Ibuprofen. He continued to experience right arm and right shoulder pain for three months thereafter. T. 39. He could not recall telling personnel at Stroger Hospital on September 4, 2007 that he was taking Ibuprofen for right shoulder pain. The doctor did not tell him he might have right shoulder bursitis. The doctor recommended he take Motrin. He followed this recommendation. T. 40. He experienced this pain "just for the three months, not after that." T. 40-41. He remembers returning to Stroger on May 13, 2008 but does not remember complaining of right shoulder pain. The doctors he saw did not describe his shoulder condition as chronic. He was still taking Ibuprofen for right shoulder pain at that time. The pain ended "right in there." T. 42. Right shoulder pain was not listed as one of his medical problems when he went to Stroger on September 9, 2008. The doctor prescribed Ibuprofen but he did not take it at that time. T. 42.

Petitioner acknowledged undergoing care at Swedish Covenant Hospital on May 2, 2017. He underwent a right arm CT scan at that time. The doctor ordered this scan because "they couldn't get a good blood pressure reading and they were looking for a clogged artery in the right side." He also underwent bilateral shoulder X-rays. T. 43.

Petitioner acknowledged he did not seek Emergency Room care on the night of the work accident. When he went to the Emergency Room the following day, he did not deny having immediate pain at the time of the accident. He also did not say he started having pain three hours after the accident. T. 44. When he saw Dr. Levi on June 2, 2017, he rated his shoulder pain at 2/10. On July 25, 2017, he rated his pain at 0/10. Dr. Levi said he could perform light duty. T. 45. When he saw Dr. Levi on September 13 and 15, 2017, he denied having right shoulder pain. He also denied having this pain on August 17 and 30, 2017. T. 46. On July 25 and August 11, 2017, he told Dr. Levi his shoulder was "doing okay." T. 47. On July 22, 2017, he did not tell Dr. Levi he was able to work a triple shift. T. 47. On July 14, 2017, he denied having right shoulder pain. On July 1, 2017, he told Dr. Levi he did not have right shoulder pain after finishing a work shift. T. 48. On June 16, 2017, he reported decreased right shoulder pain to Dr. Levi. As of June 27, 2017, he had a prescription for Norco. On that date, he told Dr. Levi his pain was better when he was taking Norco. T. 48. He still had a prescription for Norco as of September 26, 2017. He told Dr. Levi he was taking Norco for pain control. He cannot recall whether he was actually taking Norco as of June 27 or September 26, 2017. T. 49.

Petitioner testified he is currently working for Respondent. Respondent provides him with group insurance coverage through Blue Cross/Blue Shield. That coverage remains in effect. He is not aware of some of his accident-related bills having been submitted to Blue Cross/Blue Shield. T. 51.

On redirect, Petitioner testified his work accident occurred at about 9:50 PM, about ten minutes before his shift ended. T. 52. He went to the hospital the next day, after going home from work and going to bed. T. 53. Dr. Levi prescribed Norco for him at the initial visit. T. 53. On July 25, 2017, he told Dr. Levi his current pain was 0/10 but would "max" to 5/10 while he was trying to sleep. T. 53. As of July 25, 2017, he was performing light duty, subject to the same restrictions he currently has, i.e., no lifting, pushing or overhead work. He has worked full-time subject to these restrictions since Dr. Levy released him. T. 54. Dr. Levi has not lifted the restrictions. T. 54-55. He cannot recall exactly what prompted him to go to Swedish Covenant Hospital on May 2, 2017 but he knows he underwent a CT scan to check his arteries "because they couldn't get a good blood pressure reading." He was told he had asymmetrical blood pressure, meaning the pressure was different in each arm. They ordered the CT scan to check for a blockage because "they were getting a low blood pressure" in his right arm. T. 56. He did not have right shoulder pain as of the scan.

In addition to the exhibits previously referenced, Respondent offered into evidence four utilization review reports from Novare dated August 30, 2017, December 1, 2017, January 2, 2018 and January 24, 2018. RX 5-8. In the August 30, 2017 report (RX 8), Dr. Trotter, an orthopedic surgeon, conducted a retrospective review of the medical necessity of the Lidocaine ointment and Diclofenac solution Dr. Levi prescribed on June 2, 2017. Dr. Trotter found neither of these medications to be medically necessary or appropriate, indicating they are primarily recommended for neuropathic pain. In the December 1, 2017 report (RX 7), Dr. Trotter found certain topical and oral medications prescribed between June 27, 2017 and October 27, 2017 to be not medically necessary or appropriate. The doctor noted that Dr. Levi made no examination findings on July 25, 2017 to support the medication prescribed on that date. In the January 2, 2018 report, Dr. Milos, also an orthopedic surgeon, found the Lidocaine ointment and topical Diclofenac solution prescribed on July 25, 2017 to be neither medically necessary

or appropriate. He indicated he attempted peer-to-peer calls with Dr. Levi on December 26, 2017 and December 29, 2017. RX 6. In the January 24, 2018 report, Dr. Milos found the Meloxicam prescribed on September 26, 2017 to be medically necessary but the Omeprazole, Gabapentin and Ondansetron (Zofran) prescribed on November 28, 2017 to be not medically appropriate or necessary. RX 5.

Arbitrator's Credibility Assessment

Petitioner's description of the mechanics of the lifting-related work accident was detailed, convincing and corroborated by the treatment records.

Petitioner's desire to resume working on a light duty basis, documented by Dr. Levi on August 7, 2018, weighs in his favor, credibility-wise.

Respondent's Section 12 examiner, Dr. Atluri, described Petitioner as cooperative. He noted no inconsistencies during his examination. In a subsequent addendum, he relied on records dating back ten years in concluding that Petitioner was not forthright about his pre-accident shoulder condition.

Petitioner's treating surgeon, Dr. Levi, noted no evidence of malingering. In September 2018, he noted that urine test results were inconsistent. In a later note, he described subsequent urine testing as consistent.

Respondent contends Petitioner misrepresented the facts when he told Emergency Room personnel, Dr. Levi and Dr. Atluri that he did not have right shoulder problems before the accident. Respondent points to Stroger Hospital records dating back to 2007 which mention complaints of occasional right shoulder pain for which Petitioner was taking over the counter medication. The Arbitrator acknowledges that some providers who saw Petitioner at Stroger in 2007 used the term "chronic" in reference to his right shoulder pain. There is no evidence, however, indicating that these providers made significant findings on right shoulder examination or recommended imaging or treatment. The Arbitrator cannot conclude that Petitioner knowingly made false statements to his providers after the work accident. In view of his complicated medical history, involving treatment for several systemic conditions, it seems much more likely he simply forgot he had episodic right shoulder pain ten years before the work accident. There is no evidence suggesting this pain was disabling.

Dr. Atluri's ultimate causation opinion, i.e., that the work accident caused only a temporary aggravation of Petitioner's underlying arthritis, was not persuasive. Dr. Atluri originally found in Petitioner's favor on the issue of causation, while conceding Petitioner had significant arthritis as of the work accident. He changed his mind after reviewing additional information, including records from Stroger Hospital that date back to 2007 and 2008. The 2007 records document complaints of only occasional right shoulder pain while the 2008 records reflect Petitioner denied current right shoulder complaints. At his deposition, Dr. Atluri conceded he saw no other pre-accident records suggesting these complaints persisted. He also conceded that Petitioner's job was physical in nature and that he saw no information indicating any shoulder problem precluded Petitioner from performing full duty during the years before the accident. RX 1, pp. 45-47. He cited therapy records as a basis for opining that Petitioner's right shoulder problems were "relatively mild" and thus back to baseline as of August 2017 but a therapy note dated August 29, 2017 documents a complaint of constant 5/10 right shoulder pain while a note of September 2,2017 reflects that Petitioner reported waking up every two hours due to pain. PX 3.

Dr. Atluri's opinion that the arthroscopy was not reasonable or necessary was also unpersuasive. The doctor conceded that Petitioner had a large rotator cuff tear and that arthroscopic procedures are intended to address such tears. While it is true that Petitioner continued to report symptoms after the arthroscopy, the Arbitrator finds it reasonable for Dr. Levi to have taken this route, in an effort to stave off a more complicated replacement procedure.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on May 11, 2017, arising out and in the course of his employment?

The Arbitrator finds that Petitioner sustained an accident on May 11, 2017 arising out of and in the course of his employment. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony concerning the circumstances and mechanics of the accident; 2) the Emergency Room records of May 12, 2017, which corroborate Petitioner's testimony that the injury occurred while he was assisting a patient at work; and 3) the histories recorded by Drs. Levi and Atluri.

Respondent points to a delay in care as a basis for denying accident. The Arbitrator views the delay as minor. Petitioner testified his May 11, 2017 injury occurred near the end of his shift, at approximately 9:45 PM. According to the Emergency Room records of May 12, 2017, he arrived at the hospital at 5:22 AM. Respondent also points to a discrepancy as to the onset of symptoms, with Petitioner testifying his shoulder began hurting immediately and the Emergency Room records reflecting that the pain started three hours after the lifting incident. Under cross-examination, Petitioner denied telling hospital personnel he did not become symptomatic until 1:00 AM. The Arbitrator does not view the discrepancy as significant. All of the treatment records document an injury occurring at work. Respondent's examiner, Dr. Atluri, did not view Petitioner's denial of immediate symptoms as a basis for denying causation. He based his original causation opinion on the fact that Petitioner's symptoms "developed fairly rapidly within twenty-four hours." RX 1, p. 20.

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established causation, via an aggravation theory, as to his claimed current right shoulder condition. The Arbitrator further finds that Petitioner established causation as to the need for the arthroscopy performed by Dr. Levi and the replacement procedure recommended by Dr. Levi and endorsed by Respondent's examiner, Dr. Atluri. See the preceding "credibility assessment" section of this decision for an explanation of the basis for these findings. Under Illinois law, an employer takes an employee as it finds him. A claimant with a pre-existing condition may recover where an accident aggravates or accelerates that condition. See, e.g., Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003) and Schroeder v. IWCC, 2017 Ill. App. LEXIS 350 (4th Dist. 2017). Petitioner had a degenerative right shoulder condition prior to the accident but there is no evidence indicating this condition impeded his ability to perform a physical job for Respondent. The accident brought about an abrupt change, requiring him to seek Emergency Room care.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims the following medical expenses: 1) Swedish Covenant Hospital, Emergency Room, May 18, 2019, $30.42; 2) Orthopedic & Rehabilitation Centers (Dr. Levi), $5,747.00; 3) Rx Development Associates, $6,355.87; and 4) Infinite Strategic Innovation (Dr. Levi, June 27, 2017), $69.34. PX 1.

The Arbitrator declines to award the balance of $30.42 from Swedish Covenant Hospital. Petitioner did not testify to visiting the Emergency Room at this hospital on May 18, 2019. The Swedish Covenant Hospital records in evidence (PX 2, RX 2) do not include any records dated May 18, 2019. The claimed bill does not mention any shoulder treatment. PX 1.

The Arbitrator awards Petitioner the claimed bill from Orthopaedic & Rehabilitation Centers, subject to the fee schedule, except for the charges relating to the office visits of March 4, 2019 ($180.00) and May 6, 2019 ($180.00). No records concerning these office visits are in evidence. PX 3. The Arbitrator views the care rendered by Dr. Levi (and therapists acting at his direction) to be reasonable and necessary as well as related to the work accident. Dr. Atluri criticized no aspect of this care other than the arthroscopy but, at his deposition, he conceded the existence of a large rotator cuff tear and testified that arthroscopies are intended to address such tears.

The claimed Rx Development Associates bill of $6,355.87 includes charges for various medications prescribed by Dr. Levi between June 27, 2017 and July 10, 2018. The propriety of some of these medications is addressed in the utilization review reports offered by Respondent. RX 5-8. The Arbitrator, having reviewed those reports and noting an apparent lack of response by Dr. Levi, the prescribing physician, awards only those charges relating to Meloxicam (a medication approved by Dr. Milos, one of the reviewers) and Tramadol (a medication not addressed in any of the utilization review reports). While Dr. Levi very briefly touched on the issue of medication during his deposition, he did not specifically address the concerns of Respondent's reviewing physicians, Drs. Trotter and Milos.

The Arbitrator declines to award the claimed $69.34 from Infinite Strategic Innovations. This amount appears to relate to services provided by Dr. Levi at Orthopaedic and Rehabilitation Centers on June 27, 2017. The charges previously awarded (see above) include charges for the same date of service at the same facility.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from January 25, 2018 (the date of the right shoulder arthroscopy) through August 7, 2018 (the date Dr. Levi released him to light duty). Respondent disputes this claim. The parties agree Respondent paid $7,390.50 in temporary total disability benefits prior to the hearing. Arb Exh 1.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator has also found the arthroscopy to be reasonable and necessary, as well as related to the work accident. The Arbitrator views Petitioner's causally related right shoulder condition as unstable from January 25, 2018, the date of the arthroscopy, through August 7, 2018, at which point Dr. Levi released Petitioner to light duty at Petitioner's request. From February 2018 forward Dr. Levi was recommending a second procedure, i.e., a replacement surgery. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). Respondent's examiner agrees with this recommendation, although he ultimately concluded the work accident did not bring about the need for the replacement.

The Arbitrator finds that Petitioner was temporarily totally disabled from January 25, 2018 through August 7, 2018, a period of 27 6/7 weeks. Respondent is entitled to credit for its payment of $7,390.50, per the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of the reverse total right shoulder replacement recommended by Dr. Levi. The Arbitrator has previously found in Petitioner's favor on the issues of accident and causation. The Arbitrator views the recommended surgery as reasonable and necessary to restore function to Petitioner's dominant right arm. RX 1, p. 9. Respondent's examiner, Dr. Atluri, agrees the surgery is appropriate, although he ultimately disputed causation beyond a temporary aggravation.

The Arbitrator awards prospective care in the form of the reverse total right shoulder replacement recommended by Dr. Levi.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTHONY REESE,

Petitioner,

vs. NO: 18 WC 29268

CITY OF CHICAGO,

Respondent.

20IWCC0682

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 permanent partial disability (PPD) and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission vacates the Arbitrator's award of 1% loss of use of the right leg and affirms the award of 5% loss of use of the person-as-a-whole. The Commission finds that the evidence does not support a permanency award for the right leg injury. While the Commission adopts the Arbitrator's analysis of Section 8.1(b), the Commission finds that greater weight should be assigned to subsection (v) as there is no evidence of disability regarding the right leg. While no specific questions were asked regarding Petitioner's current leg condition, Petitioner did testify that he "gets pain radiating down to my buttocks often and occasionally down my leg" and he has "trouble getting on my knees" when asked about his current lower back condition. T.17-18. However, Petitioner's complaints are not corroborated by the medical records. Petitioner was seen by Dr. Sean Salehi of US MedGroup of IL on November 19, 2018. At that time, he denied any radiation down into the legs or any occasional weakness. He was released from care. PX.2. The Commission, therefore, vacates the Arbitrator's award of 1% loss of use of the right leg. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed January 17, 20120, 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 $970.87 per week for a period of 23-2/7 weeks, June 14, 2018 through November 23, 2018, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent is entitled to a credit of $22,607.40 for TTD benefits paid.

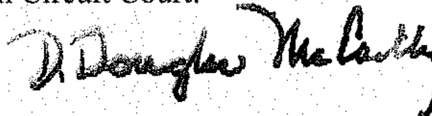
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $790.64 per week for a period of 25 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 5% loss of use of the person-as-a-whole.

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.

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: NOV 2 0 2020



D. Douglas McCarthy

DDM/tdm
O: 10/7/20
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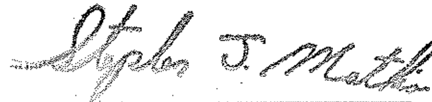
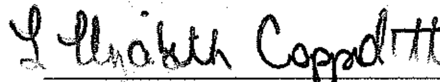


Stephen Mathis



L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REESE, ANTHONY
Employee/Petitioner

Case# **18WC029268**

CITY OF CHICAGO
Employer/Respondent

20IWCC0682

On 1/17/2020, 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 1.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
MIKE BRANDENBERG
20 S CLARK ST SUITE 1820
CHICAGO, IL 60603

0010 CITY OF CHICAGO
MATTHEW LOCKE
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Anthony Reese
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **18** WC **29268**

Consolidated cases: ____

20 I W C C 0 6 8 2

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the City of **Chicago**, on **December 3, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 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*** 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 $**75,936.36**; the average weekly wage was $**1456.31**.

On the date of accident, Petitioner was **61** years of age, ***single*** with **2** dependent children.

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

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services. The parties stipulated Respondent is liable for $4178.02 in charges (City of Chicago EMS $934.00; Loretto Hospital $1333.36; Concentra $210.66; and ION $1700.00).

Respondent shall be given a credit of $**22,607.40** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,607.40**.

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

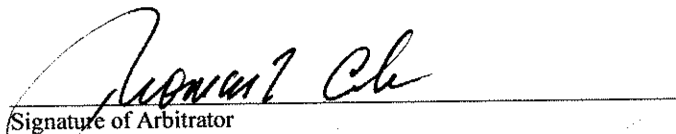
ORDER

Permanent partial disability

Based on the factors found in Section 8.1b(b), and the record taken as a whole this Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 1% (2.15 weeks) loss of right leg at $790.64 per week; and 5% (25 weeks) loss of a man as a whole at $790.64 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.



Signature of Arbitrator

1-17-2020
Date

JAN 17 2020

Anthony Reese v. City of Chicago, No. 18 WC 29268

Preface

The parties proceeded to hearing December 3, 2019 on a Request for Hearing indicating the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to accidental injuries that arose out of and in the course of employment; and what is the nature and extent of the injury. Petitioner was the only witness. No transcript was ordered by either party. Neither side offered medical testimony. Arbitrator's Exhibit 1.

Findings of Fact

Anthony Reese (Petitioner), a 61 year old male, testified that on June 13, 2018 he was a laborer with the City of Chicago (Respondent) Department of Streets and Sanitation. He had grabbed a box and while dragging it to his truck, stepped on a speed bump and fell. He said he felt back and right leg pain.

Petitioner testified he was taken by ambulance to Loretto Hospital. The records of Loretto Hospital indicate the Chicago Fire Department transported Petitioner from 185 North Lamon to the hospital June 13, 2018, in the early afternoon. Petitioner indicated he slipped and fell backwards and had right leg pain. At Loretto, Petitioner complained of right thigh pain saying he fell on his lower back. Although Petitioner denied back, neck, shoulder, arm, or leg pain, his diagnosis was lower back strain. Petitioner underwent a CT scan of his lumbar spine, which indicated: no fracture or malalignment; degenerative lower spinal spondylosis; and mild changes of arthrosis of SI joints. He was given medication and discharged home. He was released to work June 18, 2018 without restrictions. Petitioner's Exhibit 1.

Petitioner testified he followed up with his primary care physician. Neither party submitted medical records to support or refute this. Petitioner testified he was sent to Concentra by Respondent.

The records of Concentra are disorganized and nonsequential and contain records of unrelated injuries. There are apparent gaps in treatment. Some parts are paginated, some are not. There was no attempt to place the records in a fashion where it was easy to follow the treatment. It is not the responsibility of the Arbitrator to construct the medical records to support either side. All that can be gleaned from these records is that Petitioner underwent physical therapy and that there were conflicting diagnosis and assessments of Petitioner throughout the records. Petitioner could work light duty but it was not accommodated. An MRI done in July 2018 revealed chronic lumbar conditions. Petitioner's Exhibit 2.

Petitioner testified he had injections in his back. The records of Illinois Orthopedic Network indicate Petitioner received bilateral lumbar facet injections on September 20, 2018. Petitioner's Exhibit 3.

Petitioner testified he returned to work November 24, 2018 and still works as a laborer, performing all his duties.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill-being causally related to the injury. The records here are conflicting as to Petitioner's condition. He has sprain/strains and a chronic back condition. Petitioner's testimony does not really help the conflict, nor does the lack of credible medical opinion. An injured employee bears the burden of proof to establish the elements of his right to compensation, including the existence of a causal connection between his current condition of ill-being and his employment. Navistar International Transportation Corporation v. Industrial Commission, 315 Ill. App. 3d 1197, 1202-1205 (2002). A claimant must prove that some act or phase of employment was a causative factor in the injury. Vogel v. Illinois Workers' Compensation Commission, 345 Ill. App. 3d 780, 786 (2005).

Here, Petitioner testified after the fall he felt pain in his back and right leg, but at Loretto Hospital he denied back pain. Diagnostics showed chronic changes in Petitioner's lumbar spine and degenerative disc disease. The report of the Chicago Fire Department said Petitioner complained of right leg pain. Petitioner testified he has pain in his back while working and takes over the counter medication. The leg is causally related, but is the back?

In this case, I find as a conclusion of law, Petitioner suffered a muscle strain of the right leg and a lumbar contusion. There is sufficient circumstantial evidence, given the mechanism of the fall, certain medical records, and Petitioner's testimony to support an aggravation of Petitioner's back condition. Although Respondent disputed a causal connection, it did not seriously challenge or contest the issue at trial or in argument.

Disputed issue **L** is, what is the nature and extent of the injury. Petitioner suffered soft tissue injury to the leg and back. He was released to work, initially with no restrictions, then put on light duty which could not be accommodated. He was treated conservatively for five months. Here, permanent partial disability is established using the criteria found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, this Arbitrator finds as follows.

As to subsection (i) of Section 8.1b(b) This Arbitrator notes that no permanent partial disability report or opinion was submitted into evidence. Because of this I give this factor no weight in determining the level of disability.

Regarding subsection (ii) of Section 8.1b(b), the occupation of the employee, I note at the time of injury Petitioner was a laborer for Respondent. He returned to that job, which as described at the hearing is heavy duty. Petitioner testified he performs his duties with pain. I give this factor weight in determining the level of disability.

Regarding subsection (iii) of Section 8.1b(b) this Arbitrator notes Petitioner was 61 years old at the time of the accident and does not have the recuperative powers of a younger man. I give this factor weight in determining the level of disability.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings, Petitioner testified he returned to work at the same salary. I give no weight to this factor in determining the level of disability.

With regard to subsection (v) of Section 8.1b(b), evidence of disability corroborated by treating medical records, I note buried in the morass of records from Concentra is a physical therapy note of November 9, 2018 indicating Petitioner was feeling well and had no pain in his lumbar spine, and could perform the activities of daily living independently. His pain was 0/10 and he was discharged from care. However, also there is a note of November 19, 2018 from Dr. Sean Salehi indicating Petitioner could return to work without restrictions. He indicated Petitioner complained of a mild ache in the low back and takes Aleve on an occasional basis. Petitioner testified he still has pain in his back and takes over the counter medication. I give this factor weight in determining the level of disability.

Based on the above factors, the testimony offered, and my reading and consideration of the record as a whole, this Arbitrator finds: Petitioner sustained permanent partial disability of 1% (2.15 weeks) loss of the right leg at $790.64 per week (max PPD); and 5% (25 weeks) loss of a man as a whole at $790.64 per week (max PPD), pursuant to the Act.

Arbitrator

1-17-2020

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

JOZEF MIERWA,

Petitioner,

vs. NO: 15 WC 29597

THE MILLARD GROUP,

Respondent.

20IWCC0683

DECISION AND OPINION ON REVIEW

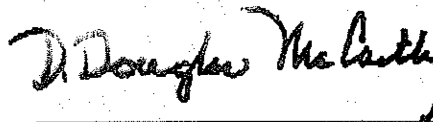
Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, affirms 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 February 4, 2020 is hereby affirmed and adopted.

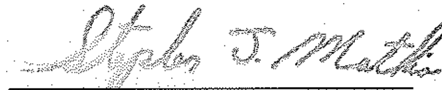
IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,300.00. 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: NOV 2 0 2020



D. Douglas McCarthy

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O: 11/18/20
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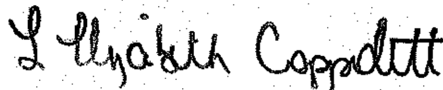


Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MIERWA, JOZEF
Employee/Petitioner

Case# **15WC029597**

THE MILLARD GROUP
Employer/Respondent

20IWCC0683

On 2/4/2020, 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 1.52% 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:

2731 SALVATO & O'TOOLE
DAVID FROYLAN
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

0445 RODDY LAW LTD
PAUL W SCHUMACHER
303 W MADISON ST SUITE 1900
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

JOZEF MIERWA
Employee/Petitioner
v.
THE MILLARD GROUP
Employer/Respondent

Case # **15** WC **029597**

20IWCC0683

An *Application for Adjustment 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 **July 15, 2019**. 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 **04/29/15**, 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, in part,*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**34,179.60**; the average weekly wage was $**657.30**.

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

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

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

Respondent shall be given a credit of **$5,258.40** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of **$0.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $438.20/week for 13-6/7 weeks, commencing 4/30/2015 to 7/22/2015 and 3/23/2016 to 4/16/2016, in accordance with §8(b) of the Act.

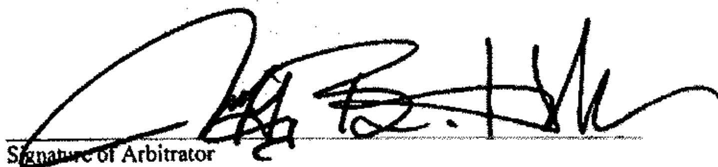
Respondent shall reasonable and necessary medical expenses of $7,640.38, in accordance with §§8(a) and 8.2 of the Act and as is set forth below.

Respondent shall pay Petitioner permanent partial disability benefits of $394.38/week for 50 weeks because the injuries sustained caused Petitioner to suffer the 10% loss of use of a person as a whole, in accordance with §8(d)2 of the Act.

Respondent shall pay Petitioner the compensation benefits that have accrued from 4/29/2015 through 7/15/2019 in a lump sum, 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, 2020
Date

FEB 4 - 2020

PRELUDE

In reviewing the documentary evidence that was submitted, the Arbitrator noted the Parties' failure to comply with Supreme Court Rule 138. SSN information was therefore redacted from PX 1, PX 2, PX 4, PX 5, PX 6 and PX 7.

STATEMENT OF FACTS

Petitioner was employed by Respondent in a janitor type position. His job duties included recycling and throwing garbage into dumpsters., mopping floors and cleaning bathrooms. He worked the third shift, from 10:00pm to 6:00am.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on April 29, 2015. Petitioner was pushing a gondola full of garbage and it became caught in a pavement gap, jarring Petitioner. Petitioner felt pain in his back. Petitioner reported the injury to his supervisor and Respondent referred him to Concentra at 87th & Harlem in Bridgeview for treatment.

At Concentra, Petitioner was examined and underwent x-rays of the lumbar and thoracic spine. Petitioner was provided work restrictions and was instructed to return back to Concentra. Petitioner underwent physical therapy at Concentra. Ultimately, Concentra referred the claimant to a physiatrist for Petitioner's ongoing back pain. Petitioner was also recommended to proceed with an MRI of Petitioner's low back. The Lumbar MRI took place on June 18, 2015 and was said to be positive for degenerative findings at L4-5 with a mild disc bulge and minimal indentation of the ventral aspect of the thecal sac. At L5-S1, a mild disc bulge and superimposed shallow central disc protrusion/extrusion with minimal indentation of the thecal sac, degenerative facet changes and mild narrowing of the neural foramina, left greater than right. (PX 1)

Petitioner returned to Concentra on June 23, 2015, at which time facet injections at the L4-L5 level were recommended. Petitioner was seeing Dr. Sajjad Murtaza, a physiatrist. Injections were recommended. Dr. Murtaza endorsed full duty work release, based on an IME. Petitioner was then referred to Dr. Sean Salehi, a neurosurgeon. (PX 1)

Petitioner first saw Dr. Salehi on October 20, 2015. Dr. Salehi diagnosed mechanical low back pain secondary to disc disease and an annular tear at L5-S1, causally related to the work injury. Dr. Salehi did recommend facet injections as well, along with weight loss and smoking cessation. Petitioner was said to be a candidate for a fusion if conservative measures failed and if he quit smoking and lost weight. (PX 1)

On November 3, 2015, Petitioner saw Dr. Murtaza and topical cream was prescribed. Dr. Murtaza performed bilateral facet injections on December 3, 2015. (PX 2, PX 3)

Petitioner testified that Dr. Salehi had recommended to him that he undergo a lumbar fusion surgery. Dr. Salehi concluded Petitioner was not a fusion surgery candidate. He recommended an FCE, which took place on January 7, 2016. The FCE showed that Petitioner was capable of 35.3% of a janitor's job functions. Significant evidence based and observational inconsistencies were noted. Petitioner showed 7.7% consistency of effort. He was said to be self-limiting and using submaximal effort. Reliability was not demonstrated. Petitioner returned to see Dr. Salehi on January 15, 2016 at which time, it was noted that Petitioner had significant back pain complaints. He was working light duty. There was no weakness, with strength graded as 5/5. Dr. Salehi commented that the FCE revealed several inconsistencies, gave Petitioner permanent work restrictions, at MMI and released him, PRN. Petitioner was not a surgical candidate for a fusion, based upon his BMI and his

continued smoking. The diagnosis was mechanical back pain, secondary to Lumbar disc disease at L5-S1, without a comment on causation as to the work injury. (PX 1)

Petitioner did not return to Dr. Salehi for further treatment.

During this timeframe, Petitioner had been working light duty and continued to do so until March 23, 2016. He was paid TTD, apparently from April 30, 2015 through July 22, 2015, per the RFH. (Arb.X 1)

Petitioner next sought care at Union Health on March 23, 2016. Petitioner testified that he had ongoing back problems and problems walking and as a result of same, decided to go to Union Health, where he had received medical care in the past. The physicians at Union Health took Petitioner off work. Petitioner was provided medications. The doctors at Union Health recommended that Petitioner try a SI joint injection. Petitioner continued to receive care and treatment at Union Health. Only the March 23, 2016 chart note contains an off work instruction. On April 25, 2016, Petitioner was seen for a painful right shoulder, subsequent to a fall. There is no mention of any back complaints. On May 23, 2016, Petitioner was seen for follow up. Occupational Health had signed off on the right shoulder. The concerns were hypertension and chronic back pain. In April of 2017, he returned to Union Health, at which time, Petitioner began using his wife's insurance. It was at this point in time that Union Health once again recommended an injection, as well as ongoing medications. Union Health also recommended a Lumbar MRI, which took place on April 19, 2017. The MRI was said to show significant degenerative changes of the L5-S1 intervertebral disc with mild to moderate right neural foraminal narrowing and mild neural foraminal narrowing at L4-L5. Union Health then referred Petitioner to a pain specialist at University Pain Center. (PX 4)

At University Pain Center, Petitioner underwent SI joint injections and facet injections. (PX 6, PX 7)

On November 15, 2018, Petitioner underwent radiofrequency ablation on the right side, at L3-L4-L5. Petitioner returned to University on December 6, 2018 and underwent radiofrequency ablation on the left side at L3-L4 and L5. (PX 7)

Throughout all of this treatment, Petitioner continued to have ongoing back pain, according to his testimony. Petitioner did undergo an additional Lumbar MRI on January 9, 2019. This MRI appeared to show improved pathology when compared to the 4/19/2017 study. At L4-L5, minimal disc bulge with no central canal stenosis and minimal bilateral neural foraminal stenosis was seen. At L5-S1 a mild disc bulge was noted, with mild to moderate foraminal stenosis and loss of disc height. (PX 5) It was also recommended that Petitioner proceed with an EMG. Petitioner remained under the care of his physicians at Union Heath in order to get a referral for additional treatment. Petitioner was referred to a neurosurgeon and was also prescribed physical therapy. Petitioner was said to be employed full time, per the chart note of May 7, 2018. (PX 4)

Petitioner testified that he has been off work since March 23, 2016. This is in contradiction with the above chart note and Petitioner's subsequent testimony that he works a part time job, 2 hours a day, cleaning offices, mopping, vacuuming, emptying garbage and washing windows, said to be light duty work.

Petitioner's back still hurts. He still has pain. Even after the multiple injections and RFA procedures, there has been no overall improvement. Petitioner denied prior major back problems and any subsequent back injuries.

Respondent sent Petitioner for three §12 examinations by Dr. Kern Singh. The first exam was on June 10, 2015. Petitioner complained of 7/10 back pain. The diagnosis was Thoracic Muscular Strain and Lumbar Muscular Strain. Strength was 5/5 and reflexes were 2+ and equal. 5/5 Waddell's Findings were noted. Light duty work was recommended, along with an MRI. (RX 1)

An Addendum Report was prepared after Dr. Singh's review of the June 18, 2015 Lumbar MRI. The diagnosis was Lumbar muscular strain, resolved. The L5-S1 DDD is not a causative factor in Petitioner's pain complaints, as the complaints appear to be non-anatomic in nature and cannot be correlated to the L5-S1 distribution. Petitioner was at MMI, not in need of any further treatment and capable of full duty work. A spinal fusion will not help Petitioner. (RX 3)

Petitioner was re-examined by Dr. Singh on April 18, 2016. Strength was again 5/5 and reflexes were 2+ and equal. 5/5 Waddell's were again noted. The diagnosis was thoracic and lumbar muscular strain, resolved. The current symptoms are not objectifiable. Petitioner was at MMI and capable of full duty work. The FCE confirms Dr. Singh's findings. Petitioner has pain complaints, nonobjectifiable in nature. (RX 2)

Petitioner was last examined by Dr. Singh on June 17, 2019. He complained of 6/10 back pain. The physical exam was benign, again. 5/5 Waddell's were noted, again. The diagnosis was lumbar muscle strain, resolved, and lumbar DDD. The current complaints are non-anatomic. Petitioner was capable of full duty work. (RX 4)

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)

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

Petitioner's current condition of ill-being regarding his low back is, in part, causally related to the injury, in that Petitioner suffered a thoracic muscular strain and a lumbar muscular strain, which have resolved, as a result of the injury. Petitioner's current complaints of non-anatomic back pain are not causally related to the injury.

The Arbitrator bases this finding on the persuasive opinions of Dr. Singh and the medical records, particularly the FCE and the records of Dr. Salehi. The FCE shows that Petitioner can work 35.3% of a janitor's work duties, in spite of the 7.7% consistency of effort that Petitioner showed. 92.3% of Petitioner's efforts were not consistent. Therefore, Dr. Singh's opinions and the 5/5 Waddell's appear to be accurate. Dr. Salehi released Petitioner from care, PRN, as of January 15, 2016. Dr. Salehi's diagnosis at that time was Lumbar disc disease at L5-S1, with mechanical low back pain secondary to the DDD condition. He did not relate Petitioner's condition to any work accident.

Additionally, Petitioner's credibility is questionable and the legitimacy of his claim is debased by the FCE results, the non-anatomic components of his complaints of back pain and the fact that he claimed TTD from March 23, 2016 to the time of trial (saying he has been off work since 3/23/2016, while the 5/7/2018 Union Health chart says that the patient is employed full time and, at some point, Petitioner began working his part time job at Clerk & Sexton (sic?), per his testimony. One should not make a claim for TTD when he is working.

Considering the above and all of the evidence adduced, Petitioner has failed to prove a causal connection between the injury and any condition of ill-being regarding his low back and thoracic spine beyond the resolved muscular strains diagnosed by Dr. Singh.

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?

According to Exhibit A to the RFH, Petitioner claimed the following medical bills: Metropolitan Institute of Pain ($1,728.00); Metro Anesthesia ($1,947.78); Metro Health ($3,884.59); Union Health ($954.62); Integrated Imaging Consultants ($558.00); Rush Oak Park Hospital ($21,583.98); and Blue Cross/Blue Shield Subrogation Claim ($16,600.26). (Arb X 1)

The bills were objected to on the basis of causation and reasonableness and necessity, given the opinions of Dr. Singh.

Considering the Arbitrator's finding on the issue of causation, above, the opinions of Dr. Singh and the recommendations for treatment made by Dr. Salehi in PX 1, the Arbitrator awards the following bills as being reasonable and necessary to cure or relieve the effects of the injury and the same are found to be causally related:

Metropolitan Inst. of Pain: (dos: 11/3/2015;12/3/2015) (PX 2)	**$1,728.00**
Metro Anesthesia: (dos: 12/3/2015) (PX 3)	**1,947.78**
Metro Health: (dos: 11/3/2015) (PX 8)	**3,884.59**
Union Health: (dos: 3/23/206) (PX 4)	**80.01**
TOTAL:	**$7,640.38**

The above bills related to the injections of 11/3/2015 and 12/3/2015 are for services rendered by Dr. Murtaza, a physician within the referral chain from Concentra, Respondent's choice of care provider and while Petitioner was still receiving treatment by Dr. Salehi.

The Arbitrator finds that one visit with Union Health is appropriate. Therefore, the 3/23/2016 dos bill is awarded. The remainder of the Union Health charges are denied as being not causally related to the injury.

The 4/19/2017 and 1/9/2019 MRI's (Integrated Imaging Consultants) are not causally related treatment and are not awarded.

The Rush Oak Park bills from 2017 and 2018 are denied as not being causally related.

The BX/BS subrogation claim is denied, as not being documented.

This award of medical expenses is in accordance with §§8(a) and 8.2 of the Act, so Respondent is entitled to any appropriate fee schedule or negotiated rate reduction.

K. What temporary benefits are in dispute?

Based upon the evidence adduced, Petitioner is awarded TTD benefits for the time period of April 30, 2015 to July 22, 2015 and March 23, 2016 to April 16, 2016, a period of 13-6/7 weeks.

It does appear that Petitioner was restricted to light duty by Concentra and he did not work for the first time period. Thereafter, Petitioner was taken off work by Union Health, effective March 23, 2016. Dr. Singh found Petitioner capable of full duty work as of April 16, 2016.

L. What is the nature and extent of the injuries?

When making the determination of permanent partial disability as related to Petitioner's injuries, the Arbitrator is to address five factors, pursuant to Section 8.1b(b) of the Workers' Compensation Act: "(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."

With regard to subsection (i) of Section 8.lb(b), the reported level of impairment pursuant to Section 8.1b(a), the Arbitrator notes that neither party entered into evidence an impairment rating. Therefore, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of Section 8.lb(b), the occupation of the injured employee, Petitioner was employed as a janitor and he now works part time as a janitor at light duty. His position requires him to be on his feet and walking around, as well as performing some clean-up tasks. There was no evidence that Petitioner is required to work only part time. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iii) of Section 8.1b(b), the age of the employee at the time of the injury, Petitioner was 49 years old at the time of his work injury. Petitioner therefore has several more work years in which he may experience the lingering effects of his injury. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iv) of Section 8.1b(b), Petitioner's future earnings capacity, Petitioner did not testify to a diminution in wages. No evidence was presented that Petitioner's future earnings capacity was diminished due to his work injury. The Arbitrator gives moderate weight to this factor.

With regard to subsection (v) of Section 8.lb(b), evidence of disability corroborated by the treating medical records, Dr. Salehi released Petitioner from care, at MMI, PRN with moderate restrictions, after the FCE and Petitioner's apparent demotivation to lose weight and stop smoking. The Arbitrator gives moderate weight to this factor.

In consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner established permanent partial disability to the extent of 10% loss of use of the person as a whole, pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS	)	[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
	) SS.	[ ] Affirm with changes	[ ] Rate Adjustment Fund (§8(g))
COUNTY OF WILLIAMSON	)	[ ] 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

PASQUINO, RICHARD,

Petitioner,

vs.

NO: 16 WC 22967

KNIGHT HAWK COAL CO.,

Respondent.

20IWCC0684

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, permanent disability, legal and evidentiary errors and §1(d)-§1(f), 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 26, 2020, is hereby affirmed and adopted.

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

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

The bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2) (West 2013)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

20 . CC0684

16 WC 22967
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DATED: NOV 2 0 2020
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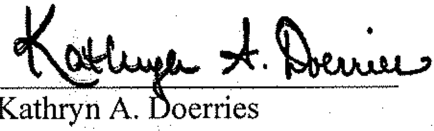
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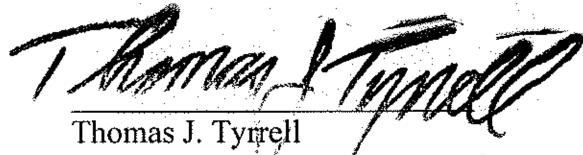
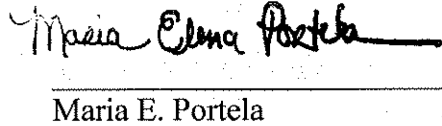

Thomas J. Tyrrell


Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PASQUINO, RICHARD Case# **16WC022967**
Employee/Petitioner

KNIGHT HAWK COAL LLC
Employer/Respondent

20IWCC0684

On 2/26/2020, 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 1.44% 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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF 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

Richard Pasquino
Employee/Petitioner

v.

Knight Hawk Coal, LLC
Employer/Respondent

Case # 16 WC 22967

Consolidated cases: ______

20 IWCC0684

An *Application for Adjustment 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 15, 2020. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On April 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 $n/a; the average weekly wage was $1,248.99.

On the date of accident, Petitioner was 65 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.

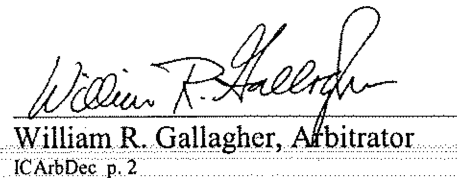
Respondent is entitled to a credit of $0.00 paid under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's 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

February 24, 2020
Date

FEB 2 6 2020

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an occupational disease to his lungs and/or heart, pulmonary system, respiratory tracts. The Application alleged a date of last exposure of April 7, 2016, 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 of 26 years (Arbitrator's Exhibit 2).

At the time of trial, Petitioner was 69 years of age. Petitioner has a high school diploma. Petitioner worked in coal mines for 26 years with all of those years being underground. In addition to coal dust, Petitioner was regularly exposed to, and breathed, silica dust, roof bolting glue fumes, and diesel fumes. Petitioner's last day of work in the coal mines was in April, 2016, at Respondent's Prairie Eagle Mine. At that time, Petitioner's job classification was ram car operator. Petitioner testified he was exposed to coal dust on that day. In 2013, Petitioner was a section foreman when a worker on his crew was killed on the job. He testified that affected him a lot. He was getting older and due to other injuries he had received at the mine, he elected to retire at that time. He testified that concerns for his breathing and his health in that regard also affected his decision to retire. After he retired from coal mining, Petitioner worked at a garage cleaning and picking up trash.

Petitioner testified he began working in the mine in February 1972 at Old Ben 21. He was hired as a bobcat operator. In that position he retrieved supplies for the bolter and rock dust to dust the face. He also cleaned the ribs with the bobcat as well as numerous other jobs. He testified that this job generated quite a bit of coal dust. After two years he became a roof bolter. In that job he positioned the roof bolting machine where the mining had been done. He would drill a hole in the roof and then run the conventional roof bolt up in the hole and tighten it to support the ceiling in the mine. After two years as a roof bolter, he went to belt maintenance. In that job he took care of the belts. He set up for belt moves on different sections and took care of changing belt rollers or whatever needed to be done with the belt. These belts took the coal out of the mine. He testified that a lot of coal dust was generated in this job.

Petitioner testified he began at Old Ben 25 in February or March 1979. He worked there until 1991. At that mine he was a roof bolter as well as a helper to the miner operator. At this mine he started using the glue pins in the roof bolting process. After drilling the hole in the roof, the glue pin was inserted in the hole and then the bolt was tightened. In that process some glue would ooze out of the hole and had a really bad smell. He was also a section manager on an idle unit at Old Ben 25. He took care of this section as far as making sure all the faces were bolted and curtains were hung up. Petitioner was also a long wall foreman. Petitioner testified that the long wall had a shear that cut the coal off the face of the mine. At one time Petitioner was in charge of the crew who performed the continuous miner process. He told the crew where to cut and what to cut and made sure everything was in order as far as what the law required. He was a working boss meaning that he was in the mine with the same exposures as the people who were running the continuous miner. Petitioner left Old Ben when Ziegler Coal

Company was going to buy them in February 1991. He testified that he took his severance pay and removed himself from the coal industry at that time.

After leaving coal mining, Petitioner testified worked at other jobs. He worked at Toys R Us in Marion for 13 or 14 years. He also worked at Farina Boats for a year and a half to two years before he got a job with Blue Cross/Blue Shield of Illinois. Petitioner also worked at Toys R Us during the evening while working at Blue Cross/Blue Shield. When Wisconsin Physicians took over the Illinois Contract for Medicare, he left Blue Cross/Blue Shield and resumed his mining career in April 2009.

When Petitioner went back to work in the mines, he went to work for Respondent at its mine at Royalton. He was hired as a scoop operator/laborer doing various jobs at the mine. He worked at that mine for about six months before they closed down. He then went to work at Respondent's Prairie Eagle South Mine. He was hired there as a ram car operator. He testified that the ram car hauls the coal from the miner where the coal is being cut and takes it to the feeder to dump it. He testified that he was right up there where they were actually cutting the coal out of the face. He also worked as section foreman for Respondent.

Petitioner testified that he first noticed breathing problems at work around 2010. He testified that he started noticing a little breathing problem. He started coughing and wheezing. Petitioner testified that from the first time he noticed breathing problems until he left the mine, the problems started getting a little worse. Since leaving the mine up until the time of trial his breathing has gotten worse. Petitioner testified that he can walk on level ground at a normal pace 150 to 200 feet without gasping for air. He testified that he may be able to climb one flight of stairs before having to stop and rest. Petitioner does not take any breathing medication. Petitioner testified that his breathing has affected him quite a bit as far as what he can do in the yard, in the house and in going places. Petitioner testified he has a Siberian husky and he has to be pretty strong to hold him back when he takes him for a walk. He testified the further he walks the harder it is breathe. Petitioner testified he has to stop two or three times while mowing the yard as well as weed eating around the house.

Petitioner testified that Dr. Tara Robbins has been his family physician for about two years. Before that it was Dr. Butt. When he left the practice, Petitioner saw another doctor at SIMCA. Petitioner testified that he has not spoken to his treating physicians about his breathing difficulties. He testified that he thought about talking to Dr. Robbins about his breathing to see what could be done, but he just did not follow up on it. Petitioner testified that he smoked for about a month when he was 17 or 18 years old.

Petitioner testified had his left knee replaced in 2002. In 2014, Petitioner had an injury while employed by Respondent wherein he injured his left rotator cuff which required two surgeries. He also had ulnar nerve surgeries on both arms and carpal tunnel releases on both hands. He had an injury to his neck and his right knee while working at Respondent. He had surgery on his neck two months prior to the date of trial. He had a right knee replacement in 2016. Petitioner testified he takes medication for high blood pressure and for pain from the injuries.

Petitioner testified on cross examination that the injuries that he sustained while working for Respondent was one of the reasons he retired. He slipped on some ice at work on January 7, 2014, injuring his shoulder. Petitioner testified that his left shoulder gives him some problems when he raises his arm and lifts things. He was off work for that injury from April 21, 2014, to February 2, 2015. Petitioner sustained a fall at work while employed by Respondent in July, 2015, injuring his knee and neck. He missed time from work for that injury from December 14, 2015, through March 14, 2016. Petitioner testified that presently his knees pop and crack and he has to rest. He cannot walk very far. The Petitioner testified that it was difficult to walk on the uneven terrain at the mine and to get in and out of the ram car that he operated. Petitioner testified that the biggest reason that he wanted to retire was the death of the worker in his crew in 2013. Petitioner testified that in regard to his neck he had popping, cracking and pain. It was difficult to look to the right or left and to see if vehicles were coming by while he was driving the ram car. Petitioner testified that he had surgery by Dr. Kube to fuse three levels in his neck on October 30, 2019. At the time of trial, he was still going to therapy. Petitioner testified that when he advised the physicians at SIMCA his symptoms and problems, he was always honest with them.

Petitioner testified that when he is not sitting watching TV, he takes the dog for a walk or is out in the yard trying to do stuff. He testified that he runs errands. He takes a cruise maybe once a year. He visits his daughter and her family.

Dr. Suhail Istanbouly examined Petitioner on October 18, 2016, at the request of Petitioner's counsel (Petitioner's Exhibit 1, p 7). Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine (Petitioner's Exhibit 1, pp 4-5). Dr. Istanbouly is board certified in internal medicine, pulmonary medicine and critical care medicine. During the course of his practice, he has had numerous occasions to work with and treat coal miners or former coal miners. In terms of the lung disease that he treats, it runs the full spectrum to include emphysema, COPD, chronic bronchitis, asthma, coal workers' pneumoconiosis and lung cancer (Petitioner's Exhibit 1, p 5). Dr. Istanbouly testified that he performs five to seven black lung examinations for attorneys each month. These examinations are always at the request of the "claimant attorney" (Petitioner's Exhibit 1, pp 30-31).

Dr. Istanbouly noted that Petitioner was a coal miner for 26 years with the last employment being in April, 2016. In the last year of coal mine employment, Petitioner was a ram car operator. Petitioner never smoked. Petitioner had exertional dyspnea. At the time of Dr. Istanbouly's examination Petitioner reported getting short of breath by walking two to three blocks with no significant change over the prior six months (Petitioner's Exhibit 1, pp 7-8). On Petitioner's spirometry the FEV1 was 89% of predicted, the FVC was 90% of predicted and the FEV1/FVC ratio was 74%. Dr. Istanbouly testified that per the *AMA Guides* if the ratio was less than 75%, it would be considered abnormal (Petitioner's Exhibit 1, p 8). Dr. Istanbouly testified that he reviewed the chest x-ray of Petitioner and same revealed mild bilateral interstitial changes consistent with simple coal workers' pneumoconiosis (Petitioner's Exhibit 1, pp 8-9). Dr. Istanbouly testified that Petitioner had simple coal workers' pneumoconiosis, early stage, based on the physical exam, PFT results and chest x-ray. He

testified that the coal workers' pneumoconiosis was caused by Petitioner's long term coal dust inhalation (Petitioner's Exhibit 1, p 9). Dr. Istanbouly testified Petitioner could not have any further exposure to coal mine dust without endangering his health (Petitioner's Exhibit 1, p 10).

Dr. Istanbouly testified that the positive chest x-ray coupled with a sufficient amount of exposure is enough to make a diagnosis of coal workers' pneumoconiosis. A negative x-ray cannot rule out the existence of coal workers' pneumoconiosis. Dr. Istanbouly testified that he is familiar with studies that show that long term coal miners who were never diagnosed during their lives by radiographic study with coal workers' pneumoconiosis will have it diagnosed at autopsy (Petitioner's Exhibit 1, p 11).

Dr. Istanbouly testified that in order to have pneumoconiosis one must have in addition to coal mine dust deposited in his lungs, a tissue reaction to the coal dust. The tissue reaction can be called scarring or fibrosis. Dr. Istanbouly testified that the scarring of coal workers' pneumoconiosis cannot perform the function of normal healthy lung tissue (Petitioner's Exhibit 1, p 12). By definition, if one has coal workers' pneumoconiosis, he would have some sort of impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not (Petitioner's Exhibit 1, p 13). Dr. Istanbouly testified that when abnormalities of pneumoconiosis show up on pathology, on autopsy or biopsy, those are the same as the ones that are seen on x-ray just smaller and maybe more profuse. He testified that when a man with many years of experience as a coal miner leaves the coal mine, he never evacuates the coal mine dust that has entered his lungs (Petitioner's Exhibit 1, pp 27-28). Tissue that is next to the coal mine dust that does not clear from the lungs is exposed to the coal mine dust for the rest of the miner's life (Petitioner's Exhibit 1, p 29).

Petitioner told Dr. Istanbouly that he had been diagnosed with COPD in the past. Dr. Istanbouly did not review any treatment records regarding Petitioner. Dr. Istanbouly testified that he subscribes to the so-called GOLD, Global Initiative for Chronic Obstructive Pulmonary Disease, standard for the diagnosis of COPD. Petitioner did not meet that standard (Petitioner's Exhibit 1, p 31). Dr. Istanbouly testified that under the *AMA Guides, Sixth Edition*, an FEV1/FVC below the lower limit of normal and/or 75% is considered abnormal. Petitioner's FEV1/FVC was above the lower limit of normal but less than 75%. Dr. Istanbouly testified that based on the *AMA* guidelines, Petitioner's FEV1/FVC ratio was normal at 74% which was exactly what was predicted for a gentleman in normal health of his height, age and sex. He testified that there was no abnormality on the testing. There was no evidence of obstruction in the testing performed on Petitioner (Petitioner's Exhibit 1, p 34). Dr. Istanbouly testified that with a forced vital capacity of 90% of predicted, there was no indication of restriction in Petitioner (Petitioner's Exhibit 1, pp 34-35).

In regard to Petitioner's complaint of cough, it had been present for a little more than a year. He told Dr. Istanbouly that the cough was occasionally productive. The only trigger identified by Petitioner was exertion. Dr. Istanbouly testified that the complaint of dyspnea on exertion could be due to things other than respiratory disease including deconditioning. Petitioner was not taking any breathing medication when he was seen by Dr. Istanbouly and did not relate a

history of ever having taken breathing medication (Petitioner's Exhibit 1, p 32). Petitioner did not tell Dr. Istanbouly that he left work at the mine due to respiratory disease or symptoms or that he had difficulty from a respiratory standpoint in fulfilling the duties of his last job in the mine (Petitioner's Exhibit 1, p 33).

Dr. Istanbouly was provided with Dr. Smith's interpretation of the May 19, 2016, chest x-ray. He was provided no other interpretations of Petitioner's chest imaging. Dr. Istanbouly testified that he does not provide profusion ratings on the films that he reviews for black lung. He determines whether a film is positive or negative for black lung. If it is positive, then he classifies the film as early, moderate or severe. In Petitioner's case, he classified the film as early. Dr. Istanbouly could not say whether the film revealed a 1/0 profusion or a 0/1 profusion. Dr. Istanbouly is neither an A-reader nor a B-reader of chest films. Dr. Istanbouly testified that the studies that have been done to determine whether black lung is present on autopsy are from Appalachia. He was unaware of any such studies from the Illinois coal basin (Petitioner's Exhibit 1, pp 35-36).

Dr. Henry K. Smith, a board certified radiologist and B-reader, interpreted Petitioner's chest x-ray dated May 19, 2016. Dr. Smith found the film to be quality 1. Dr. Smith interpreted the film as positive for pneumoconiosis, profusion 1/1 with P/S opacities in all lung zones (Petitioner's Exhibit 2).

Dr. Cristopher Meyer reviewed a PA chest radiograph of Petitioner dated May 19, 2016. He testified that the film was quality 2 due to under-inflation. He testified that in this case there was probably no significance to the under-inflation; however, overall, in looking at an examination and trying to decide whether there are increased interstitial markings, low lung volumes will crowd the normal structures in the lungs and can simulate interstitial lung disease (Respondent's Exhibit 1, pp 40-41). Dr. Meyer testified that there was a mild elevation of Petitioner's left diaphragm. His impression was clear lungs with no radiographic findings of coal workers' pneumoconiosis. Dr. Meyer did not know the cause of elevation of the left diaphragm. He testified that it was not a manifestation of coal mine dust exposure (Respondent's Exhibit 1, p 41).

Dr. Meyer also reviewed a CT of Petitioner's chest taken March 27, 2018. He testified that the CT was of diagnostic quality and was done at 3mm slice thickness which was adequate. Dr. Meyer testified that there were no centrilobular or perilymphatic nodules or large opacities on the CT scan. He testified that there was a calcified granuloma in the right lower lobe and areas of linear scarring in the left apex and in the lingula. He testified that there was no emphysema on the CT scan. There was one mildly enlarged right peritracheal lymph node and coronary artery calcifications. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis on the CT scan. He also noted post inflammatory scarring in the left upper lobe which included both the left upper lobe and the lingula (Respondent's Exhibit 3, pp 8-9). Dr. Meyer testified that post inflammatory scarring of the lingula often times represents areas of linear scarring in older individuals' lungs from prior infection. When the infection clears, the individual is left with a small band of lung that has healed and left behind a little

linear scar. He testified that this is not a sequela of dust exposure (Respondent's Exhibit 3, p 9). Dr. Meyer testified that along with the CT scan he also received a sealed envelope containing the interpretation of Dr. Randy Balmforth. Dr. Meyer testified that his interpretation was essentially the same as Dr. Balmforth's interpretation (Respondent's Exhibit 3, pp 5, 11).

Dr. Meyer testified that CTs are more sensitive in picking up sequela of dust exposure or any lung disease than plain films of the chest. Dr. Meyer testified that he agreed with the position stated in the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition* in Section 5.4b that "computed tomograms and high-resolution computed tomography are radiographic techniques that may augment the standard radiograph." Dr. Meyer also agreed with the statement in the *AMA Guides* that the Standard CT and/or high resolution CAT scan can provide greater accuracy as part of a thorough assessment of the pulmonary parenchyma. Dr. Meyer testified that next to pathology there is no more diagnostic study that could be done of the lungs to determine the presence of disease than a CT of the chest (Respondent's Exhibit 3, pp 11-12).

Dr. Meyer has been board certified in radiology since 1992 (Respondent's Exhibit 1, p 7). Dr. Meyer has been a B-reader since 1999 (Respondent's Exhibit 1, p 19). 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 19-22). Dr. Meyer was on the American College of Radiology Pneumoconiosis Task Force, which was engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam (Respondent's Exhibit 1, p 32).

Dr. Meyer is one of the co-directors of the ACR B-reading course. He testified that NIOSH has contracted with the American College of Radiology to reinvigorate the B-reading course, and he has been asked to be one of the co-directors of that program. His responsibility will entail several days of teaching physicians who want to become B-readers the mechanics of applying the B-reading system and in reviewing a series of cases with them so that they are comfortable sitting for the B-reading exam (Respondent's Exhibit 3, p 4). 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. One of the most important parts of the B-reader training examination is making the distinction between a film with profusion of 0/1 versus a film with 1/0 profusion (Respondent's Exhibit 1, pp 34-35).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities. Based on the size and appearance of those small opacities, they are given a letter score (Respondent's Exhibit 1, p 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described as revealing small round opacities. Diseases that cause pulmonary fibrosis, such as asbestosis, are described by small linear or small irregular opacities (Respondent's Exhibit 1, p 28). The distribution of the opacities is also

described as different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. The last component of the interpretation is the extent of the lung involvement or the profusion (Respondent's Exhibit 1, p 23). Dr. Meyer testified that the profusion is essentially an attempt to define the density of the small opacities in the lung (Respondent's Exhibit 1, p 30).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and film regarding Petitioner (Respondent's Exhibit 2, p 18). Dr. Castle is a pulmonologist and is board certified in internal medicine and in the subspecialty of pulmonary disease (Respondent's Exhibit 2, p 3). Dr. Castle practiced in Roanoke, Virginia, for 30 years. His practice was limited to pulmonary disease and chest disease which encompassed critical care medicine (Respondent's Exhibit 2, p 6). Dr. Castle's practice included treating patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis (Respondent's Exhibit 2, pp 6-7). Dr. Castle was continuously certified as a B-reader from 1985 through June 30, 2017 (Respondent's Exhibit 2, p 12). Dr. Castle allowed his B-reading certificate to lapse because he did not want to make the trip to Morgantown, West Virginia, to take the test (Respondent's Exhibit 2, p 41).

Dr. Castle reviewed a chest x-ray of Petitioner taken at Harrisburg Medical Center on May 19, 2016. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. He testified that there was elevation of the left hemodiaphragm and atherosclerosis in the thoracic aorta, but there was no evidence of coal workers' pneumoconiosis radiographically (Respondent's Exhibit 2, p 29). Dr. Castle testified that for a proper reading of a chest x-ray for pneumoconiosis one has to compare the subject film to the standard ILO classification films in order to classify it in that system. He testified that the first thing that goes on the form is the name of the patient and the quality of the film. If the x-ray is flat out normal, one marks the area on the form that says no parenchymal abnormalities. Assuming that there is something abnormal on the film, then the reader compares it to the ILO standard films based on the size of the opacity. Next the reader notes in which of the six lung zones the opacities occur. Based upon the average of the amount in the lung zones, the reader compares it to the standard films and then classifies it as 0/1 or 1/0 or whatever classification. If there are no large opacities, that is also marked on the form. Dr. Castle testified that Section 4b contains the obligatory symbols to note any other changes or abnormalities on the x-ray (Respondent's Exhibit 2, p 30). Dr. Castle testified that P, Q and R are the small round opacities with P being the smallest and R being the largest of the round opacities. The S, T and U opacities are the linear opacities with S being smallest and U being the largest. Dr. Castle testified that profusion is important because that is what determines whether or not the x-ray is positive or negative (Respondent's Exhibit 2, p 31).

Dr. Castle agreed with the position of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk from working in currently permissible dust levels until he reaches retirement age. Dr. Castle testified that it is very unlikely for simple pneumoconiosis to progress once the exposure ceases. Dr. Castle testified that there is basically no clinical significance to subradiographic pneumoconiosis. It means that an

individual might have a biopsy or some pathology that would show the presence of pneumoconiosis, but it is of insufficient severity of profusion to show up on an x-ray and therefore it is not going to be of sufficient severity to cause any impairment. Petitioner's diffusion capacity over 114% indicated that he had intact alveolar-capillary membrane and no diffusion abnormality. Dr. Castle testified that 1/0 profusion is the minimal amount necessary to make a diagnosis of pneumoconiosis radiographically (Respondent's Exhibit 2, pp 31-33).

Dr. Castle testified that with regard to pulmonary function testing performed on Petitioner, it was normal. There was not any evidence of obstruction, restriction or impairment in gas exchange. Dr. Castle agreed with Dr. Istanbouly that Petitioner does not have COPD (Respondent's Exhibit 2, p 33). Dr. Castle is familiar with the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*. He testified that if he applied the results from the pulmonary function testing on Petitioner to Table 5-4 of the *AMA Guides*, Petitioner would fall in Class 0 impairment. Dr. Castle testified that Petitioner was capable of heavy manual labor from a respiratory standpoint (Respondent's Exhibit 2, pp 33-34). Dr. Castle testified based on the data he reviewed, Petitioner did not have chronic bronchitis (Respondent's Exhibit 2, p 39).

Dr. Castle testified that notwithstanding negative chest x-ray readings, Petitioner could still have coal workers' pneumoconiosis (Respondent's Exhibit 2, p 40). No matter what Dr. Castle saw on the films, he could not rule out the possibility that Petitioner could have pneumoconiosis that could be found pathologically or at autopsy (Respondent's Exhibit 2, p 45). He testified that there are studies that have shown that as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by a radiographic study during their life (Respondent's Exhibit 2, p 46). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology (Respondent's Exhibit 2, p 29). Dr. Castle testified that there was not any pathologic evidence in the medical that he reviewed on Petitioner (Respondent's Exhibit 2, p 73). Dr. Castle described the abnormality of coal workers' pneumoconiosis as basically trapped coal dust in a part of the lung that ends up wrapped in scar tissue and can be accompanied by emphysema around it. By definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring (Respondent's Exhibit 2, pp 50-51). Dr. Castle agreed with the *Guides to the Evaluation of Permanent Impairment, Sixth Edition*, that chest x-ray findings correlate poorly with physiologic measures of lung function. Findings from chest imaging are not used as a factor in assessment of impairment by the *Guides* (Respondent's Exhibit 2, pp 68-69).

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. Petitioner was seen on February 2, 2010, with complaint of chest pain with history of hypertension. It was noted he had started working again in the coal mines in April, 2009, after being off for 18 years. He reported noticing progressive tightness and sharpness in his chest over the prior couple of weeks. Petitioner reported he smoked cigars in his youth, but he had not smoked for most of his adult life. His review of systems respiratory revealed no chronic cough. Lungs were clear to auscultation. Chest x-ray revealed low lung volumes with an asymmetric elevation of the left diaphragm (Respondent's Exhibit 6, pp 26-29). Petitioner was seen on

May 12, 2010, in follow up to his cardiac catheterization. His review of systems respiratory revealed no cough, but he did complain of shortness of breath (Respondent's Exhibit 6, pp 15-16).

Petitioner was seen on March 21, 2016, with chief complaint of chest pain. His main complaint was shortness of breath and chest tightness. He reported very minimal activity brought same on. His review of systems respiratory revealed shortness of breath and chronic cough. Diagnoses rendered were chest pain, hypertension and hypercholesterolemia (Respondent Exhibit 6, pp 10-13).

Petitioner was seen on August 8, 2019, for follow up. He was there to discuss his Holter results as well as surgical clearance for lumbar surgery. Petitioner had a history of hypertension, hyperlipidemia, non-occlusive CAD, bladder cancer, sleep apnea, chronic neck pain and chronic back pain. He denied any significant shortness of breath. Petitioner complained of buttocks claudication pain, worse on the right, which would occur after walking four to five blocks, but he was able to continue walking one to two miles. He had chronic back pain and was scheduled for lumbar fusion. His review of systems respiratory was positive for shortness of breath but negative for coughing. Physical examination pulmonary showed normal effort and breath sounds (Respondent's Exhibit 11, pp 4-7).

Medical records of SIMCA and Heartland Family Practice were admitted into evidence. Petitioner was seen on May 26, 2015. On that date it was noted he was a never smoker. He had been diagnosed with a bladder tumor which was resected on November 25, 2014. Petitioner underwent a rotator cuff repair in April, 2015. Petitioner related no shortness of breath or cough. Physical examination of the chest revealed the lungs to be clear to auscultation (Respondent's Exhibit 5, pp 219-222). When seen on August 19, 2015, Petitioner was complaining of hip and knee problems. Petitioner related no shortness of breath when walking and no cough, wheeze or sputum production (Respondent's Exhibit 5, pp 212-215). Petitioner was seen on October 5, 2015, due to workers' compensation injury. He reported that he sustained a fall at work on July 1, 2015, when he stepped in a low spot. He fell forward on his left side and jarred his neck. He related no shortness of breath, cough or wheeze (Respondent's Exhibit 5, pp 208-210). On October 11, 2015, Petitioner underwent polysomnography that revealed significant sleep apnea (Respondent's Exhibit 5, p 203). Petitioner was seen on October 15, 2015, for follow up. Review of systems that date revealed no exercise intolerance, cough or sputum production (Respondent's Exhibit 5, pp 197-198). Petitioner was seen on December 2, 2015, for a preoperative exam for anticipated right knee replacement. Petitioner denied history of cardiac or pulmonary issues. He had moderate exercise tolerance, but his stamina was limited by his knee. He denied cough. Physical examination of the chest revealed lungs were clear to auscultation (Respondent's Exhibit 5, pp 176-179).

Petitioner was seen on February 19, 2016, regarding his neck pain. In review of systems he denied shortness of breath and had no cough or any sounds on examination of the lungs (Respondent's Exhibit 5, pp 166-170). Petitioner was seen on March 24, 2016, for follow up

of neck complaints. Petitioner denied cough and wheezing (Respondent's Exhibit 5, pp 160-162). Petitioner was seen for an adult wellness exam on April 12, 2016. Physical examination of the chest revealed the lungs were clear to auscultation, no wheezing, rales/crackles or rhonchi and good air movement (Respondent's Exhibit 5, pp 156-159). Petitioner was seen on July 12, 2016, regarding CPAP necessity and a knot on his right elbow. Review of systems revealed no shortness of breath or cough. Physical examination of the chest revealed no dyspnea and the lungs were clear to auscultation (Respondent's Exhibit 5, pp 148-151). When seen on October 20, 2016, Petitioner's review of systems revealed no cough (Respondent's Exhibit 5, pp 130-133).

Petitioner was seen on February 16, 2017, with chief complaint of leg swelling. He is also noted to be short of breath. He reported that his breathing was worse with walking. He had a stress test the year prior which was good. He had gained weight. He related no cough or wheeze. Physical examination of the chest revealed a few crackles at the lung bases (Respondent's Exhibit 5, pp 125-128). Venous Doppler ultrasound was performed on February 17, 2017, and revealed no evidence of deep vein thrombosis (Respondent's Exhibit 5, p 123). On that same date Petitioner underwent chest x-ray which was interpreted as revealing mild left diaphragmatic elevation or eventration but no acute pulmonary disease (Respondent's Exhibit 5, p 121). On February 28, 2017, Petitioner reported that he had been exposed to someone with the flu. He had a three day history of wheezing, cough and congestion with post nasal drip. He related no wheezing or shortness of breath. His lungs were clear to auscultation on examination. The assessment included upper respiratory infection (Respondent's Exhibit 5, pp 117-120). Petitioner was seen on April 6, 2017, with low grade fever, chest congestion, cough and sinus complaints. He related cough that was productive and shortness of breath but no wheezing. Physical examination of the chest revealed no dyspnea but some rhonchi. The assessment was bronchitis (Respondent's Exhibit 5, pp 113-115). Petitioner returned on April 18, 2017, for six month recheck. Albuterol and Atenolol had been added to his medications. Review of systems was negative for wheezing or shortness of breath. Physical examination of the chest revealed no dyspnea. Auscultation, no wheezing, rales/crackles, or rhonci and breath sounds were normal with good air movement. The assessment included allergic rhinitis (Respondent's Exhibit 5, pp 107-112). Petitioner underwent chest x-ray on April 23, 2017. The radiologist noted infiltration of the left hemidiaphragm. There was no acute cardiopulmonary disease (Respondent's Exhibit 5, p 105). Echocardiogram was performed on the same date with indication for same being chest pain and dyspnea. Same was interpreted as revealing no evidence of hypertrophy. His systolic function was normal and he had an ejection fraction of 63% (Respondent's Exhibit 5, pp 101-103). Petitioner was seen on May 16, 2017, for hospital follow up. It was noted that he had been seen in Carbondale due to chest pain. He was having no symptoms on this date. It was noted he had been in the ER for chest pain and underwent cardiac catheterization which revealed a 20 to 30% blockage. He was still having some breathing issues. Physical examination of the chest revealed no dyspnea. Auscultation no wheezing, rales/crackles or rhonci and breath sounds were normal with good air movement (Respondent's Exhibit 5, pp 97-100). On August 29, 2017, Petitioner underwent pulmonary function testing. The indication for same was dyspnea. The interpretation was that the spirometry revealed no obstruction with no significant improvement in the FEV1 with

bronchodilator. Lung volumes were normal and the diffusion capacity was increased (Respondent's Exhibit 5, p 92). Petitioner was seen on December 21, 2017, for six month recheck. He complained of a knot on his neck and indicated he needed a lift chair. He related difficulty getting out of a chair due to arthritis in his knees (Respondent's Exhibit 5, pp 78-81).

Petitioner was seen on February 16, 2018. Petitioner's problems list was reviewed on that date and did not include pulmonary disease. He reported no cough, wheeze or shortness of breath. Physical examination of the chest revealed no dyspnea and no adventitious sounds (Respondent's Exhibit 5, pp 73-77). On March 27, 2018, Petitioner underwent CT of the chest with contrast. Indication for same was mediastinal lymphadenopathy. The interpretation was scarring or subsegmental atelectasis of the left upper lobe versus resolving pneumonia, mild prominent mediastinal lymphadenopathy which appeared unchanged from prior exam (Respondent's Exhibit 5, pp 71-72). Petitioner was seen on May 11, 2018, following a fall. On that date he reported no cough, wheeze or shortness of breath (Respondent's Exhibit 5, pp 67-70). Petitioner was seen for low back pain on May 23, 2018. Under review of systems it was noted that he reported no cough, wheeze or shortness of breath. Physical examination of the chest revealed no dyspnea or adventitious sounds (Respondent's Exhibit 5, pp 58-62). Petitioner was seen on August 10, 2018, for follow up. He related having a little bit of fatigue. Petitioner denied cough, wheeze or shortness of breath. Physical examination of the chest revealed the lungs to be clear to auscultation with no adventitious sounds. Petitioner's problem list did not include respiratory problems other than obstructive sleep apnea (Respondent's Exhibit 5, pp 22-29). Petitioner was seen on September 19, 2018, complaining of dizziness. He was taking allergy medications for allergy symptoms. Petitioner denied cough or shortness of breath (Respondent's Exhibit 5, pp 22-26). Petitioner was seen on November 12, 2018, with complaint of dizziness. He had undergone a carotid ultrasound with no significant finding. He also underwent Holter monitoring which he related was unremarkable. Petitioner denied cough, wheeze or shortness of breath. Lungs were clear to auscultation with no adventitious sounds (Respondent's Exhibit 5, pp 18-22). On December 5, 2018, Petitioner underwent CT of the chest with indication for same being mediastinal lymphadenopathy. The impression was stable appearance with mildly prominent mediastinal lymph nodes unchanged from previous studies (Respondent's Exhibit 5, pp 40-41).

Petitioner was seen on January 4, 2019, relating cough and sputum production. He also related a rash, runny nose, nasal congestion, frequent sneezing, sinus pressure and itching. Physical examination of the chest revealed the lungs were clear to auscultation with no adventitious sounds. The assessment included acute bronchitis (Respondent's Exhibit 5, pp 10-14). Petitioner was seen with complaints of dizziness on April 8, 2019. Physical examination of the chest revealed the lungs were clear to auscultation with no adventitious sounds. Petitioner denied cough, wheeze or shortness of breath (Respondent's Exhibit 5, pp 6-10). Petitioner was seen on May 6, 2019, because of low back pain. He related difficulty walking due to pain. He denied cough, wheeze or shortness of breath. Physical examination of the chest revealed the lungs were clear to auscultation with no adventitious sounds. The assessment was degenerative lumbar spinal stenosis and Petitioner was restricted from work. His restrictions included no lifting, bending or stooping (Respondent's Exhibit 5, pp 3-6).

Petitioner was seen on September 3, 2019, with complaint of cough for three to four days. He was taking an over the counter allergy medicine as needed. Petitioner had a long problem list with the only pulmonary condition noted as obstructive sleep apnea. Petitioner was complaining of cough, wheeze, shortness of breath and sore throat. He was producing light green phlegm. Review of systems revealed cough and sputum production but no wheezing and no shortness of breath. Physical examination of the chest revealed the lungs were clear to auscultation with no adventitious sounds. The assessment was acute sinusitis (Respondent's Exhibit 10, pp 6-10). Petitioner underwent a chest x-ray on September 18, 2019. Impression was atelectasis and/or early infiltrate within the right lung base (Respondent's Exhibit 10, p 16). Petitioner was seen for surgical clearance on September 18, 2019. He was to undergo a fusion of the neck. He had a very long problem list that included nothing regarding pulmonary disease other than sleep apnea. On this date he had no complaint of chest pain or shortness of breath. Physical examination of the chest revealed the lungs were clear to auscultation with no adventitious sounds (Respondent's Exhibit 10, pp 3-6).

Medical records of Bonutti Orthopedic Services were admitted into evidence. Petitioner was seen on November 9, 2015, with complaints of bilateral knee pain. He had a left total knee replacement in 2002. On this date he had arthritic changes in the right knee and evidence of loosening debris in the left knee. Review of systems respiratory revealed Petitioner complained of shortness of breath with wheezing, cough and snoring (Respondent's Exhibit 9, pp 12-15). Petitioner underwent right total knee replacement on December 14, 2015 (Respondent's Exhibit 9, pp 8-9). On February 29, 2016, Petitioner was given a return to work slip that indicated he could return to work without restrictions on March 14, 2016 (Respondent's Exhibit 9, p 2).

Medical records of Harrisburg Medical Center were admitted into evidence. Petitioner underwent a chest x-ray on January 13, 2000. The indication for same was coal miner. The impression of the radiologist was negative chest, category classification 0/0 (Respondent's Exhibit 7, 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 with Respondent.

In support of this conclusion the Arbitrator notes the following:

According to Dr. Istanbouly, Petitioner's FEV1/FVC ratio was normal at 74% which was exactly what was predicted for a gentleman in normal health of his height, age and sex. He testified that there was no abnormality on the testing.

Dr. Castle testified that pulmonary function testing on Petitioner was normal. There was not any evidence of obstruction, restriction or impairment in gas exchange. Dr. Istanbouly testified that Petitioner did not meet the gold standard to have COPD and Dr. Castle agreed. Dr. Castle opined that Petitioner did not suffer from any pulmonary disease or impairment that had occurred as a result of his occupational exposure to coal mine dust. Dr. Castle testified that based on Petitioner's objective testing from a pulmonary perspective, he was capable of heavy manual labor.

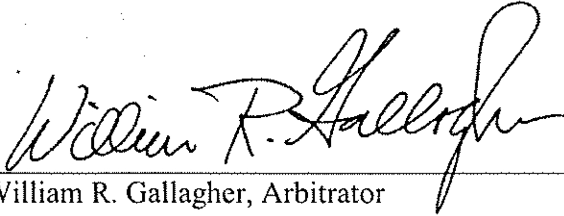
Dr. Henry K. Smith, a B-reader and board certified radiologist, interpreted Petitioner's chest x-ray of May 19, 2016, as positive for coal workers' pneumoconiosis. Dr. Istanbouly, who also interpreted this film, is not an A-reader or B-reader. Dr. Istanbouly does not have the special training for interpreting chest x-rays for occupational lung disease that was described by Dr. Meyer. Dr. Meyer and Dr. Castle, B-readers, reviewed Petitioner's chest x-ray dated May 19, 2016. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on the film. Dr. Castle testified as to what is required for a proper reading of the chest x-ray for pneumoconiosis. Dr. Istanbouly did not follow that protocol. Dr. Castle also testified to the importance of identifying the profusion when interpreting a chest x-ray for pneumoconiosis. He testified that the profusion is what determines whether or not the x-ray is positive or negative. Dr. Istanbouly does not provide profusion ratings on the films that he reviews for black lung.

Dr. Meyer also reviewed a CT scan of Petitioner's chest taken March 27, 2018. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis on the CT scan. Dr. Meyer's interpretation of the CT scan was essentially the same as the interpretation of the treating radiologist. Dr. Meyer testified that CT scans are more sensitive in picking up sequela of dust exposure or any lung disease than plain films of the chest. Next to pathology there is no more diagnostic study that could be done of the lungs to determine the presence of disease than a CT of the chest. Petitioner offered no evidence contrary to Dr. Meyer's negative interpretation of the CT scan.

The Arbitrator finds the opinions of Dr. Castle and Dr. Meyer to be more persuasive than those of Dr. Istanbouly and Dr. Smith.

Petitioner testified that he first noticed breathing problems while working for Respondent in 2010. Although Petitioner's medical records contain intermittent complaints of shortness of breath, no physician ever related these complaints to an occupational lung disease. Petitioner was 65 years old on the date that he retired. He testified that he retired mainly because of how he had been affected when a worker on his crew was killed on the job. He testified that he did have some concerns for his breathing and other health conditions when he made the decision to retire. Dr. Castle testified that Petitioner was capable of heavy manual labor from a respiratory standpoint. No physician ever restricted Petitioner from work as a result of an occupational lung disease.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CRAIG FOSTER,

Petitioner,

vs. NO: 16 WC 18248

HAYES MECHANICAL,

Respondent.

20 I W C C 0 6 8 5

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, permanent partial disability, penalties and attorney fees, and other-maintenance and wage differential, 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, herein, modifies the Decision of the Arbitrator, page 5, paragraph 3, to read:

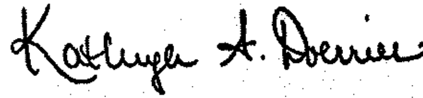
> "There is no evidence that Petitioner was engaged in a prescribed vocational rehabilitation program or self-directed job search from March 14, 2018 through April 8, 2018, a time during which the Petitioner claims to be entitled to maintenance."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2020 is, otherwise, 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.

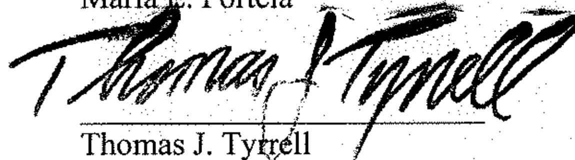
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing 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: NOV 2 0 2020
o-11/10/20
KAD/jsf



Kathryn A. Doerries

Maria E. Portela



Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FOSTER, CRAIG
Employee/Petitioner

Case# **16WC018248**

HAYES MECHANICAL
Employer/Respondent

20IWCC0685

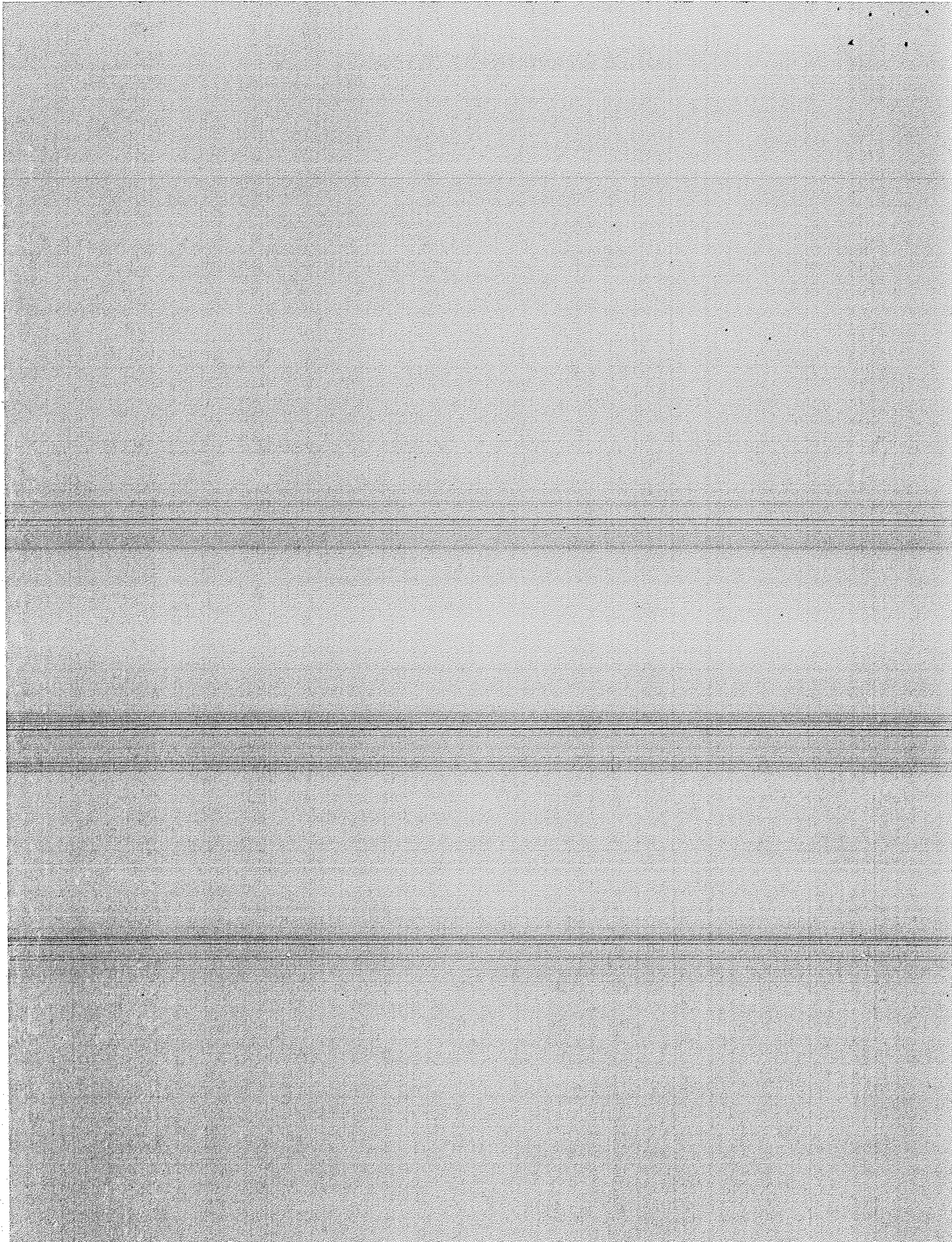
On 4/2/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST
SPRINGFIELD, IL 62705

1109 GAROFALO SCHREIBER STORM
JAMES CLUNE
55 W WACKER DR 10TH FL
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

Craig Foster
Employee/Petitioner

v.

Hayes Mechanical
Employer/Respondent

Case # **16** WC **18248**

Consolidated cases: ___

20IWCC0685

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **2/24/2020**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/23/2016**, 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 **$87,027.20**; the average weekly wage was **$1,673.60**.

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

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

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

Respondent shall be given a credit of **$2,231.46** for TTD, **$0** for TPD, **$91,489.86** for maintenance, and **$0** for other benefits, for a total credit of **$93,721.32**.

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

ORDER

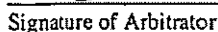
1. THE PETITIONER HAS NOT ESTABLISHED BY A PREPONDERANCE OF THE CREDIBLE EVIDENCE THAT HE HAS SUSTAINED A WAGE DIFFERENTIAL AS A RESULT OF THE DISABLITY ASSOCIATED WITH THE ACCIDENT IN THIS CASE. THE ARBITRATOR FINDS THE PETITIONER IS DISABLED TO THE EXTENT OF 25% UNDER SECTION 8(D)2 OF THE ACT AS A RESULT OF A PARTIAL INCAPACITY TO PURSUE THE DUTIES OF HIS USUAL AND CUSTOMARY LINE OF EMPLOYMENT.

2. THE RESPONDENT HAS NOT ACTED IN A VEXATIOUS MANNER IN THE HANDLING OF THIS CASE OR THE PAYMENT OF BENEFITS. THE PETITIONER IS NOT ENTITLED TO PENALTIES OR FEES.

3. THE PETITIONER IS NOT ENTITLED TO TTD. THE PETITIONER IS ONLY ENTITLED TO MAINTENANCE DURING THE TIME HE WAS IN A VOCATIONAL REHABILITATION PROGRAM FROM APRIL 29, 2019 THROUGH NOVEMBER 5, 2019 AT WHICH TIME THE PETITIONER WITHDREW FROM FURTHER PARTICIPATION IN THE VOCATIONAL REHABILITATION PROGRAM, NOR DID HE CONTINUE TO LOOK FOR WORK. WHILE THE PETITIONER CLAIMS TO HAVE LOOKED FOR WORK FROM SOME UNDEFINED DATE IN JANUARY 2019 THROUGH APRIL 29, 2019 HE PROVIDED NO PROOF OF A SEARCH NOR JOB LOGS SUBSTANTIATING A SEARCH. MAINTENANCE IS LIMITED TO APRIL 29, 2019 THROUGH NOVEMBER 5, 2019, WHICH IS 27&2/7 WEEKS OR $30,443.29.

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

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



Signature of Arbitrator

3/26/20

Date

APR 2 - 2020

Craig Foster v Hayes Mechanical 16WC18248

Findings of Fact and Conclusions of Law

Findings of Fact:

The petitioner is a resident of Sherman Illinois, which the arbitrator notes is located near Springfield, Illinois.(TR 10) He began his employment with Hayes mechanical in November 2015. (TR 11) He provided, PX 10, wage records from January 26, 2016 through February 23, 2016, or the time covering about one month prior to the accident. (TR 94, PX 10)

The petitioner was drilling a piece of angle iron when the angle iron came loose from the chain vice. The piece of iron struck the petition's right little finger. (TR 11-13, PX 1 at TR 94) Ultimately, after a number of surgeries, the finger was fused at the proximal joint. (TR 12-13)

The petitioner performed accommodated light duty work (TR 15-16) through March 13, 2018. (TR 15-16) This work was performed at the respondent's office in Belleville. (TR 16-17) The petitioner later conceded that before the accident he was a traveling pipefitter and took jobs all over the state. (TR 33-34)

The petitioner was provided with permanent restrictions by one of his treating physicians on March 13, 2018, which included no lifting more than 20 pounds with his right hand. (TR 17 – 19) The petitioner also underwent a functional capacity evaluation on February 21, 2018 wherein it was determined the petitioner could lift up to 43 pounds and was qualified to work at a medium to heavy work capacity. (TR 94, PX 7)

The petitioner's former job required him to lift up to 50 pounds. In fact, the petitioner conceded he could lift 50 pounds based on a limitation of 20 pounds with his right hand and 30 pounds with this left hand. (TR 35) The left hand was not restricted. (TR 49 – 50)

The petitioner complains of loss of grip strength in his right hand and pain in his right little finger. (TR 28 – 29) The petitioner agrees he can perform some things with his left hand that he had previously performed with his right hand. The petitioner agrees he has the use of four of his five fingers on his right hand to use a computer. (TR 31-32) He is a high school graduate. He has HVAC training and truck driver training. (TR 95, RX 2)

The job of a pipefitter is defined as a heavy-duty job. (TR 94, PX 7 at pages 3-5) The petitioner was laid off from respondent on March 13, 2018. (TR 18, PX 9 at TR 94)

The petitioner testified that he looked for work on his own between January 2019 and April 29, 2019 without success. The petitioner provided no other evidence of a job search during that period of time. (TR 21 – 22, 35 – 37) April 29, 2019 is the date when the petitioner began a vocational rehabilitation program with a consultant provided by the respondent. (TR 95, RX 2)

When the petitioner applied for jobs he unilaterally limited his available hours to daytime hours only and no work on Sundays. (TR 38, 55-56) The petitioner conceded he has work night shift jobs in other employments. (TR 40 – 41) These unilateral restrictions prevented the petitioner from being considered for employment with an employer seeking second and third shift workers. (TR 58) The petitioner also missed an opportunity to work for $16.00 per hour at Grand Rivers Jackpot due to inflexibility regarding the hours that he was willing to work. (TR 62-63)

Through the efforts of the vocational counselor the petitioner obtained an interview and employment at Panera Bread earning $9.50 per hour. (TR 22 – 25) The vocational consultant had located other job opportunities for the petitioner in other industries and in some more distant locations (Bloomington-Normal, Decatur), but the petitioner declined to pursue them. (TR 52-54, 57-58; TR 95, RX 2) The petitioner also declined to pursue sales jobs based on commission or salary and commission. (TR 59 – 62) The petitioner's unwillingness to engage in any job involving sales prevented him from being considered for jobs with a base pay of $34,000.00 per year with the possibility of increases due to "upsale" bonuses. (TR 63) The vocational counselor also identified stable job markets in the truck driving industry with starting pay at $40,000.00 - $50,000.00 per hour and wages up to $75,000.00 - $90,000.00 per year. (TR 66)

<u>Legal Standard</u>:

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission* (1970) 47 Ill.2d 144, 265 N.E. 2d 129. A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission* (1977) 68 Ill.2d 236, 369 N.E.2d 853. Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission* (4th Dist. 1989) 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794. A claimant has the burden of proving all the elements of the claim in order

to establish a right to compensation. *Greater Peoria Mass Transit District v. Industrial Commission* (1980) 81 Ill.2d 38, 43; 39 Ill.Dec. 817; 405 N.E.2d 796. The burden of the claimant is to prove a compensable injury by a preponderance of credible evidence. *A.M.T.C. of Illinois, Inc. v. Industrial Commission* (1979) 77 Ill.2d. 482, 488; 34 Ill.Dec. 132; 397 N.E.2d 804.

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission* (1982) 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 . The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission* (1983) 98 Ill.2d 20, 455 N.E.2d 86. To argue to the contrary would require that an award be entered or affirmed whenever a claimant testifies to an injury no matter how much his testimony may be contradicted by the evidence, or how evident it may be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission* (1956) 8 Ill.2d 407, 134 N.E. 2d 307. It is not enough that the petitioner is working when an accidental injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission* (1969) 44 Ill.2d 207, 214, 254 N.E.2d 522; see also *Hansel & Gretel Day Care Center v Industrial Commission* (1991) 215 Ill.App.3d 284, 574 N.E.2d 1244.

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission* (1980) 83 Ill.2d 213, 414 N.E.2d 740. In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission* (1986) 141 Ill.App.3d 289, 490 N.E.2d 124. Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See Generally, *Gallentine v. Industrial Commission* (2nd Dist. 1990) 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880, see also *Seiber v Industrial Commission* (1980) 82 Ill.2d 87, 411 N.E.2d 249; *Caterpillar v Industrial Commission* (1978) 73 Ill.2d 311, 383 N.E.2d 220. It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission* (1980) 79 Ill.2d 249, 253, 403 N.E.2d 221, 223; *Hosteny v Workers' Compensation Commission* (2009) 397 Ill.App. 3d 665, 674.

Conclusions of Law:

F.
Was the employee's condition of ill-being causally related to the injury?

The petitioner, a union pipefitter, (TR 11) sustained a small finger injury on February 23, 2020 when a piece of angle iron came loose from a chain vice and struck, and twisted, his right little finger. (Tr. 11, and PX 1 at TR 94) There is no evidence that the petitioner's condition has been aggravated or reinjured since the original accident due to an intervening accident. The Arbitrator concludes that the petitioner's physical condition of ill-being is causally related to the stipulated accident.

The injury resulted in a permanent restriction to the petitioner's right little finger that prevents him from returning to work as a union pipefitter. The petitioner, by virtue of the Apex FCE, has a medium / heavy work restriction. (TR 94, PX 7, pg. 4) The pipefitter position is defined in the Dictionary of Occupational Titles as being in the heavy physical demand level. (TR 94, PX 7, pg. 5) The job description of the respondent is described as requiring lifting and carrying up to 50 pounds. (TR 94, PX 7, pg 5)

The Arbitrator concludes that the petitioner's condition of being unable to return to his customary occupation is causally related to the accident and the subsequently related surgeries to repair the damage.

K.
What temporary benefits (Maintenance / TTD) are in dispute?

The petitioner claims (See Arbitrator Exhibit 1) to be entitled to maintenance for from March 14, 2018 through April 8, 2018 as well as from November 4, 2019 though the date of Arbitration, February 24, 2020. These dates amount to 19 5/7 weeks.

As an alternative, the petitioner clarified in the transcript (TR 7 – 8) that the petitioner was seeking maintenance from March 14, 2018 through November 3, 2019. These dates amount to 85 4/7 weeks.

The petitioner also states in the record that he seeks wage differential for the dates of November 4, 2019 through November 6, 2019. The petitioner presumably seeks wage differential also from November 6, 2019 when he started at Panera Bread, through the date of Arbitration, and ongoing until age 67.

Respondent denies that petitioner was either temporarily and totally disabled or entitled to maintenance during these dates. The respondent denies the petitioner has met his burden of proving wage differential, however this will be discussed in

the subparagraph below regarding the nature and extent of the petitioner's disability.

To be entitled to TTD, the petitioner must prove by the preponderance of the evidence not only that he was not working, but also that he was unable to work. The petitioner was examined on February 21, 2018 at Apex Physical Therapy and found to be capable of working at the medium / heavy level. Consequently, the petitioner would not be able to prove that he was unable to work after that date and any claim for TTD would fail.

Maintenance is a component of, or incidental to, vocational rehabilitation. (See 820 ILCS 305 § 8(a); See *Euclid Beverage v Illinois Workers' Compensation Commission*, 2019 IL APP (2d) 180090WC; 124 N.E.3d 1027, 429 Ill.Dec. 517, February 25, 2019) "Since maintenance is awarded incidental to vocational rehabilitation, an employer is obligated to pay maintenance only while a claimant is engaged in a prescribed vocational-rehabilitation program." Citing *W.B. Olson, Inc.*, 2012 IL App (1st) 113129WC, 366 Ill.Dec. 960, 981 N.E.2d 25.

There is no evidence that the petitioner was engaged in a prescribed vocational rehabilitation program from March 14, 2018 through April 8, 2018, a time during which the petitioner claims to be entitled to maintenance.

The vocational reports (RX 2, TR 95) of Karen Kane, respondent's rehabilitation expert, confirm that the petitioner had his first vocational meeting on April 29, 2019 and began work for Panera Bread on November 6, 2019 (TR 94, PX 16). During this time, a period of 27 2/7 weeks, the petitioner would have been entitled to maintenance in the amount of $30,443.49.

Once the petitioner obtained employment with Panera he stopped looking for work. The Arbitrator notes that seven vocational reports were issued during the time Karen Kane was working with the petitioner to find alternative employment. The last report is dated December 20, 2019, covering the reporting period from October 27, 2019 through December 20, 2019. This report confirms the petitioner's interview with Panera as of October 31, 2019 and confirms he was to start work on November 4, 2019. (TR95, RX2, report of December 20, 2019 at page 3) Petitioner actually started work with Panera on November 6, 2019.

The report of December 20, 2019 confirms the petitioner was also provided with five job leads on October 29, 2019. There is no evidence the petitioner followed up with these leads. The vocational consultant noted on page 4 that she was provided with no employer contact logs from the petitioner during "this reporting period" (October 27 – December 20, 2019). This evidence was not contradicted or rebutted by the petitioner. The Arbitrator concludes the petitioner stopped his participation in the vocational rehabilitation program once he became employed at Panera on November 6, 2019.

The Arbitrator concludes the petitioner was entitled to maintenance from April 29, 2019 at the time of the initial meeting with the vocational consultant and with his participation ending upon his employment with Panera on November 6, 2019 his entitlement to maintenance ceased as well. Thereafter the petitioner has shown no inclination or effort to become employed at a higher earning level despite the availability of more lucrative positions as will be discussed below.

L.

What was the nature and extent of the injury?

The petitioner complains of loss of grip strength in his right hand and pain in his right little finger. (TR 28 – 29) The petitioner claims he is entitled to wage differential pursuant to Section 8(d)1 of the Act by virtue of his employment at Panera working between nine and twenty-five hours per week at a rate of $9.50 or $9.60 per hour as of the Arbitration date.

The respondent argues that the petitioner has self-limited his employment options, has failed to pursue viable job opportunities at a higher wage, and argues that there is a stable market for the petitioner at a greater earning potential, which market is supported by the testimony and labor market survey of vocational expert Karen Kane.

The Arbitrator agrees with the respondent. While the petitioner has confirmed he cannot return to work as a union pipe fitter based upon medical evidence and the FCE, the petitioner has not proved by a preponderance of the evidence what 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, nor has he established what he is able to earn in some suitable employment after the accident, all as required by Section 8(d)1 of the Act. Petitioner's exhibit 14 provides guidance of what journeymen pipefitters earn per hour as of the time of the Arbitration, but there is no evidence that the petitioner worked, or would be working, 40 hours per week, 52 weeks per year in his fomer employment. In other words, there is insufficient evidence to establish what the petitioner could have earned in the full performance of his duties in his former occupation. Petitioner's exhibit 10 provides a snapshot of the petitioner's earnings during the three weeks prior to the accident in 2016, but no evidence of the hours or weeks of earnings for jobs in 2020.

The stipulation of the parties on the Request for Hearing form is based on Section 10 of the Act, which necessarily excludes the weeks and parts thereof when the petitioner was not working. This does not establish what the petitioner would have been able to earn in the full performance of his duties currently. Section 8(d)1 requires the calculation of the upper and lower brackets of the petitioner's former and current wages to be based on 52 week denominators and not the petitioner's average weekly wage. Had the legislature intended the wage differential to be calculated based upon the petitioner's average weekly wage it

would have included such language in Section 8(d)1. (See *Marion High School v IWCC*, 2019 IL App (5th) 1901142WC-U) The petitioner has failed to provide sufficient evidence for the calculation of either the upper bracket or the lower bracket.

Although there is no evidence that the petitioner is limited in his ability to work full work weeks, his employment at Panera shows his highest number of hours worked to be twenty-five hours per week.

Furthermore, Karen Kane testified had the petitioner engaged in good faith in the vocational program she set forth, and based upon the reasonably stable market available to the petitioner, he could be earning minimally $11.00 per hour full time and up to $40.00 per hour full time. This evidence was not rebutted.

The Arbitrator concludes that the petitioner has purposely limited his employment to an artificially low level that fails to establish what the petitioner is able to earn. The Arbitrator finds the testimony of Karen Kane to be credible. The Arbitrator finds that there is insufficient evidence to establish with reasonable certainty what the petitioner would have been able to earn in the full performance of his former occupation nor is there reasonable certainty to what he is able to earn, except that it is clear he can earn more than $9.50 per hour for 25 hours per week.

The Arbitrator concludes, therefore, that the petitioner has failed to prove by a preponderance of credible evidence that the petitioner has sustained a wage differential under Section 8(d)1 of the Act. The Arbitrator concludes that the evidence supports a finding that the petitioner has sustained injuries that partially incapacitate him from pursuing the duties of his usual and customary line of employment, thereby sustaining a disability under the provisions of Section 8(d)2 of the Act. The Arbitrator finds the petitioner is disabled to the extent of 25% under Section 8(d)2 at the maximum PPD rate of $755.22 .

M.

Should penalties or fees be imposed on the Respondent?

The Arbitrator finds that the petitioner has received those benefits he was entitled to receive during the time he participated in a vocational rehabilitation program. In fact, the petitioner has been overpaid and the respondent is entitled to credit for the overpayment, which credit is recited on page two of the initial pages of the Arbitrator's decision. The respondent has not acted in a vexatious manner. Penalties and fees are 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 WILLIAMSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Shadowens,
Petitioner,

20IWCC0686

vs. NO: 15 WC 33991

The American Coal Co.,
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 disease 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 November 13, 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.

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

DATED: NOV 23 2020
o11/5/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0686

SHADOWENS, ROBERT
Employee/Petitioner

Case# **15WC033991**

THE AMERICAN COAL COMPANY
Employer/Respondent

On 11/13/2019, 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 1.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

6236 CULLEY FEIST KUPPART & TAYLOR
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

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

STATE OF ILLINOIS)
)SS.
COUNTY OF 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

ROBERT SHADOWENS
Employee/Petitioner

Case # 15WC 033991

v.

Consolidated cases: ____

THE AMERICAN COAL COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **August 14, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0686

FINDINGS

On **September 29, 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's average weekly wage was **$852.42**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

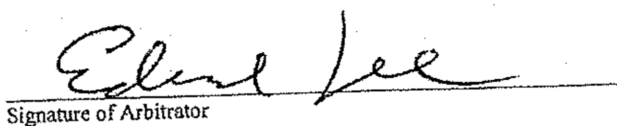
Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

No benefits are awarded.

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

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



Signature of Arbitrator

11/11/19

Date

NOV 13 2019

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FINDINGS OF FACT

The Arbitrator finds:

Petitioner lives in Herrin, Illinois. He was 50 years old at the time of arbitration and was married. Petitioner graduated from high school. Petitioner worked in the coal mines for almost eight years. While working in the mines, he was exposed to coal and rock dust on a daily basis. Petitioner testified that he used a lot of fly ash to fix the roads and that same bothered his breathing.

Petitioner testified that the last day that he worked for Respondent was September 29, 2015, at its Galatia mine. He was 45 years old at that time. Petitioner testified that on March 24, 2015, he was laid off by Respondent. Prior to his layoff in March 2015, his job classification was slope rehab. He testified that he was a welder rebuilding the slope. He testified that the slope was falling in and they were setting beams and welding them in place. On September 29, 2015, he was called back to work at Respondent. On that date he had an altercation with his supervisor. He quit his employment with Respondent on that day because of the altercation. On his last date of employment, he was an equipment operator. He testified that his job duties included operating the road grader. They would haul in fly ash and rock dust and he would have to get the roads looking good. He testified that on September 29, 2015, he was hauling supplies into the longwall. He testified that they did not have a piece of plywood at the air shaft so he could not bring it into the longwall and that is why the altercation took place. He testified that they were very upset because he did not have the plywood that was not there for him to bring in. Petitioner testified that he was exposed to and breathed coal dust on his last day of employment in the mine.

Petitioner testified that after leaving his employment with Respondent, he looked for and found work. The first job he found was a part-time job with Rend Lake Conservancy District. He started there at $9.00 per hour and after approximately a month was bumped to $10.00 per hour. He worked there for approximately six months and then was laid off. After that he found work at Aisin in Marion which is where he was employed at the time of arbitration. The plant where Petitioner works makes bumpers for different vehicles. Petitioner testified that when he started working at Aisin, he earned $9.00 per hour. As of arbitration he was making $15.48 an hour. When he works overtime he makes $23.22 an hour. He testified that Aisin was the best job that he could find at the time. Petitioner testified that he has not been exposed to coal or rock dust since he left Respondent. While at Respondent, he generally worked 40 hours per week. He would work five days a week. While working for Respondent he made approximately $23.00 an hour.

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Petitioner graduated from high school in 1989. He worked at Park Avenue Nursing Home in the kitchen for two years. He then worked at the Kroger deli in Herrin for one year. He worked at Mariah Boat Factory in West Frankfort for eight to nine months. In 1996 he started working for Maytag in Herrin and worked there for approximately 10 years. In that job he loaded small parts on the beltline. After he left Maytag he went to John A. Logan College and obtained his welding certificate. From there he went to work at Respondent in summer 2007. He worked there until he quit on September 29, 2015. In his first job classification for Respondent he shoveled the muck. He testified that he moved it from one crosscut to another with wheelbarrows and shovels. During that time he also set cribs, which were stacked up to hold the top and keep it from falling in. He testified that the cribs weighed up to 30 pounds each. He testified that the props were like telephone poles that were wedged in on top of the cribs to hold up the roof. He testified that it would take two people to pack the props. His next job was on the rock dusting machine. In that job he dusted travel ways, crosscuts, beltlines, returns and anywhere in the coal mine that needed rock dust. He testified that the rock dusting machine is a ram car that has two pods on the back of it that are filled with rock dust. He used a hose to spray everything with rock dust. He testified that same was a very dusty job. His next job was equipment operator where he mostly drove a ram car and sometimes a scoop. The ram car is a piece of machinery with a bed on it used to haul supplies and to haul rock dust and fly ash to fix the roads. Petitioner ran the ram car for approximately four years. Petitioner also worked as a grader operator fixing the roads. He testified that same was a very dusty job. He did this job for approximately two years. Petitioner testified that he considered his jobs in the mine to be heavy manual labor.

Petitioner testified that as of arbitration he had breathing problems. He testified that he had breathing problems four to five years into his mining career. Petitioner testified that as of arbitration walking any distance or walking down stairs he could definitely tell he had breathing problems. He testified that while working in the mines he noticed a problem with his breathing while packing crib ties and getting in and out of his ram car. He described his breathing problems as moderate. Petitioner testified that at normal pace he could walk three or four blocks before he noticed a change in his breathing. Petitioner testified that when he saw Dr. Istanbouly he could walk half a mile but that has changed. Petitioner testified that he could climb a flight of stairs before he became short of breath. From the onset of his breathing problems to the time of arbitration they have stayed about the same.

Petitioner was not taking any breathing medication and was not on oxygen. Petitioner testified that his breathing problems affect his activities of daily life such as getting out and doing things like hunting and fishing. He testified that he gets out of breath if he has to walk a certain distance. He testified that his breathing problems have not stopped him from doing the activities, but they have definitely slowed him down. Petitioner testified that while working in the mines at times he would have to stop and take

a break because of shortness of breath. Petitioner testified that his treating physician is Dr. Parks at Logan Primary Care. He testified that he usually sees the PA, Micah Oakley. Petitioner testified that he has talked to Mr. Oakley about his breathing problems and about working in the coal mine in the dust.

Petitioner testified that he has never had a desk job. He testified that he is not very good at using a computer. Petitioner testified that he has never done anything other than manual labor.

Petitioner testified that he was not currently smoking. He testified that he used to smoke. He started in high school. He testified that he quit for eight years and then picked up the habit again and smoked for another two years. He testified that he quit completely in 2006. He testified that when he smoked, he would smoke maybe a half a pack per day. Petitioner testified that in addition to his breathing problems, he has had a lot of problems with kidney stones. Petitioner testified that he had recently had a knee replacement. He could not recall any other health problems.

On cross examination Petitioner testified that he was recalled to work on September 28, 2015, and worked a full day. He went to work the next day on September 29, which was when he had the altercation. Petitioner could not recall the name of his supervisor with whom he got in the altercation. Petitioner testified that the plywood he was to deliver was on his list but it was not at the air shaft. He testified that was the only thing that he did not get. He testified that he and his supervisor had words. He left that day about half way through his shift. Petitioner testified that the particular mine where he was working subsequently closed. Petitioner testified that Respondent had two mines where he worked. Both of those mines are closed now.

Petitioner testified that when he started working at Aisin it was through a temporary agency, Staff Quick. He had a three month probationary period and then Aisin hired him. Petitioner testified that at Aisin he loads different bumpers into totes to be shipped to the different factories. Petitioner's job at Aisin involves a lot of lifting. He works eight hours a day, five days a week. Petitioner testified that he was honest with Dr. Istanbouly regarding the problems he was having. Petitioner testified that he has always been honest with his treating physician and PA regarding the symptoms he had and whatever problems he was having.

Petitioner testified that he hunts. He testified that he has slowed down a bit but hunts mostly turkey and duck and some deer. He testified that he turkey hunted in spring 2019. He testified that it has been several years since he deer hunted. Petitioner testified that he spends as much time as he can with his family just hanging out and getting things done around the house. His son plays football and goes to his son's activities and things of that nature.

Dr. Suhail Istanbouly examined Petitioner on January 21, 2016, at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 7). Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. (Petitioner's Exhibit No. 1, p. 5). 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 of Herrin Hospital since approximately 2005. (Petitioner's Exhibit No. 1, p. 6). Dr. Istanbouly performs five to seven examinations such as that performed on Petitioner every month. Those exams are always at the request of a claimant's attorney. (Petitioner's Exhibit No. 1, p. 17).

Dr. Istanbouly noted that Petitioner was a coal miner for seven years and was laid off in April 2015. Petitioner worked as ram car operator underground. Dr. Istanbouly testified that said job included significant coal dust exposure. Petitioner reported smoking in the past on and off for a total of 10 to 12 years, half a pack a day. Petitioner mentioned coughing on a daily basis as a coal miner and the cough was productive of mild dark sputum, but on the day of Dr. Istanbouly's evaluation Petitioner reported the cough had improved and at that time was intermittent. Petitioner mentioned mild exertional dyspnea and was able to walk for half a mile without any breathing problems. Petitioner reported frequent episodes of heartburn. (Petitioner's Exhibit No. 1, p. 8).

Physical examination of Petitioner's chest was within normal limits. (Petitioner's Exhibit No. 1, p. 9). Dr. Istanbouly performed pulmonary function testing which was within normal limits. Dr. Istanbouly testified that having pulmonary function studies within the range of normal does not mean the lungs have not been damaged. He testified that there can be damage, but the damage is not significant enough to be revealed on pulmonary function testing. (Petitioner's Exhibit No. 1, p. 10). Dr. Istanbouly reviewed the chest x-ray taken on August 18, 2015. He testified that the chest x-ray he reviewed was of diagnostic quality. (Petitioner's Exhibit No. 1, p. 11). Dr. Istanbouly's findings on the chest x-ray included mild bilateral interstitial changes consistent with simple coal workers' pneumoconiosis. (Petitioner's Exhibit No. 1, pp. 11-12). Dr. Istanbouly testified that he reads five to ten chest x-rays per day. (Petitioner's Exhibit No. 1, p. 13). Dr. Istanbouly testified that Petitioner had coal workers' pneumoconiosis which was caused by his long term coal dust inhalation. (Petitioner's Exhibit No. 1, p. 13).

Dr. Istanbouly described coal workers' pneumoconiosis as fine particles being inhaled into the deep parts of the airways ending in the alveoli creating a local irritation or inflammation that ends up with tiny scars which are seen as small, round opacities on the x-ray. The tiny scars replace the normal lung tissue and affect the gas exchange to the vascular parenchymal barrier. (Petitioner's Exhibit No. 1, pp. 13-14). The scarring and fibrosis of coal workers' pneumoconiosis are permanent. By definition, if one has coal

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workers' pneumoconiosis, he has impairment of the function of his lungs at least at the site of the scar or fibrosis. (Petitioner's Exhibit No. 1, pp. 14-15).

Dr. Istanbouly testified that Petitioner had clinically significant pulmonary impairment based on his intermittent cough and wheezing. (Petitioner's Exhibit No. 1, p. 15). He testified that it was medically advisable for Petitioner to avoid any further coal dust inhalation to prevent the progression of his underlying pulmonary disease. He testified that Petitioner could not have additional exposure to coal dust without endangering his health. (Petitioner's Exhibit No. 1, pp. 15-16).

Petitioner denied chronic daily cough when seen by Dr. Istanbouly. His cough was mostly dry. Petitioner had no significant exertional dyspnea and provided no past history of respiratory disease. (Petitioner's Exhibit No. 1, p. 18). At the time of Dr. Istanbouly's examination, Petitioner was taking hydrocodone, acetaminophen for pain. He was taking Xanax which would be for anxiety and Amoxicillin which would be an antibiotic which was temporary for an infection. (Petitioner's Exhibit No. 1, pp. 18-19). Petitioner was not taking any breathing medications. He did not relate to Dr. Istanbouly a past history of having taken breathing medications. Dr. Istanbouly did not review any treatment records regarding Petitioner. (Petitioner's Exhibit No. 1, p. 19).

Dr. Istanbouly testified that based on the spirometry performed on Petitioner, there was no indication of a restriction or obstruction in Petitioner. (Petitioner's Exhibit No. 1, pp. 19-20). Petitioner did not tell Dr. Istanbouly that he left work at the mine at the time he did due to respiratory disease or symptoms. Petitioner advised Dr. Istanbouly that he left the mine because he was laid off. Petitioner did not tell Dr. Istanbouly that he had difficulty in physically performing the last job that he had in the coal mine. (Petitioner's Exhibit No. 1, p. 20).

Dr. Istanbouly was provided with Dr. Smith's interpretation of the August 18, 2015, chest x-ray. He was provided no other interpretations of Petitioner's chest imaging. (Petitioner's Exhibit No. 1, p. 21). Dr. Istanbouly testified that he does not use the standard ILO films in his interpretation of the chest x-rays for black lung. Dr. Istanbouly testified that he is neither an A or a B-reader. He does not provide profusion ratings on the films he interprets for black lung. (Petitioner's Exhibit No. 1, pp. 21-22). Dr. Istanbouly testified that when he interprets a film for black lung, he determines whether it is present or not and if present, he characterizes what he sees as early, moderate or severe. He classified Petitioner's film as early. Dr. Istanbouly testified that he could not say whether Petitioner's chest x-ray revealed a 1/0 or a 0/1 profusion. Dr. Istanbouly's sole diagnosis for Petitioner was simple pneumoconiosis. (Petitioner's Exhibit No. 1, p. 22).

Dr. Henry K. Smith is a diagnostic radiologist. (Petitioner's Exhibit No. 2, p. 4). Dr. Smith has been board certified in radiology since 1973. He first took the B-reader

exam in 1987 and has been continually certified as a B-reader since that time. (Petitioner's Exhibit No. 2, p. 11). Dr. Smith testified that he failed the B-reading recertification exam twice somewhere around 1999. He testified that he failed because of overreading the films. He testified that he was finding more disease than was present on the standard film. (Petitioner's Exhibit No. 2, pp. 49-50). Dr. Smith received his Doctor of Osteopathic Medicine in 1968 from Kirksville College of Osteopathic Medicine. (Petitioner's Exhibit No. 2, p. 7, Deposition Exhibit 1). Dr. Smith received a D.O., not a M.D. (Petitioner's Exhibit No. 2, p. 44). Dr. Smith did a rotating general internship at Carson City Hospital in Carson City, Michigan and a radiology residency at Memorial Osteopathic Hospital in York, Pennsylvania. (Petitioner's Exhibit No. 2, Deposition Exhibit 1). Dr. Smith operated his own private radiology practice from 1988 to 2016. Since closing his practice he has been doing consulting work in the field of radiology including a lot of B-readings. (Petitioner's Exhibit No. 2, pp. 10-11).

Dr. Smith testified that in performing a B-reading, he starts with determining the quality of the film. The next step is to determine if there are any small opacities present. If opacities are present, he determines if there are enough to be called pneumoconiosis. If so, then he determines whether they are round or linear opacities and categorizes them by size. (Petitioner's Exhibit No. 2, pp. 20-21). Dr. Smith testified that with coal workers' pneumoconiosis, the preponderance of small opacities are round. He testified that with other kinds of pneumoconiosis, such as asbestos related, they are linear or irregular opacities. In coal workers' pneumoconiosis opacities occur primarily in the upper to mid lung zones. With asbestos, it predominantly occurs in the mid to lower lung zones. (Petitioner's Exhibit No. 2, pp. 21-22). The next thing the B-reader considers is the profusion which is the concentration or density of the findings in the lungs. (Petitioner's Exhibit No. 2, p. 22). Dr. Smith testified that the profusion tells the reader what degree of involvement is present. (Petitioner's Exhibit No. 2, p. 23). Dr. Smith testified that the last thing included in completing the B-reading form is the obligatory findings which are things that need to be recorded other than the findings of black lung. (Petitioner's Exhibit No. 2, p. 25). Dr. Smith described an opacity as a small, abnormal density that one would not see on a normal chest x-ray. It is often seen with people that have occupational lung disease or pneumoconioses. (Petitioner's Exhibit No. 2, pp. 28-29). Dr. Smith testified that mottle on a film is a pixely type of look. Dr. Smith testified that it may look like there is disease there but the reader is getting a false sense of there being opacities present because of the mottled appearance. (Petitioner's Exhibit No. 2, p. 28).

Dr. Smith reviewed two chest x-rays and a chest CT scan of Petitioner at the request of Petitioner's counsel. (Petitioner's Exhibit No. 2, p. 35). Dr. Smith testified that the November 16, 2010, chest x-ray was quality 1, and he did not note any mottle or underexposure on the film. Dr. Smith interpreted the film as having small opacities size P/S in all lung zones, profusion 1/0. (Petitioner's Exhibit No. 2, p. 35-36). Dr. Smith testified that the November 16, 2010, CT scan had findings which were consistent with

type P radiographic pneumoconiosis. He testified that they were between a 1/0 and 1/1 profusion. He testified that he also found focal emphysema on the CT scan. (Petitioner's Exhibit No. 2, pp. 37-38). Dr. Smith found the August 18, 2015, chest x-ray to be quality 1. He did not note any mottle or underinflation. He interpreted the film as having small opacities size P/S in all lungs with a profusion of 1/0. (Petitioner's Exhibit No. 2, p. 39). Dr. Smith testified that Petitioner's chest x-rays and CT scan were consistent with the diagnosis of coal workers' pneumoconiosis and the opacities he saw on the chest x-rays and CT scan would be consistent with damage to Petitioner's lung because of pneumoconiosis. (Petitioner's Exhibit No. 2, pp. 36, 38-40).

From 1988 to 2016, Smith Radiology was a freestanding diagnostic, walk-in medical facility. (Petitioner's Exhibit No. 2, p. 53). Dr. Smith testified that Smith Radiology was netting $1.25 million in annual income after expenses. He testified that of that income maybe 5% was for medical legal exams or interpretations. (Petitioner's Exhibit No. 2, p. 54). Dr. Smith testified that over time he interpreted chest x-rays for black lung for over 20 different law firms. He testified that 80% of those firms represented claimants. (Petitioner's Exhibit No. 2, p. 55). Dr. Smith testified that presently he is reviewing films for black lung for five firms that represent claimants. Dr. Smith testified that one of those firms is Petitioner's counsel. He has also reviewed films for Culley & Wissore. He testified that he has read more than 345 films for Culley & Wissore or Petitioner's counsel. (Petitioner's Exhibit No. 2, pp. 56-58). Dr. Smith testified that when he received films from Culley & Wissore, he would get two or three films at a time on a frequency of twice a month. He might receive a tiny bit more than that from Petitioner's counsel. (Petitioner's Exhibit No. 2, pp. 59-60). The medical/legal interpretations he is performing at this time are primarily for the claimant. (Petitioner's Exhibit No. 2, p. 57). Dr. Smith testified that at his peak he was interpreting 2,000 films a year for law firms. Presently he is interpreting about 1,500 films a year. (Petitioner's Exhibit No. 2, pp. 60-61).

Dr. Smith has never sat on any committee with NIOSH. Dr. Smith has not held any office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. (Petitioner's Exhibit No. 2, p. 63). Dr. Smith testified that the syllabus he uses to study for the B-reading exam he pretty much takes as gospel. He testified that the panel that puts that together are the peers that he aspires to be. He testified that the leaders in the field have been chosen to put that syllabus together. Dr. Smith testified that a new syllabus has been authored by NIOSH and that Dr. Cris Meyer was one of the authors of that syllabus. Dr. Smith testified that he agrees with the current B-reading syllabus that small opacities associated with the exposure to silica and coal dust are usually rounded. (Petitioner's Exhibit No. 2, pp. 64-65). Dr. Smith agreed with the B-reading syllabus that the small rounded opacities usually involve the upper lung zones first and as the dust exposure continues, all the lung zones may become involved. He testified that has been his experience. (Petitioner's Exhibit No. 2, p. 68).

Dr. Smith testified that simple pneumoconiosis is unlikely to progress once the exposure ceases. (Petitioner's Exhibit No. 2, pp. 68-69). Dr. Smith testified that pulmonary impairment is determined by appropriate valid pulmonary function testing and not by chest x-ray. (Petitioner's Exhibit No. 2, p. 69). Dr. Smith testified that when he was deliberating, he considered the films he interpreted of Petitioner as negative for pneumoconiosis. He testified that there was no lower profusion rating those films could have been given and still be positive for pneumoconiosis. (Petitioner's Exhibit No. 2, p. 71).

Dr. Smith did not know whether the monitors he uses for interpreting chest x-rays meet the guidelines that are set forth in the Code of Federal Regulations. He did not know whether the equipment complied with the DICOM standard that is set forth in the Code of Federal Regulations. (Petitioner's Exhibit No. 2, pp. 70-71).

Dr. Cristopher Meyer reviewed a PA chest radiograph from Ferrell Hospital dated August 18, 2015, and a chest CT scan from Herrin Hospital dated November 16, 2010. Dr. Meyer testified that the chest x-ray was quality 2 due to underinflation and some minor mottle. He testified that it was an adequate CT examination, but they do not get judged on the same quality parameters as chest x-rays. (Respondent's Exhibit No. 1, p. 41). Dr. Meyer testified that the chest radiograph demonstrated low lung volumes with some crowding of the vessels at the lung bases. There were no small round or small irregular opacities. He testified that there were no findings of coal workers' pneumoconiosis. Dr. Meyer testified that the CT demonstrated clear lungs with minimal linear lingual scarring. Dr. Meyer testified that the CT showed no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, p. 42).

Dr. Meyer testified that it is important to know the quality of the film described by the interpreter so that it is known whether he or she took that into consideration in interpreting the film. He testified that there are some very specific types of quality that impact the B-reading interpretation and those are actually called out on the B-reading form. When the lung volumes are low, the normal vessels are crowded in the lungs which can simulate small opacities although typically simulating small irregular opacities. He testified that the other quality component in Petitioner's film was mottle. Dr. Meyer testified that mottle is essentially image noise. It makes the image look grainy and the mottle can be mistaken for small opacities of size P. (Respondent's Exhibit No. 1, p. 43). Dr. Meyer testified that in the B-reader course and the exam taken to be certified as the B-reader, the physician is actually taught and tested on his ability to interpret film quality. (Respondent's Exhibit No. 1, pp. 43-44).

Dr. Meyer has been board certified in radiology since 1992. (Respondent's Exhibit No. 1, p. 8). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit

No. 1, pp. 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the teaching course which is called the B-reader program. (Respondent's Exhibit No. 1, pp. 21-23). Dr. Meyer has recently been asked to have a more 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 and submitting cases for the B-reader training module and exam. (Respondent's Exhibit No. 1, p. 33). 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 the distinction between a 0/1 and 1/0 film. (Respondent's Exhibit No. 1, pp. 35-36).

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. Dr. Meyer testified that the faculty is typically experienced senior level B-readers. Typically after one takes the course, he then takes the B-reading exam. (Respondent's Exhibit No. 1, pp. 33-34). Dr. Meyer testified that the certifying exam is six hours long with 120 chest x-rays to be characterized. The pass rate of the examination runs roughly 60%. (Respondent's Exhibit No. 1, p. 35).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or linear opacities and based on the size and appearance of those small opacities they are given a letter score. (Petitioner's Exhibit No. 1, p. 23). 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 No. 1, p. 29). 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 No. 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 No. 1, p. 31).

At the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and chest x-ray regarding Petitioner. (Respondent's Exhibit No. 2, p. 21). Dr. Castle is a pulmonologist and is board certified in internal medicine and in the subspecialty of pulmonary disease. (Respondent's Exhibit No. 2, p. 4). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest

disease which encompassed critical care medicine. (Respondent's Exhibit No. 2, p. 7). Dr. Castle's practice included treating patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 8). Dr. Castle was continuously certified as a B-reader from 1985 through June 30, 2017. (Respondent's Exhibit No. 2, p. 14).

Dr. Castle reviewed a chest x-ray of Petitioner taken at Ferrell Hospital on August 18, 2015. Dr. Castle testified that there were no findings of coal workers' pneumoconiosis on this chest x-ray. (Respondent's Exhibit No. 2, p. 51). Dr. Castle testified that to do a proper B-reading, one needs to compare the subject film to the standard ILO films. He testified that the first thing that goes on the form is the name of the patient and the quality of the film. The next question to be answered is whether or not there are any findings consistent with pneumoconiosis. (Respondent's Exhibit No. 2, pp. 51-52). Dr. Castle testified that if there are findings consistent with pneumoconiosis, then the reader classifies those findings using the standard films as either P, Q and R or S, T and U or some combination thereof. Once those are categorized, then the reader would list the areas where he finds those changes. Next the reader looks for any large opacities or pleural changes. The last section the reader marks is the obligatory findings which indicates such things as cancer, bullae, emphysema and various things that are important that should be noted by the person doing the reading. As part of the interpretation the profusion is also indicated. Dr. Castle testified that profusion is the measure of the amount of opacities in any given area and this is done by comparing the subject film to the standard ILO films. (Respondent's Exhibit No. 2, pp. 52-53). He testified that 1/0 profusion is the minimal amount necessary to make a diagnosis of pneumoconiosis radiographically. (Respondent's Exhibit No. 2, p. 53).

Dr. Castle testified that it is not very likely for simple pneumoconiosis to progress once the exposure ceases. (Respondent's Exhibit No. 2, p. 54). Dr. Castle concluded based upon his review of the data that he had, that Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure while working in the coal mines. Dr. Castle testified that he assumed Petitioner's exposure history was sufficient enough to have possibly caused him to develop coal workers' pneumoconiosis if he were a susceptible host, however, the occupational history was somewhat limited in the data set which he reviewed. (Respondent's Exhibit 2, pp. 54-55). Dr. Castle testified that another risk factor for the development of pulmonary disease is that of bronchial asthma. He testified that Petitioner's primary care physician indicated that he had the diagnosis of asthma. On one occasion it was noted that Petitioner indicated he had asthma as a child. Dr. Castle, however, noted that there were no documented episodes of periodic shortness of breath associated with wheezing. Only one physical examination indicated the presence of wheezing and this was felt to be due to an acute infection or bronchitis. Dr. Castle testified that there was no apparent justification in the records for a diagnosis of bronchial asthma. (Respondent's Exhibit No. 2, p. 56). Dr.

Castle testified that obesity is a risk factor for the development of pulmonary symptoms and disease. Petitioner had an elevated BMI on several occasions. (Respondent's Exhibit No. 2, pp. 56-57).

Dr. Castle testified that Petitioner developed evidence of transient "faint" nodularity present on a chest x-ray on two different occasions. These findings were followed up with repeat CT scans of the chest and on both occasions the CT scans completely cleared and there was no residual finding of any nodularity. He was treated for an infectious process on both occasions. Dr. Castle testified that the fact that Petitioner had resolution of the nodules clearly indicated that they were not related to a permanent irreversible process such as coal workers' pneumoconiosis. These findings were clearly due to a transient process, most likely an atypical infection. Dr. Castle testified that Petitioner did not have radiographic evidence indicating the presence of coal workers' pneumoconiosis or a coal mine dust induced lung disease. (Respondent's Exhibit No. 2, pp. 57-58). Dr. Castle testified that Petitioner had a pulmonary function study obtained when he was referred to a pulmonologist because of the abnormalities found on chest x-ray which proved to be an infectious process. That study was interpreted by the pulmonologist as showing very mild airway obstruction. Dr. Castle testified that there were no tracings or data printout with which to validate this study so it was not used for evaluation. He testified that this study done as part of a screening evaluation for pre-employment was invalid because of less than maximal effort during the forced vital capacity maneuver. He testified that despite the fact that the study was invalid, Petitioner had normal physiologic function. Dr. Castle testified that the study obtained by Dr. Istanbouly in 2016 was valid and was a totally normal study. Petitioner had no evidence of any obstruction or restriction. (Respondent's Exhibit No. 2, pp. 58-59). Dr. Castle concluded that Petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. (Respondent's Exhibit No. 2, pp. 59-60).

Dr. Castle described coal workers' pneumoconiosis as a chronic dust disease brought about by the inhalation of coal mine dust over a period of working in or around the coal mines. He testified that it is manifested by the presence of an abnormal chest x-ray with small, round regular-type opacities primarily in the upper lung zones but depending upon the severity may involve the middle and occasionally the lower lung zones. The disease may or may not be symptomatic. (Respondent's Exhibit No. 2, pp. 62-63). Coal workers' pneumoconiosis is a type of interstitial lung disease. Along with that disease process there is scarring and fibrosis that can occur in the lungs. (Respondent's Exhibit No. 2, p. 63). Dr. Castle testified that the scar tissue cannot carry on the function of normal healthy lung tissue. (Respondent's Exhibit No. 2, pp. 63-64). Dr. Castle testified that the scarring and fibrosis that occurs with pneumoconiosis is permanent and irreversible. (Respondent's Exhibit No. 2, pp. 64-65).

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Dr. Castle testified that on the pulmonary function study of March 10, 2010, Petitioner was diagnosed with having a mild obstructive defect without response to bronchodilators. That study was done a few days after he was diagnosed with or treated for a pneumonia. The study was done again. Dr. Castle testified that there were not any tracings from that study either, but it was noted that Petitioner "passed." (Respondent's Exhibit No. 2, p. 89). Dr. Castle testified that Section 5.4b of the *AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition*, contains a statement regarding the efficacy of chest imaging being used for the purpose of impairment. Dr. Castle testified that he agreed with the statement in that section that chest x-rays correlate poorly with physiologic measurements of impairment. He testified that is why the major societies like the American Thoracic Society and the European Respiratory Society all recommend that impairment be defined by physiological studies, not x-rays. He testified that chest x-ray findings are not a factor in determination of impairment under the *AMA Guides*. (Respondent's Exhibit No. 2, p. 96). Dr. Castle testified that if the *AMA Guides* Table 5-4 are applied to the results from Petitioner's pulmonary function testing, he would fall in Class 0 impairment. (Respondent's Exhibit No. 2, pp. 50-51).

Medical records of Alexander Family Practice were admitted into evidence. On August 19, 2008, Petitioner was seen for pre-employment physical. At that time it was indicated that Petitioner did not smoke. Physical examination was normal, including respiratory. (Respondent's Exhibit No. 3, pp. 19-22). On August 22, 2008, spirometry was performed, which showed an FVC of 5.41, 97% of predicted; FEV1 of 3.82, 82% of predicted; and a FEV1/FVC ratio of 71%. This was marked as normal spirometry. Chest x-ray was also taken at that time, which was negative with classification 0/0. Petitioner was marked as being fully able to work. (Respondent's Exhibit No. 3, pp. 12-16). On May 9, 2014, Petitioner was seen with a chief complaint of work comp related low back pain. Petitioner received pain medications. (Respondent's Exhibit No. 3, pp. 7-9). On May 14, 2014, Petitioner was seen for a recheck of the back injury. He stated he was feeling better and was ready to go back to work full duty. (Respondent's Exhibit No. 3, pp. 3-6).

Medical records of Herrin Hospital were admitted into evidence. On June 15, 2000, Petitioner was seen with a sudden onset of flank pain. Petitioner had no other chronic health problems. Physical examination of the chest showed the lungs were clear to auscultation with normal breath sounds present in all fields. (Respondent's Exhibit No. 5, pp. 468-475). On June 16, 2000, Petitioner returned with left ureteral colic. Physical examination of the lungs was unremarkable. (Respondent's Exhibit No. 5, pp. 454-457). On July 3, 2003, Petitioner was seen complaining of headaches and sinusitis. (Respondent's Exhibit No. 5, pp. 447-448). On September 8, 2004, Petitioner was complaining of severe left flank pain. Review of systems cardiorespiratory was negative and physical examination of the chest continued to show the lungs were clear to auscultation and percussion. (Respondent's Exhibit No. 5, pp. 430-431). On September

23, 2006, Petitioner was seen for cough and congestion for the past two weeks. He denied productive sputum. Oxygen saturation was 97%. At that time, it was noted Petitioner was a smoker, smoking a half a pack of cigarettes per day. Review of systems respiratory was positive for cough, but negative for dyspnea, wheezing or sputum. Physical examination of the chest showed rales on the left side. Initial impression was cough with the potential of pneumonia. Final diagnoses were left otitis media and pneumonia. On September 25, 2006, a chest x-ray was done for history of shortness of breath and pneumonia. The impression was unremarkable. (Respondent's Exhibit No. 5, pp. 416-420).

On July 3, 2008, Petitioner was admitted to the hospital with extreme pain in the left foot and leg. Petitioner also complained of bilateral chest pain at the low rib area which was described as positional. CT of the sinuses was done without contrast, which showed no evidence of sinusitis. (Respondent's Exhibit No. 5, pp. 351-352). While in the hospital, on July 6, 2008, Petitioner denied any chronic cough, hemoptysis or snoring. Physical examination of the chest at that time showed breath sounds that were diminished in both bases but no crackles or wheezing. There was some increased dullness in the left base, but that was not shifting. EKG was done at that time, which showed normal sinus rhythm. The impression showed Petitioner as an ex-smoker and pulmonary nodules on CT, which were small and non-specific. (Respondent's Exhibit No. 5, pp. 353-355). Petitioner was discharged on July 8, 2008. Review of systems pulmonary was negative. Physical examination of the chest showed the lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales. There were normal inspiratory and expiratory phases. (Respondent's Exhibit No. 5, p. 349). On July 9, 2008, Petitioner returned for pain on the left side. He described the pain as sharp and intermittent for the past day. He had no respiratory complaints. Physical examination respiratory was negative. Final diagnosis was nephrolithiasis. CT of the pelvis and abdomen were done without contrast for the flank pain. This showed lung base abnormalities including left posterior base nodule measuring 1.8 centimeter and suggestion of a smaller developing nodule in the anterior left base. (Respondent's Exhibit No. 5, pp. 336-346). On July 15, 2008, Petitioner had chest x-ray for history of the pulmonary nodules by CT and left pleural effusion. The impression was few scattered bilateral basilar densities, which could be secondary to pulmonary nodule seen by CT and there were no acute infiltrates. (Respondent's Exhibit No. 5, p. 327).

On July 24, 2008, Petitioner underwent a PET/CT scan from the skull to the mid-thigh for a history of lung cancer. The impression showed hyperactive focus in the left parapharyngeal space. Direct visualization was recommended. There were a few mildly hyperreactive nodular densities in both lung fields. (Respondent's Exhibit No. 5, pp. 323-324). On September 5, 2008, Petitioner underwent a CT of the chest with contrast for follow up of the pulmonary nodules. The impression showed a normal CT of the chest. The previously-seen nodules were likely due to infectious or inflammatory process. There

were no nodules on the current study. (Respondent's Exhibit No. 5, p. 316). On November 13, 2008, Petitioner underwent another PET/CT scan from the skull to the mid-thigh for history of pharyngeal lesion. The impression showed there was symmetrically increased metabolic activity in the parapharyngeal space. It was suggested this could be inflammatory. The previously noted nodular densities in the lung fields were no longer present. (Respondent's Exhibit No. 5, pp. 311-312). On March 22, 2009, Petitioner was seen with a complaint of stomach cramps. Review of systems respiratory was negative. Physical examination respiratory was also negative. CT of the pelvis and abdomen showed the chest was clear at the lung bases. (Respondent's Exhibit No. 5, pp. 299-302). On January 4, 2010, Petitioner was again seen with lower abdominal pain. Review of systems respiratory was negative and physical examination respiratory was also negative. (Respondent's Exhibit No. 5, pp. 281-284). On January 6, 2010, Petitioner was seen for management of kidney stones. It was indicated that he no longer smoked. On review of systems respiratory he denied any shortness of breath, cough or wheezing. On physical examination of the chest the lung bases were clear to auscultation, with a normal chest wall movement and no wheezing, rhonchi or rales. (Respondent's Exhibit No. 5, pp. 256-258).

On February 25, 2010, a CT of the chest without contrast was done due to a history of shortness of breath. The impression showed nodular infiltrates present in the right lung and the findings were suspicious for an atypical infectious process. (Respondent's Exhibit No. 5, p. 248). On March 10, 2010, Petitioner underwent spirometry testing. Pre-bronchodilator FEV1 was 4.42, 98% of predicted; FVC was 6.42, 117% of predicted; and the FEV1/FVC ratio was 68%. Post-bronchodilator FEV1 was 4.61, 102% of predicted; FVC was 6.18, 112% of predicted. TLC was 8.66, 116% of predicted; RV was 2.24, 103% of predicted; and DLCO was 34.96, 115% of predicted. The conclusion of Dr. Istanbouly was mild obstructive defect with no good response to bronchodilator treatment. There was no restrictive defect and there was normal gas diffusion capacity. (Respondent's Exhibit No. 5, pp. 235-240). On November 16, 2010, Petitioner underwent a CT of the chest with contrast due to a history of neoplasm of unspecific nature. The impression showed the previously-noted subtle nodular infiltrates in the right lung had resolved in the interval. (Respondent's Exhibit No. 5, p. 174). On February 8, 2011, Petitioner underwent CT of the chest for shortness of breath. The impression was no evidence of acute pulmonary embolism. (Respondent's Exhibit No. 5, p. 164). On May 18, 2013, review of systems respiratory was negative. Physical examination respiratory was also marked as negative. (Respondent's Exhibit No. 5, p. 113). On January 16, 2016, Petitioner was seen with complaints of upper respiratory infection and sinusitis. SPO2 was 95% at that time. Review of systems respiratory showed he denied dyspnea on exertion, hemoptysis and cough. EKG was done, which showed normal sinus rhythm. Petitioner received antibiotics. CT of the head was done without contrast and compared to an MRI of March 4, 2011, and showed fluid in the right ethmoid sinus, which could indicate acute or chronic sinusitis. (Respondent's Exhibit No. 5, pp. 73-80). On January 21, 2016, spirometry was done, which showed an FEV1 of 4.06, 99.3% of predicted; FVC

of 5.52, 101.1% of predicted and the FEV1/FVC ratio was 73.5%. This was described by Dr. Istanbouly as a normal study. (Respondent's Exhibit No. 5, pp. 43-45).

Medical records of Logan Primary Care were admitted into evidence. On June 4, 2001, Petitioner was seen for a rash. Physical examination of the lungs showed rate and depth were regular and unlabored on auscultation anteriorly and posteriorly and breath sounds were clear without adventitious sounds. (Respondent's Exhibit No. 4, p. 419). On May 30, 2002, Petitioner presented with depression. Physical examination of the chest showed the lungs remained clear to auscultation bilaterally without wheezes, rhonchi or rales. There was no dullness to percussion and there was normal inspiratory and expiratory phases. (Respondent's Exhibit No. 4, p. 408). Physical examination of the chest showed the lungs remained clear to auscultation bilaterally on June 13, 2002, and July 18, 2002. (Respondent's Exhibit No. 4, pp. 406-407). On February 11, 2003, Petitioner was seen for a sinus problem. Physical examination of the chest showed the lungs were clear to auscultation bilaterally with no wheezes, rhonchi or rales. Again, there were normal inspiratory and expiratory phases. Assessment was sinusitis and depression. Petitioner received refills of his medications as well as E-mycin. (Respondent's Exhibit No. 4, p. 403). On June 27, 2003, Petitioner presented with sinus headache for the past few days. He also had sinus pressure. Physical examination of the chest showed the lungs remained clear to auscultation and percussion. (Respondent's Exhibit No. 4, p. 400). On July 1, 2003, Petitioner followed up for headache. Petitioner was currently on an antibiotic and physical examination of the lungs remained clear. Assessment was sinusitis. (Respondent's Exhibit No. 4, p. 399). On October 10, 2003, Petitioner was seen with complaints of upper respiratory infection type symptoms. These included coughing and sneezing. Physical examination of the lungs remained clear to auscultation bilaterally. Petitioner received antibiotics. (Respondent's Exhibit No. 4, p. 391). Lungs remained clear to auscultation with no consolidation on March 16, 2005. (Respondent's Exhibit No. 4, p. 366). On July 11, 2005, Petitioner was noted to smoke approximately one and a half packs of cigarettes per day and wanted help with quitting at that time. (Respondent's Exhibit No. 4, pp. 364-365).

On June 13, 2006, review of systems respiratory was negative. Physical examination of the lungs remained clear to auscultation and percussion without dullness. (Respondent's Exhibit No. 4, pp. 360-361). On September 25, 2006, Petitioner was seen following a diagnosis at the Herrin Hospital ER of "bad pneumonia." He noted chest pain and shortness of breath. Review of systems respiratory was otherwise negative. Physical examination of the chest showed the lungs were clear to auscultation bilaterally without wheezes, rhonchi or rales. There was no dullness to percussion and there were normal inspiratory and expiratory phases. Oxygen saturation was 98% on room air. A chest x-ray was taken at that time, which was unremarkable. Petitioner received Rocephin. (Respondent's Exhibit No. 4, pp. 355-357). On November 3, 2006, Petitioner was seen for sinusitis type symptoms. He continued to smoke a half pack of cigarettes per day.

Physical examination of the lungs showed wheezing bilaterally and the assessment was sinusitis. Petitioner received a Depo-Medrol injection and was instructed to avoid cigarette smoke. (Respondent's Exhibit No. 4, pp. 350-351). On November 29, 2006, it was noted that the medication Albuterol had been added to Petitioner's medication list. On February 14, 2007, assessment included the addition of asthma, without additional notations. (Respondent's Exhibit No. 4, p. 340). On April 28, 2008, Petitioner returned for follow up for asthma. Physical examination of the chest showed the lungs remained clear. (Respondent's Exhibit No. 4, pp. 324-325). On July 5, 2008, a CT of the chest was done due to a history of syncope. The impression was no evidence of pulmonary embolism. Prominent bilateral dependent atelectasis was noted. Also, scattered bilateral indeterminate pulmonary nodules were noted. (Respondent's Exhibit No. 4, pp. 308-309). On July 10, 2008, Petitioner was seen with regard to kidney stones. At this time, he stated that he feels short of breath at times. He thought this was asthma related which he indicated he had had since youth. (Respondent's Exhibit No. 4, pp. 298-302). On July 14, 2008, Petitioner underwent a bone scan due to a history of left lung nodule. This was a normal study. (Respondent's Exhibit No. 4, p. 297). On July 15, 2008, Petitioner was seen for a kidney stone again. Review of systems respiratory was negative and physical examination of the chest showed the lungs were clear to auscultation bilaterally without wheezes, rhonchi or rales. There were normal inspiratory and expiratory phases. A chest x-ray was taken at that time, which showed a few scattered bilateral basilar densities, which could be secondary to the pulmonary nodule seen by CT. No acute infiltrates. (Respondent's Exhibit No. 4, pp. 294-296). On August 18, 2008, Petitioner was seen for cellulitis. Physical examination of the chest showed the lungs were clear to auscultation bilaterally without wheezes or rhonchi. (Respondent's Exhibit No. 4, pp. 282-283).

On March 23, 2009, Petitioner presented for an evaluation of depression, insomnia and anxiety. Physical examination of the chest showed the lungs remained clear. (Respondent's Exhibit No. 4, pp. 255-257). On December 1, 2009, Petitioner was doing well without complaints. Physical examination of the chest showed the lungs were clear. (Respondent's Exhibit No. 4, pp. 237-238).

On December 29, 2009, Petitioner was seen with complaints of expiratory wheezes, cough and congestion with proximal nocturnal dyspnea. Petitioner had no fever but stated he felt ill for the past two days. Physical examination of the chest showed the lungs had mild expiratory wheezes. There were normal inspiratory and expiratory phases. Assessment was acute bronchitis and shift work sleep disorder. (Respondent's Exhibit No. 4, pp. 235-236). On February 22, 2010, Petitioner underwent a chest x-ray due to a history of shortness of breath. This showed no acute cardiopulmonary process. At the time of the exam he did not have any shortness of breath or nausea. He indicated that the shortness of breath occurred with exertion. It was indicated there was no exertional chest pain or cough. Pulse oximetry was 96%. Physical examination of the chest showed the lungs were clear. The assessment was dyspnea. Petitioner received Phenergan and was

referred to Dr. Tazbaz for pulmonary function testing. (Respondent's Exhibit No. 4, pp. 229-233). On February 26, 2010, had no fever but still indicated he had shortness of breath with exertion. There was no cough. Physical examination of the chest continued to show the lungs were clear. Petitioner received prescriptions for Zithromax, Levaquin and a ProAir Inhaler. (Respondent's Exhibit No. 4, pp. 226-227).

On October 6, 2010, review of systems respiratory was negative. Physical examination of the chest showed the lungs were clear. (Respondent's Exhibit No. 4, pp. 206-208). On October 12, 2011, Petitioner indicated he felt his back pain was getting worse. Physical examination of the chest showed the lungs remained clear. (Respondent's Exhibit No. 4, pp. 176-177). On December 16, 2011, Petitioner was seeking pain relief for migraine headaches. He stated that he was also having some shortness of breath. Petitioner indicated at that time he was a nonsmoker and quit smoking approximately five years prior. At the time he was smoking, he smoked one pack per day. Review of systems respiratory was otherwise negative. Physical examination of the chest showed the lungs were clear to auscultation bilaterally without wheezes, rhonchi or rales. Petitioner was given Spiriva Handi-Inhaler and Imitrex. (Respondent's Exhibit No. 4, pp. 169-171). On June 14, 2012, physical examination of the chest showed the lungs remained clear to auscultation. (Respondent's Exhibit No. 4, pp. 154-155). Petitioner had upper respiratory infection type symptoms on September 29, 2012. Physical examination of the lungs remained clear to auscultation and percussion. Assessment was fatigue. (Respondent's Exhibit No. 4, pp. 145-146).

Review of systems respiratory was negative and physical examination of the lungs remained clear on December 3, 2012, and January 7, 2013. (Respondent's Exhibit No. 4, pp. 135-140). On February 13, 2013, Petitioner had complaints of chest congestion and a dry cough. He had no body aches or chills. There was no hemoptysis, shortness of breath, wheezing or chest pain. Physical examination of the chest showed the lungs remained clear. The assessment was pharyngitis. (Respondent's Exhibit No. 4, pp. 127-129). On September 16, 2014, Petitioner complained of right knee pain. Review of systems respiratory was negative and on physical examination of the chest the lungs remained clear. (Respondent's Exhibit No. 4, pp. 107-110). Petitioner was seen on December 15, 2015, with a chief complaint of right elbow pain. Major problems were noted to include asthma as well as his other orthopedic complaints. Review of systems respiratory was negative. Physical examination of the chest showed the lungs were clear to auscultation with no adventitious sounds. Oximetry was 96%. (Respondent's Exhibit No. 4, pp. 72-74). Physical examination of the chest continued to show the lungs were clear to auscultation with no adventitious sounds on January 26, 2016, April 12, 2016, and May 4, 2016. (Respondent's Exhibit No. 4, pp. 63-71). On September 12, 2017, Petitioner returned for left knee pain. Physical examination of the chest showed the lungs remained clear to auscultation with no adventitious sounds. Oxygen saturation was 96%. (Respondent's Exhibit No. 4, pp. 4-6). On October 26, 2017, review of systems

respiratory was negative for cough and shortness of breath. (Respondent's Exhibit No. 4, p. 6). This was also true on March 12, 2018. Physical examination of the chest at that time showed the lungs remained clear to auscultation with no adventitious sounds. (Respondent's Exhibit No. 4, pp. 12-13). On August 27, 2018, Petitioner related that he suffered a low grade fever for the past two days that was associated with body aches and joint pain. Review of systems was otherwise negative. Physical examination of the chest showed the lungs were clear to auscultation with no adventitious sounds. Oxygen saturation was 96%. Assessment was illness of viral etiology. (Respondent's Exhibit No. 4, pp. 16-18). On December 10, 2018, Petitioner denied any cough or shortness of breath. He indicated that he felt fine except for knee pain. Review of systems was negative. Physical examination of the chest remained clear to auscultation with no adventitious sounds. (Respondent's Exhibit No. 4, pp. 18-22). On January 25, 2019, Petitioner was status post left knee total replacement and was doing physical therapy three times a week. SPO2 was 97%. Physical examination pulmonary showed normal effort and normal breath sounds. There was no respiratory distress, wheezing or rales. Diagnoses included osteoarthritis and moderate pain. (Respondent's Exhibit No. 6, pp. 14-16).

CONCLUSIONS OF LAW

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

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

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

Dr. Istanbouly testified that based on his review of Petitioner's chest x-ray, he had coal workers' pneumoconiosis. Dr. Istanbouly's sole diagnosis for Petitioner was coal workers' pneumoconiosis. Dr. Istanbouly could not say whether the x-ray he interpreted had a profusion of 1/0 or 0/1. Dr. Smith interpreted the chest x-rays of November 16, 2010, and August 18, 2015, as positive for pneumoconiosis, profusion 1/0. Dr. Smith also testified that the CT scan of November 16, 2010, had findings which were consistent with type P radiographic pneumoconiosis which was between a 1/0 and 1/1 profusion. He testified that his assigned profusion of the film could not have been lower and the film remain positive for pneumoconiosis. Dr. Meyer and Dr. Castle reviewed the chest x-ray dated August 18, 2015 and interpreted same as negative for pneumoconiosis. Dr. Meyer also reviewed the chest CT scan of November 16, 2010 and testified that same showed no findings of coal workers' pneumoconiosis. Dr. Meyer testified to the training and

examination required to become a B-reader. Dr. Istanbouly has not had that training or passed the examination and is not an A-reader or B-reader. Dr. Smith testified that on the two occasions where he did not pass the B-reading certification exam, he was overreading films meaning that he was finding more disease than was present on a standard film. The diagnosis of coal workers' pneumoconiosis does not appear in Petitioner's treatment records. The Arbitrator finds the x-ray interpretations by Drs. Meyer and Castle to be more credible and persuasive than the interpretations by Drs. Istanbouly and Smith.

Drs. Istanbouly testified that the only diagnosis he made for Petitioner was coal workers' pneumoconiosis. The medical records do contain references to a diagnosis of asthma. The Arbitrator finds that if Petitioner in fact does have asthma, same preexisted his coal mine dust exposure and is not causally related to his coal mine work with Respondent.

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

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

To prove disablement under the Act, Petitioner must show that he suffered an impairment in the function of the body or the event of becoming disabled from earning full wages as a coal miner as a result of an occupational disease. Petitioner must prove that but for his occupational lung disease, he would have continued his coal mining employment. *Dawson v. Workers' Compensation Comm'n*, 382 Ill. App. 3d 581 (5th Dist. 2008). Petitioner testified that he worked for Respondent until he was laid off on March 24, 2015. He was recalled to work for Respondent on September 28, 2015. On September 29, 2015, he got into an altercation with his supervisor regarding supplies. Petitioner quit his job with Respondent on that date and left about halfway through his shift. The evidence in the record reveals that Petitioner voluntarily left his coal mine employment. There was no evidence in the record that any physician took Petitioner off work as a result of an occupational disease. The pulmonary function study performed as part of Dr. Istanbouly's examination was normal. Petitioner had no evidence of any obstruction, restriction or other pulmonary impairment.

Given the Arbitrator's findings on the issues above, the remaining issues in dispute are moot.

Petitioner's claim for 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 MCLEAN	)		☐ Reverse	☐ Second Injury Fund (§8(e)18)
				☐ PTD/Fatal denied
			☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martha Wynn,
Petitioner,

20 IWCC0687

vs.

NO: 17 WC 18490

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 18,2020, 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.

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: NOV 23 2020
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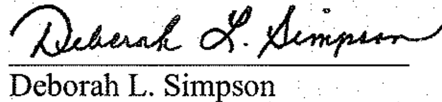
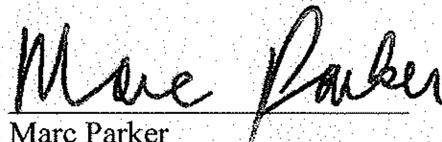
DLS/rm
046


Deborah L. Simpson

Barbara N. Flores


Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0687

WYNN, MARTHA
Employee/Petitioner

Case# **17WC018490**

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

On 3/18/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.30% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
SPRINGFIELD, IL 62704

6079 ASSISTANT ATTORNEY GENERAL
BRADLEY De FREITAS
500 S SECOND ST
SPRINGFIELD, IL 62706

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 18 2020

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0687

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

Martha Wynn
Employee/Petitioner

v.

Illinois Dept. of Human Services
Employer/Respondent

Case # **17** WC **18490**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **January 29, 2020**. 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 __________

20 IWCC0687

FINDINGS

On **June 6, 2017,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Per the stipulation of the parties, Petitioner's earning in the year preceding the injury were **$76,960.00,** the average weekly wage was **$1,480.00**.

On the date of accident, Petitioner was **58** 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 **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

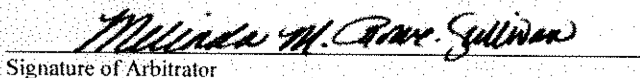
ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

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



Signature of Arbitrator

3/17/2020
Date

ICArbDec p. 2

MAR 18 2020

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Martha Wynn
Employee/Petitioner

Case # **17** WC **18490**

v.

Consolidated cases: N/A

Illinois Dept. of Human Services
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on June 6, 2017, she was employed by Respondent. She testified that on the date of accident, she was leaving the agency that she worked for to go to an agency in Decatur as a manager was administering discipline to an employee who needed a union representative. She testified that she was contacted by a union official to represent the employee at the meeting, and that she was a secretary of Local 674.

Petitioner testified that on the date of the accident while on the way to her meeting, she had to be in Decatur at 10:00 a.m. so she left the office at about 9:00 a.m. She testified that she was heading towards the south of town and was stopped at a red light, that she heard tires squealing, and that her car was hit in the rear end. She testified that she remembered getting out of the car and dialing 9-1-1, and that she walked back to see if the person was okay. She testified that the paramedics came to the scene and that she talked to them, and that all of a sudden she fell down.

When asked which parts of her body she noticed that she was having problems with after the motor vehicle accident, Petitioner responded that she immediately noticed her neck and that she felt faint and went down. She testified that she was taken by ambulance to OSF St. Joseph Medical Center in Bloomington. She testified that she was then referred to Dr. Madagoola, who ordered physical therapy for her neck and low back as well as prescribing a muscle relaxer.

Petitioner testified that she also saw Dr. Shimofinick, a chiropractor, as well as Dr. Naour. She testified that she was provided with chiropractic manipulation and ultrasound for her neck, low back, and right arm. She testified that she had pain down her arm that started sometime after the accident, but was unable to recall when. She further testified that she had constant pain and pain with movement, and that she had numbness in three fingers of her right hand. She testified that she is right-handed.

Petitioner testified that she also went to McLean County Orthopedics. She testified that she was given Gabapentin and was ordered to undergo more physical therapy. When asked what she noticed about her neck during her course of treatment, Petitioner responded that she had constant, sharp pain in the neck and that she underwent an MRI. She testified that her right arm and hand during treatment was numb, and that it was not the whole hand but rather just three of the fingers on the right hand. She testified that as to her low back, she felt sharp pain down her back down to her legs and feet.

Petitioner testified that as to the current condition in her neck, her pain in the neck was much better and that she rarely feels pain. She testified that she gets pain occasionally down her right arm and that her fingers are fine, but that her thumb never healed and is still numb. She testified that she feels pain down her arm a couple of times a week, and that she notices that moving it in certain ways is when she notices it. She testified that she has never regained the strength in her hand. She testified that she used to be able to do housework, but that she is only able to do light housework now. She testified that she pays someone to clean her home. She testified that she is unable to run the vacuum cleaner like she used to. She testified that she is not able to concentrate like she used to, and that her doctor indicated that it may be because she is not sleeping. She testified that she has limited range of motion of her right arm, and that she has to get a massage in order to be flexible. She testified that as to her low back, she only gets inflammation that comes and goes. She testified that she used to be able to sit as long as she wanted, and that now she can no longer sit longer than 20 minutes. She testified that the inflammation causes pain in her legs, but that it was not as bad as it was in the beginning.

Petitioner testified that she uses ice and a heating pad at least once a week, and that she also uses Gabapentin which seems to help. Petitioner denied having any back problems before the accident, but admitted that she did have neck pain since 2016. Petitioner testified that she had had physical therapy, took Gabapentin, and had had an injection in January 2016. When asked to describe the difference in her neck pain after the June 6, 2017 accident, Petitioner responded that it was more intense, that the pain was much sharper, and that she had had her right arm start to hurt. Petitioner testified that she had been having similar problems before the accident but that her right arm got worse, her fingers went numb, and her thumb was never the same.

Petitioner testified that she lost time from work from October 2, 2017 through February 12, 2018 as her chiropractor took her off work. She testified that she had used accrued personal time, vacation time, and sick days up until the end of November, and that after about December 15th she was no longer paid until she returned to work. She testified that TriStar paid for some of her bills, as did her group health insurance with Health Alliance.

Petitioner testified that Petitioner's Exhibit 8 was her union contract that she worked under, and that it was why she was called to assist as a representative for someone who had a disciplinary issue.

On cross examination, Petitioner agreed that on the date of accident she left her regular work location to attend the disciplinary hearing. Petitioner testified that her job duties with Respondent at the time was that of a manager, and that she had six employees that she supervised. When asked whether she traveled for her regular job duties, Petitioner responded that it was limited to such things as trainings and meetings in places like Champaign, Springfield, and Peoria.

On cross examination, Petitioner agreed that as to June 6, 2017, her drive was purely for union work. She testified that she was the union representative for the disciplined employee. When asked to agree that her union duties were not a part of her job duties with Respondent, Petitioner responded that it was not a part of her duties in her title. When asked whether it was in her job description to do union work, Petitioner responded that it was not in her title but that it was in her contract.

On cross examination when asked of the cause of her neck pain in 2016, Petitioner responded that she had had a similar motor vehicle accident.

On cross examination when asked whether she had to get approval from her supervisor to go to the union meeting, Petitioner responded in the affirmative. She testified that they were allowed to deny her the opportunity to go if there was an agency need. She denied that she had ever been denied the opportunity to attend a union grievance meeting. She testified that she was paid a salary while working for Respondent.

On redirect, Petitioner testified that when she returned to work, she returned on regular duty. She further testified that she retired in January 2019.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of OSF St. Joseph 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 June 6, 2017, at which time it was noted that she was a driver and was stopped at a stoplight, that she was rear-ended by a car going 30 MPH, that she had minor damage to her car, and that she was seat-belted. It was noted that Petitioner had no complaints and was refusing EMS transport, that when her blood pressure was taken it was elevated, and that she decided to be transported to the emergency department. It was noted that during EMS transport the paramedics stated that Petitioner became very sleepy and that she now complained of feeling drowsy. The Emergency Medical Services Radio Communication Log noted that the assessment was noted to be that of neck pain to the side, tingling, in and out of consciousness, and "lethargic." The diagnosis was noted to be that of motor vehicle collision. Petitioner was recommended to follow-up with her family physician. (PX2).

The medical records of OSF Ft. Jesse Rehabilitation Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent an initial physical therapy evaluation on November 3, 2017, at which time it was noted that it was a chronic problem, that the onset was that of five weeks ago, that the problem was affecting the ankle on the right side, and that Petitioner was standing and her ankle "gave out." It was noted that co-morbidities were that of chronic low back pain and chronic neck pain. At the time of the initial physical therapy evaluation on November 10, 2017, it was noted that the problem was affecting the lumbar region of the back, that both sides were affected, that Petitioner believed the problem was caused by a motor vehicle accident in June 2017, and that she had had chronic pain in the low back region since the injury. It was noted that Petitioner was unable to bend, that driving aggravated the low back pain, and that she was in a motor vehicle accident in August 2016 at which time she injured her low back. The Discharge Summary dated December 15, 2017 noted that Petitioner attended physical therapy for evaluations of ankle and low back pain, that she did not return to physical therapy, and that she would be discharged. (PX3).

The medical records of OSF Ft. Jesse Family Medicine /Dr. Madhavi Madagula were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on June 7, 2017, at which time it was noted that she was seen at the emergency room yesterday following a motor vehicle accident. It was noted that Petitioner was rear-ended at a stop sign, that there was minor damage to the car, that at the time of the accident she was located in the driver's seat restrained by a shoulder strap, and that there was no loss of consciousness. It was noted that the airbag was not deployed, that Petitioner was ambulatory at the scene, that she had neck and low back pain following the accident, that no imaging was required in the emergency room, and that she was discharged home on Norflex. It was noted that Petitioner noted continued neck pain and low back pain, that the neck pain radiated down to the right arm, that the low back pain did not radiate down the legs, and that she denied weakness, falls, headache, fever, dizziness, or change in bowel/bladder control. It was noted that Petitioner had chronic neck pain but that it was worse since the accident, that she had an injection in January at MCO with Dr. Naour, that the MRI in December was stable, that she was referred to Dr. Holt to discuss a breast reduction, and that she was hoping to schedule that in the next month. It was noted that Petitioner was taking Advil for pain 1-2x daily, that she had not taken Norflex yet because it made her sleepy, and that she was waiting until the next day after work to take it. The assessment was noted to be that of acute cervical strain, acute bilateral low back pain without sciatica, and motor vehicle accident. It was noted that Petitioner was to start physical therapy again and was to see Dr. Naour if no improvement in her pain with physical therapy. Petitioner

was recommended to avoid sitting for long periods of time and was recommended to take Ibuprofen, as well as using heat or ice to the sore area. Petitioner was recommended to return in two weeks. (PX4).

The records of OSF Ft. Jesse Family Medicine reflect that Petitioner was seen on June 21, 2017, at which time it was noted that she was seen in follow-up for motor vehicle accident with resulting neck and back pain. It was noted that Petitioner was referred to physical therapy at the last office visit two weeks ago but had not started yet, that she was seen by Dr. Naour Monday and had an x-ray, that she stated that Dr. Naour gave her a note to take off work for three days, and that she stated that being able to rest had helped the pain the most. It was noted that Petitioner had work comp paperwork to be completed, and that Dr. Naour was setting up the physical therapy and started her on Gabapentin. It was noted that Petitioner noted overall improvement in the neck pain and low back pain but that it was not resolved, that the pain was currently a 4-5/10, that the neck pain radiated down to the right arm, and that the low back pain did not radiate down the legs. The assessment was noted to be that of neck pain, motor vehicle accident, cervical strain, and acute bilateral low back pain without sciatica. Petitioner was recommended to continue her current medications, to start physical therapy as ordered, and to follow-up with Dr. Naour in two weeks as scheduled. (PX4).

The records of OSF Ft. Jesse Family Medicine reflect that Petitioner was seen on August 25, 2017, at which time it was noted that she was seen for fatigue with an onset of the past couple of months. It was noted that Petitioner had daytime sleepiness and no dizziness, and that she was not sleeping at night. It was noted that Petitioner was having difficulties functioning at work, that she had trouble with her memory, and that she had a recent motor vehicle accident where she was rear-ended. It was also noted that Petitioner started Gabapentin in June which was started by Dr. Naour. The assessment was noted to be that of fatigue. Petitioner was recommended to call Dr. Naour and see if he thought Neurontin may be contributing to her symptoms. At the time of the September 11, 2017 visit, it was noted that Petitioner was in a car accident in June, that she had had neck pain and low back pain since the accident, that she had been following with Dr. Naour and was on Gabapentin nightly, and that she was trying to get injections approved by insurance. It was noted that Petitioner was doing physical therapy twice weekly, that she felt like she had not been able to heal because she did not have the time to rest and follow-up with her home exercise program, and that she had been off work since September 1, 2017 and felt like she needed another two weeks to continue to help improve on her symptoms. It was noted that Petitioner worked for the Department of Human Services as a manager and that she stated that she walked a lot during the day, and that this aggravated her back and neck pain and was causing pain in her legs and ankles. It was noted that Petitioner had restricted range of motion in her back and neck, and that the pain radiated down both legs and arms. The assessment was noted to be that of neck pain and acute bilateral low back pain with bilateral sciatica. It was noted that Petitioner was recommended to continue with physical therapy and a home exercise program, and that she was to follow-up with Dr. Naour regarding injections. It was also noted that a letter was given to Petitioner to be off work until the next office visit in two weeks, and that she was advised that it was felt that she should be ready to return to work by that time. (PX4).

The records of OSF Ft. Jesse Family Medicine reflect that Petitioner was seen on September 18, 2017, at which time it was noted that she was there for a right ankle injury which happened that morning. It was noted that Petitioner was involved in a motor vehicle accident three months ago, that she was having issues with back pain, leg pain, and weakness since then, that she was doing physical therapy and that her symptoms were slowly improving, and that she was taking Meloxicam for pain control. It was noted that Petitioner still felt weak in the legs and ankles and that that morning while she was trying to climb on the steps, her right ankle/foot suddenly gave away and she fell on her bottom. The assessment was noted to be that of right ankle injury, likely ankle sprain. Petitioner was recommended to undergo x-rays of the right ankle and to use RICE therapy. Petitioner was recommended to return in one week. At the time of the September 26, 2017 visit, it was noted that Petitioner was seen for fatigue and back pain. It was noted that Petitioner was feeling better, that she still had days where she was very tired, that her sleeping at night was

improved, and that she was still off work. It was noted that Petitioner had been off work the past two weeks due to back and neck pain so that she could try and recover, that she worked for the State of Illinois, that she had decreased her Gabapentin use, and that she also was taking Meloxicam and Vitamin D. It was noted that Petitioner was exercising at the gym and was also attending physical therapy twice weekly for her back pain, that her back pain had improved, that she was following with Dr. Naour, and that she was scheduled to have injections that week. The assessment was noted to be that of neck pain, low back pain, and fatigue. Petitioner was recommended to continue with Gabapentin and Meloxicam and was given a return to work note effective October 3, 2017. Petitioner was recommended to return in about four weeks for back pain/fatigue. (PX4).

The records of OSF Ft. Jesse Family Medicine reflect that Petitioner was seen on October 24, 2017, at which time it was noted that she was seen for follow-up on back pain and fatigue. It was noted that Petitioner's neck was much better, that her low back pain was improving, that it did not radiate down the legs but that she felt tingling and weakness in the legs, and that she did physical therapy. It was noted that Petitioner still felt very tired, that she was having trouble sleeping at night since the motor vehicle accident in June, worse over the last few weeks, and that she hardly slept 1-2 hours at night. It was noted that Petitioner followed with Dr. Naour at MCO for back pain, that she had a steroid injection in the low back in September which helped to some extent, that she had a C-spine MRI in July and an L-spine MRI in August which showed no alarming findings, and that she saw Dr. Jhee who recommended that she continue physical therapy. It was noted that Petitioner continued to have right ankle pain, that the x-ray was normal, that she was using an ankle brace for support, and that she had been off work. It was noted that Petitioner was recommended by Dr. Jhee to try ½ days for a couple of weeks and then full time but that she was not able to do so, that she said she was unable to work at that time, and that she was requesting a note for another two weeks until her appointment with Dr. Jhee. The assessment was noted to be that of chronic neck pain, low back pain, primary insomnia, bilateral leg weakness, and right ankle pain. Petitioner was recommended to undergo physical therapy, was given a prescription for Norflex, and was recommended to try over-the-counter Melatonin. (PX4).

The records of OSF Ft. Jesse Family Medicine reflect that Petitioner was seen on November 9, 2017, at which time it was noted that she had seen Dr. Jhee for low back pain and bilateral leg weakness. It was noted that Petitioner was recommended physical therapy but that she said she was still waiting on approval from insurance. It was noted that Petitioner's leg weakness was improving and that she was planning on retirement. It was noted that Petitioner went to physical therapy for her right ankle pain and that it was improved, that the Melatonin was helping her a lot with sleep, and that she was taking a muscle relaxer for her back which was helping her sleep also. It was noted that Petitioner also complained of sinus congestion and cough for the past five days, that she reported that she was feeling much better on that date, and that she missed work the last four days and was requesting a note. It was also noted that Petitioner followed with Dr. Holt for breast reduction surgery and that she was complaining of numbness and tingling in the right arm. The assessment was noted to be that of bilateral leg weakness, primary insomnia, low back pain without sciatica, and chronic neck pain, among other issues. Petitioner was recommended to return in three months. (PX4).

The medical records of McLean County Orthopedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that on September 28, 2017, Petitioner underwent bilateral transforaminal epidural steroid injection at L5-S1 by Dr. Naour at the Center for Outpatient Medicine for pre- and post-operative diagnoses of (1) lumbar disc herniation; (2) lumbar radiculopathy. At the time of the December 1, 2017 visit, it was noted that Petitioner was six weeks status post bilateral L5-S1 epidural steroid injection. It was noted that Petitioner noted mild improvement since the injection, that she noted significant relief for three weeks but that her pain was slowly returning, and that she rated her pain as a 2-3 on that date. It was noted that Petitioner reported weakness, stiffness of the low back with any activity, that she had been seeing a chiropractor and noted improvement with her pain since starting

that, and that she was taking Mobic as needed. It was also noted that Petitioner had been undergoing follow-up since September 5, 2017 for ongoing cervical and lumbar radicular symptoms following a work-related car accident, that she continued to have pain in her bilateral neck radiating down the bilateral upper extremities into the fingers, that her bilateral low back pain and bilateral lower extremities radiating down the posterior legs to heels had improved after she underwent a bilateral lumbar transforaminal epidural steroid injection L5-S1 on September 28, 2017. It was noted that Petitioner's pain worsened with increased activity, that she continued to work full time as a manager despite her pain worsening as her day progressed, and that her pain continued to increase to a level 3 on the pain scale. It was noted that Petitioner completed physical therapy and continued with chiropractic care, that she completed a bilateral upper extremity EMG which revealed potential bilateral carpal tunnel and right C7 radiculopathy, that she underwent a cervical epidural steroid injection C7-T7 on January 12, 2017 with significant benefit lasting several months, and that she had stopped taking Gabapentin due to inefficacy and had re-started taking the Meloxicam. It was noted that they discussed the option of repeating Petitioner's cervical epidural steroid injection and that they would continue her work status restrictions. The assessment was noted to be that of (1) lumbar radiculopathy; (2) cervical radiculopathy. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on September 5, 2017, at which time it was noted that she was a 58-year-old female with a history of cervical radiculopathy, that she recently had a motor vehicle collision while at work which increased her neck pain as well as low back pain, and that she had a lumbar MRI that revealed a central disc herniation at L5-S1 that may be causing more of her symptoms. It was noted that Petitioner felt that she was having difficulty with walking but she was participating in physical therapy, that on exam on that date she had no obvious weakness, that she was able to heel-toe walk, and that as to her cervical spine she did have an EMG that revealed a C7 radiculopathy as well as potential for carpal tunnel disease, which likely was worsened due to the accident at work in June. It was noted that Petitioner felt that she was not able to perform her duties as she had been in the past and that she had been provided work restrictions. The assessment was noted to be that of (1) cervical radiculopathy; (2) lumbar radiculopathy. It was noted that the plan was that of bilateral L5-S1 transforaminal epidural steroid injection and continued physical therapy. At the time of the August 23, 2017 visit, it was noted that Petitioner had right arm symptoms. It was noted that Petitioner was the restrained driver of a car that was rear-ended June 6, 2017, that she had been treated for neck and arm problems in 2015 but those resolved, and that she did well until this motor vehicle collision. It was noted that Petitioner was right-handed. It was noted that Petitioner complained of numbness and tingling in the neck and down both arms, that aggravating factors were that of increased activity, and that alleviating factors were that of rest. It was noted that the plan was for follow-up with Dr. Naour. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on August 21, 2017, at which time it was noted that she reported no improvement of her symptoms and that she continued to have left greater than right pain. It was noted that Petitioner was taking Ibuprofen and Gabapentin for some relief of her symptoms. It was noted that Petitioner had hired a housekeeper for her home cleaning, that she continued to work full time despite her pain worsening as her day progressed, and that her pain would increase to a level 3 on the pain scale. It was noted that Petitioner underwent her physical therapy evaluation for low back pain and would continue therapy sessions as well as home exercises. It was noted that Petitioner completed her last physical therapy session for cervical radiculopathy in March 2017, that she was scheduled for a bilateral upper extremity EMG that week, and that she was to follow-up to review the results next week. It was noted that they reviewed Petitioner's lumbar and cervical MRI results including cervical disc protrusion C4-C5 as well as lumbar herniation at L5-S1, that she underwent a cervical epidural steroid injection at C7-T1 with significant relief, that they discussed the option of pursuing a bilateral lumbar transforaminal epidural steroid injection at L5-S1, and that she wanted to proceed with work comp authorization. The assessment was noted to be that of (1) cervical radiculopathy; (2) lumbar radiculopathy. It was noted that they would update Petitioner's work status to shorten her workday from 8 AM to 3 PM daily as she underwent physical therapy exercising. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen on July 5, 2017, at which time it was noted that she was seen for follow-up on her cervical and lumbar symptoms. It was noted that Petitioner reported no improvement of her symptoms and that there continued to be left greater than right pain. It was noted that Petitioner was taking Ibuprofen and Gabapentin for relief of some of her symptoms. It was noted that Petitioner was describing her pain as a 2/10 with use of medications including Gabapentin and Ibuprofen, that her pain was increased with any walking, sitting, or standing and improved with lying down, that she did not feel that she was able to continue performing her job due to the radiating pain of her bilateral upper extremities and the numbness and tingling associated with it into her hands, and that she described weakness subjectively but on objective measures this was not apparent. The assessment was noted to be that of (1) lumbar radiculopathy; (2) cervical radiculopathy. It was noted that Petitioner was recommended to increase her Gabapentin and to use Mobic instead of Ibuprofen, and that she was referred to Dr. Pegg for EMG. At the time of the June 19, 2017 visit, it was noted that Petitioner was a 58-year-old female with a history of cervical radiculopathy, that she had been previously treated for a C5-6 radicular syndrome, that she was undergoing usage of Gabapentin, cervical epidural steroid placement as well as physical therapy with significant benefit, and that she stated that she was improving and then had a motor vehicle collision in the form of a rear-end collision. It was noted that Petitioner began having increased head, neck, and back pain, that she was seen at OSF emergency department with no imaging, that she described pain in many areas of her body including the neck, trapezius, thoracic, and low back areas, and that she described pain radiating into her right upper extremity and right lower extremity consistent with radicular symptoms. It was noted that Petitioner was not having significant weakness but did have some weakness on exam that was likely pain-related, and that she had a cane for assistance but did not require this. The assessment was noted to be that of (1) lumbar radiculopathy; (2) cervical radiculopathy. Petitioner was recommended to undergo x-rays of the lumbar and cervical spine, and was prescribed Gabapentin and a Medrol dose pack. It was noted that lumbar spine x-rays were interpreted as revealing mild degenerative scoliotic changes with transition at L4/5, disc height loss at L5/S1 and L2/3, and no flexion extension instabilities. It was also noted that cervical spine x-rays were interpreted as revealing degenerative disc changes prominent at C5/6. Petitioner was recommended to be excused from work for June 20th and June 21st. (PX5).

The records of McLean County Orthopedics reflect that Petitioner underwent a nerve conduction study/EMG on August 23, 2017, which was interpreted as revealing a right C7 radiculopathy and a mild median neuropathy at both wrists. Petitioner underwent an MRI of the lumbar spine on August 7, 2017, which was interpreted as revealing low-grade degenerative disk disease at L4-5 and L5-S1 levels with mild lateral recess stenosis at both of these levels. The "Reason For Exam" was noted to be that of lumbar radiculopathy; left-sided lower extremity pain; history of auto accident in the past. Petitioner underwent an MRI of the cervical spine on July 22, 2017, which was interpreted as revealing no MRI evidence of interval change in multilevel degenerative changes of the cervical spine. It was noted that the comparison film was dated December 30, 2016. The "Reason For Exam" was noted to be that of cervical radiculopathy, right-sided neck pain, and arm pain with numbness to the finger. A work slip was issued by Dr. Naour on September 21, 2017, indicating that Petitioner was to work ¾ daily from 8:00 a.m. until 3:00 p.m. as she participated in physical therapy sessions along with assigned home exercises until physical therapy could be completed and six-week follow-up with Dr. Naour. A work slip was issued by Dr. Naour on August 21, 2017, indicating that Petitioner was to work ¾ daily from 8:00 am until 3:00 pm as she participated in physical therapy sessions along with assigned home exercises until September 8th when physical therapy may be completed. A work slip was issued by Dr. Naour on August 9, 2017, indicating that Petitioner was seen in the office on July 5, 2017 and that no restrictions were noted. A work slip was issued by Dr. Naour on June 19, 2017, indicating that Petitioner was to be excused from work for June 20, 2017 and June 21, 2017. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was discharged by physical therapy on July 6, 2018, at which time it was noted that she was doing better, that she stated that she was

about 75% better and feeling stronger, that her pain was largely reduced although she continued to have numbness in the right thumb, that she stated that she had been consistent with activity and felt much better with this, and that she was looking to avoid surgery at all costs. Included within the records of McLean County Orthopedics was an Operative Report dated March 5, 2018, which noted that Petitioner underwent interlaminar cervical epidural steroid injection at C7-T1 on that date by Dr. Naour for a pre- and post-operative diagnosis of cervical radiculopathy. It was noted that Petitioner had undergone previous cervical epidural steroid injections over a year ago for one attempt and had significant benefit. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Carmichael on November 21, 2018, at which time it was noted that she was seen for a right arm symptoms, that it started after a motor vehicle accident in August 2016, that she had an exacerbation of the symptoms after a repeat motor vehicle accident in June 2017 where she was the restrained driver of a car that was rear-ended on June 6, 2017, and that she was right-handed. It was noted that Petitioner's current symptoms were that of pain in the neck, and pain, numbness, and tingling down the right arm. It was noted that aggravating factors were increased activity and that alleviating factors were rest. It was noted that on EMG there were mild median neuropathies at both wrists that were approximately equal on the left and right sides, and that in addition there was a right C6 or C7 radiculopathy that was mostly evident in the pronator teres muscle. It was noted that the plan was for follow-up with Dr. Novotny. At the time of the November 13, 2018 visit with Dr. Novotny, it was noted that Petitioner presented with persistent numbness in the thumb after a motor vehicle accident in August 2016, that she had an exacerbation of the symptoms after a repeat motor vehicle accident in June 2017, and that she had prior EMG studies that showed cervical radiculopathy at C7 and had had prior interventions with minimal long-term benefit in terms of her cervical injections. It was noted that Petitioner had been diagnosed by EMG studies with mild median neuropathy at the wrists in August 2017, that at that point they were going to see if there had been a significant progression of the median neuropathy with a repeat EMG study, and that otherwise they may be at Petitioner's limits in terms of providing her with any significant benefit by orthopedic intervention. The assessment was noted to be that of carpal tunnel syndrome, right upper limb. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Naour on November 7, 2018, at which time it was noted that she presented back for review of primarily right-sided hand pain. It was noted that Petitioner had a component of cervical radicular pain however had undergone EMG which showed severe median neuropathy, that she had seen Dr. Novotny and had been recommended surgical intervention for this, and that she was referred back to Dr. Novotny for potential scheduling of the surgery. The assessment was noted to be that of (1) cervical spondylosis; (2) cervical radiculopathy. Petitioner was recommended to continue Gabapentin and was recommended to follow-up as needed. At the time of the August 1, 2018 visit with Dr. Naour, it was noted that Petitioner had a history of cervical radiculopathy affecting her right upper extremity, that she had undergone EMG as recently as August 2017 which revealed mild carpal tunnel disease as well as a little C7 radiculopathy, that also on review of her MRI she had degenerative changes most significant at C5-6, and that she had undergone two separate epidural steroid injections with significant benefit, her last in March 2015. It was noted that Petitioner had also undergone physical therapy with what she described as benefit. The assessment was noted to be that of (1) cervical spondylosis; (2) cervical radiculopathy. It was noted that Petitioner was to consider epidural steroid injection in the future if she had significant pain increase and that she was to continue physical therapy to completion. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Naour on May 16, 2018, at which time it was noted that she returned for follow-up since March 16, 2018 in regard to right neck pain in the setting of cervical radiculopathy due to a work-related car accident. It was noted that Petitioner had done a cervical epidural steroid injection at C7-T1 on March 5, 2018 that provided 100% improvement, but that she reported that her symptoms had returned after beginning physical therapy. It was noted that this was the third time that they had done the injection, that while it was promising that

Petitioner responded well to them the fact that they were so short-lived made Dr. Naour hesitant to repeat the injection, and that she described her pain as sharp, burning, achy, and rated it 10/10. It was noted that the pain radiated into Petitioner's right upper extremity with associated numbness of the right fingers, generalized weakness of the right upper extremity, and stiffness, and that she was currently taking Ibuprofen for pain control. It was noted that they discussed options of oral steroids, continue with physical therapy and/or seek surgical consultation for neck vs. shoulder, that neuroadjuvants were a consideration, that Petitioner trialed Gabapentin last year but discontinued it for reasons she could not recall, and that based on MRI there were no major surgical indications. It was noted that the plan was to start Petitioner on a Medrol dose pack since she had had benefit from this in the past, and to have her continue physical therapy for cervical work-up. The assessment was noted to be that of cervical radiculopathy. Petitioner was recommended to return in 4-6 weeks to determine the next steps. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Naour on March 16, 2018, at which time it was noted that she returned 11 days after an interlaminar CSI at C7-T1, that she reported 100% improvement, that there was no longer pain, weakness, or spasms, and that she stated she had some numbness in the right thumb and mild stiffness of the neck but was doing significantly better as compared to before. It was noted that Dr. Naour thought that Petitioner would benefit from a few sessions of guided cervical work-up at physical therapy, that she had been referred, and that she was to return as needed. The assessment was noted to be that of cervical radiculopathy. At the time of the January 26, 2018 visit with Dr. Naour, it was noted that Petitioner was seen for follow-up since December 1, 2017 for ongoing cervical and lumbar radicular symptoms following a work-related car accident. It was noted that Petitioner continued to have pain in her bilateral neck radiating down the bilateral upper extremities into the left wrist and right hand to thumb, that her bilateral low back pain bilateral lower extremity radiating down posterior legs to heels was stable, and that her pain worsened with increased activity. It was noted that Petitioner had taken a leave of absence from her work as a full-time manager due to her pain and a recent bilateral breast surgical reduction by Dr. Holt, that she completed physical therapy and continued with chiropractic care, that she did not complete the recent scheduled cervical epidural steroid injection C7-T1 due to scheduling conflict with her breast reduction, and that she had stopped taking Gabapentin due to inefficacy and Meloxicam due to her recent surgery. It was noted that they discussed the option of rescheduling Petitioner's cervical epidural steroid injection, and that she was agreeable. The assessment was noted to be that of (1) cervical radiculopathy; (2) lumbar radiculopathy. (PX5).

The records of McLean County Orthopedics reflect that Petitioner was seen by Dr. Novotny on January 9, 2018, at which time it was noted that she had been complaining of numbness and tingling in the right upper extremity mostly in the median nerve distribution since a car accident in August 2016, that she had an exacerbation of this during a repeat motor vehicle accident in 2017, that she was being treated for a C7 radiculopathy, and that she essentially had constant numbness. It was noted that Petitioner also had evidence of median nerve compression of both wrists bilaterally, and that as they were concerned about the possibility of double crush phenomenon, they would proceed with a right open carpal tunnel release at her convenience. The assessment was noted to be that of right carpal tunnel syndrome. (PX5).

The medical records of Bloomington-Normal Spine Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on November 15, 2017, at which time it was noted that her complaints were that of neck pain, mid back pain, low back pain, hand pain, sciatic pain, and headaches. The diagnoses were noted to be that of (1) cervicobrachial syndrome; (2) sciatica, left side; (3) sciatica, right side; (4) sprain of ligaments of cervical spine; (5) strain of muscle, fascia, and tendon of lower back; (6) injury of nerve root of cervical spine; (7) sprain of ligaments of lumbar spine. It was noted that Petitioner was recommended spinal manipulation three times per week for two months, interferential therapy, and ultrasound three times per week for two months, and massage once a week for six weeks. At the time of the November 16, 2017 visit, it was noted that Petitioner stated that her

legs felt week, that her lower back was tender, that her neck was sore, and that her thumb and pointer finger were constantly numb. (PX6).

The records of Bloomington-Normal Spine Clinic reflect that Petitioner was seen on November 10, 2017, at which time it was noted that she stated that her mid to low back had been bothering her since Thursday and that she used some heat and ice over the weekend, that she was feeling stiff that morning, that her pain had been traveling up and down her leg to the knee but was really bad after sitting and first getting up for a few minutes, and that her right thumb and index finger were still numb. At the time of the November 28, 2017 visit, it was noted that Petitioner stated that her lower back was sore, that her left wrist was painful, that her right thumb was numb, and that her mid back was a little stiff. At the time of the November 30, 2017 visit, it was noted that Petitioner stated that her mid to lower back was sore, that her right thumb was numb, and that her right wrist was painful. At the time of the December 4, 2017 visit, it was noted that Petitioner stated that her left wrist was bothering her, that her right thumb was still numb, and that her mid back was bothering her as well. At the time of the December 7, 2017 visit, it was noted that Petitioner stated that her wrist was getting better and that she did not feel as much weakness, and that her lower back and neck were bothering her. (PX6).

The records of Bloomington-Normal Spine Clinic reflect that Petitioner was seen on December 12, 2017, at which time it was noted that she stated that her neck and lower back were bothering her, that she had been working on the computer a lot and lifted a box about 20 pounds from one desk to another, that she was having numbness in her hands, and that her leg was aching in the night and woke her up and that she had to get up and stretch to go back to sleep. At the time of the December 14, 2017 visit, it was noted that Petitioner stated that her wrist and lower back were causing her the most problem, that she was still having numbness in her hand, that her neck was not too bad, and that her mid back had slight pain. At the time of the December 18, 2017 visit, it was noted that Petitioner stated that her low back was in worse shape than her last visit, that she drove to St. Louis over the weekend, and that her hand was also having on and off pain or sensitivity. At the time of the December 21, 2017 visit, it was noted that Petitioner stated that her lower back was a constant pain, that she also stated that she could feel some inflammation in her mid back as well as some pain in her wrist, that she reported that her neck was feeling better with only a little bit of pain when she turned her head, and that she stated that today had been her best day. (PX6).

The records of Bloomington-Normal Spine Clinic reflect that Petitioner was seen on December 27, 2017, at which time it was noted that she stated that her low back was still bothering her, that she also stated that her sinuses had gotten better, that she stated that her neck was still bothering her, and that she also stated that her thumb was numb. At the time of the December 29, 2017 visit, it was noted that Petitioner was still having problems with her low back, that it was feeling a little worse as compared to her last visit, that she also noted that her thumb was feeling stiff and numb and was feeling worse than her last visit, that her neck had improved, and that her mid back was not having any pain. At the time of the January 3, 2018 visit, it was noted that Petitioner stated that her lower back was bothering her and did not feel any better or worse than her last visit, and that her hand was feeling slightly less stiff and numb. At the time of the January 4, 2018 visit, it was noted that Petitioner stated that her legs and low back were stiff that morning from spending some nights in the hospital with her daughter, that her low back was feeling worse because she had not been able to rest or sleep in her bed, that she had not noticed any change in the nerve pain or numbness in the legs as it came and went and usually took a day or two before it acted up, that her neck had started bothering her again, and that the numbness and stiffness in her hand had continued to decrease. (PX6).

The records of Bloomington-Normal Spine Clinic reflect that Petitioner was seen on January 9, 2018, at which time it was noted that she stated that she had some mid back pain in addition to some pains in both wrists, that she stated that she slipped on ice and fell forward on her right hand, that she could tell that her wrist was sore and that she hurt it but could not say how bad at that time, and that she felt

improvement in her low back and neck and thought they were okay from the fall. At the time of the January 11, 2018 visit, it was noted that Petitioner stated that her mid back was bothering her, that she also stated that her hands were numb and that her right wrist was painful, that she also stated that her neck was sore and stiff, and that her low back and sciatica were about the same and not bothering her too bad. At the time of the January 15, 2018 visit, it was noted that Petitioner stated that she was still having back pain mid to lower, and that she also stated that her neck was more stiff. (PX6).

The Illinois Traffic Crash Report was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

An Excerpt from the Union Contract was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report reflects that Petitioner was traveling to Decatur for union business, that she was stopped at the traffic light located at South Main and Veterans Parkway when another car rear-ended her stopped vehicle, and that the impact of being hit "knocked the wind out of her and incapacitated her for a spell." (RX1).

The 5(b) Lien Itemization was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner failed to prove that she sustained an accidental injury on June 6, 2017 that arose out of and in the course of her employment with Respondent.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something

incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

In the case at hand, Petitioner testified that her job duties with Respondent at the time was that of a manager, and that she had six employees that she supervised. The Arbitrator notes that Petitioner testified that on the date of accident she was leaving the agency that she worked for to go to an agency in Decatur as a manager was administering discipline to an employee who needed a union representative, that she was contacted by a union official to represent the employee at the meeting, and that she was a secretary of Local 674. The Arbitrator further notes, however, that on cross examination Petitioner agreed that as to June 6, 2017, her drive was purely for union work and when asked to agree that her union duties were not a part of her job duties with Respondent, Petitioner responded that it was not a part of her duties in her title.

Having considered and reviewed the entirety of the evidence in this matter, the Arbitrator finds that Petitioner's risk of injury in this case was connected with union business and not that of Respondent and, as such, the Arbitrator finds that Petitioner's injury did not arise out of her employment. Furthermore, the Arbitrator further finds that Petitioner was driving to a union disciplinary hearing at the time of the motor vehicle accident at issue and, as such, the injury did not occur in the course of Petitioner's employment with Respondent. As to Petitioner's suggestion that she was on union business agreed to by both Respondent and Petitioner in the union contract - an excerpt of which was entered into evidence at the time of Arbitration as Petitioner's Exhibit 8 - the Arbitrator notes that Article IX, Section 6, subpart (b) provides, in pertinent part, that "All time spent by an employee, including travel time, who is required by the Employer to attend an investigatory interview away from the employee's regular workplace shall be paid by the Employer at the appropriate rate." (PX8). In the case at hand, however, the facts reveal that Petitioner was not the employee being disciplined, but rather was attending the hearing in her capacity as a union representative.

Having considered and reviewed the entirety of the evidence in this matter, the Arbitrator finds that Petitioner failed to prove by a preponderance of evidence that she sustained an accident on June 6, 2017 that arose out of and in the course of her employment. In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (J), (K), and (L), as those issues are rendered moot. The claim is denied.

STATE OF ILLINOIS	)
	) SS.
COUNTY OF COOK	)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MELINDA REED,

Petitioner,

20 IWCC0688

vs. NO: 19 WC 14334

SUMMERVILLE SCHOOL DISTRICT #79,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, choice of physicians, and medical expenses both current and prospective, and being advised of the facts and law, modifies the Decision of the Arbitrator as indicated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The parties stipulated that Petitioner sustained an accident on December 1, 2017 while working as a teacher's assistant when she tripped over a fallen child in the cafeteria. In finding causal connection between her work accident and the condition of ill-being of her right knee, the Arbitrator noted that although she had pre-existing pathology from an automobile accident in 2007, her condition basically resolved in October of 2012 and she was able to work until the instant accident. He also found Petitioner's testimony credible, her reports to providers were consistent, and her testimony was supported by the medical records. The Arbitrator also relied on the opinions of Petitioner's treaters, Dr. Bradley, Dr. McIntosh, and Dr. Harrison over the opinions of Dr. Petkovich, Respondent's §12 medical examiner.

The Arbitrator also found that all medical treatment provided to date was reasonable and necessary to treat her work-related condition of ill-being. He awarded the expenses submitted into evidence as well as ordering Respondent to authorize and pay for prospective treatment, including surgery recommended by Dr. Bradley. The Commission agrees with the Arbitrator's determination that Petitioner sustained her burden of proving that her condition of ill-being of her right knee was causally related to her work accident, that all medical treatment provided was reasonable and necessary, and that prospective surgery recommended by Dr. Bradley is indicated.

However, the record reveals that Petitioner chose to treat with Dr. Harrison, her primary care physician as her first choice of doctors, chose to treat with Dr. McIntosh, her previous orthopedic surgeon as her second choice of doctors, and then chose to treat with another orthopedic surgeon Dr. Bradley. Dr. Bradley testified at deposition that there was no indication in his records that Petitioner was referred to him by any other doctor, and he believed Petitioner was referred to him by her lawyer. The Arbitrator did not address the issue of choice of physicians at arbitration or in his decision.

The Commission agrees with Respondent that Dr. Bradley constituted Petitioner's third choice of physicians. Therefore, Respondent is not financially liable for the medical services rendered by Dr. Bradley. *See*, 820 ILCS 305/8(a)1. Respondent argues that not only is it not liable for the medical services actually rendered by Dr. Bradley, it is also not liable for any prospective treatment he may recommend. The Commission disagrees.

The Act only specifically absolves employers from paying for medical services actually provided by a third or subsequent doctor outside the chain of referrals. Here, Dr. Bradley testified by deposition. At that time he effectively became Petitioner's §12 medical examiner. While the Act precludes the Commission from awarding Dr. Bradley's medical bills, it does not preclude the Commission from considering his opinions concerning the efficacy of prospective treatment. The Commission notes that it agrees with the Arbitrator's determination that the prospective treatment recommended by Dr. Bradley was indicated and necessary. The Commission also notes that Respondent's §12 medical examiner, Dr. Petkovich, also agreed that the recommended surgery was indicated, though he questioned causation.

The Commission agrees with the Arbitrator's order to direct Respondent to authorize and pay for prospective treatment, including surgery recommended by Dr. Bradley. However, because Dr. Bradley is outside the chain of permissible referrals, we cannot direct Respondent to pay for prospective treatment actually provided by Dr. Bradley. Rather, the Commission suggests that Petitioner either go back and receive treatment from Dr. McIntosh, an orthopedic surgeon who treater her in the past, or go back to Dr. Harrison, her primary care physician, who can refer her to another orthopedic surgeon, perhaps even Dr. Bradley.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 5, 2020 is hereby modified as specified above and otherwise is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay for reasonable and necessary medical services as submitted into evidence by Petitioner, pursuant to §8(a), subject to the applicable medical fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment recommended by an orthopedic surgeon within the proper chain of referrals.

IT IS FURTHER ORDERED BY THE COMMISSION that this award in no instance shall be a bar to a further hearing and determination of temporary total compensation or of compensation for permanent disability, if any.

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

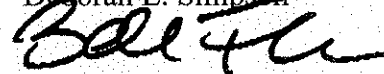
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

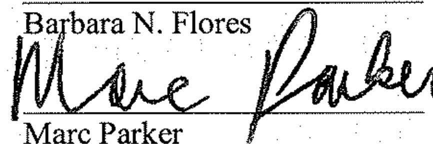
IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: NOV 23 2020

Deborah L. Simpson


Barbara N. Flores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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

20IWCC0688

REED, MELINDA Case# **19WC014334**
Employee/Petitioner

SUMMERVILLE SCHOOL DIST #79
Employer/Respondent

On 3/5/2020, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH COOKSEY & CHAPPELL
THOMAS C RICH
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20IWCC0688

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)

MELINDA REED
Employee/Petitioner
v.
SUMMERVILLE SCHOOL DIST. #79
Employer/Respondent

Case # 19 WC 14334

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 **December 12, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident, **12/1/2017**, 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 **$19,594.32**; the average weekly wage was **$544.29**.

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

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

Respondent shall be given a credit of **$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 **any benefits paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) and § 8.2 of the Act.

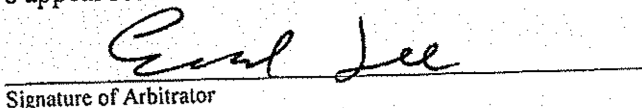
Respondent shall be given credit for medical benefits that have been paid through its group carrier, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. Bradley, including but not limited to surgery.

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

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

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



Signature of Arbitrator

3/3/20
Date

ICArbDec19(b)

MAR 5 - 2020

The Arbitrator finds the following facts:

This matter was presented for Arbitration on December 12, 2019 on Petitioner's motion pursuant to Sections 19(b) and 8(a) of the Act. Respondent disputed causal connection, medical expenses, and prospective medical treatment.

Petitioner is a teacher's aide for Respondent, and 55 years old at the time of her injury. The parties stipulated that Petitioner suffered an accidental injury on December 1, 2017, while working for Respondent. (AX 1). Petitioner testified that on that date she was working in the school cafeteria when a small child had slipped and fallen on spilled fruit juice. (T. 9-10). She did not see the child on the ground, and fell over the child, injuring both of her knees and hands. (T. 10).

Following the accident Petitioner was seen by Dr. Franklin Harrison at Prompt Care in Mt. Vernon, IL on December 1, 2017. He noted that Petitioner was seen with a chief complaint of right knee pain after a slip and fall injury involving a child at work. In order to avoid falling onto the child, Petitioner landed with her outstretched arms, but "she did land hard onto her right knee which is swollen and very painful since the fall." Both of Petitioner's wrists and shoulders were also sore during the evaluation. Dr. Harrison noted that Petitioner's gait was affected and was consistent with pain in the right knee. He noted that during physical examination, Petitioner's right knee was swollen and painful to palpation, range of motion, and joint stability testing. A transverse friction skin tear and superficial open wound were noted. Petitioner was diagnosed with right knee pain, right wrist sprain, left wrist sprain, right shoulder pain, and left shoulder pain. X-rays were ordered of the bilateral wrists and right knee. Petitioner was to limit weight bearing and walking, elevate and ice her right knee, avoid activities involving wrists and shoulders, and to take Percocet at home. Dr. Harrison discussed the possibility of time off work to allow healing for her injuries but Petitioner expressed her preference to continue working if it would not cause additional damage to her injured joints. They discussed her job activities and Dr. Harrison allowed her to return to work. (PX 3).

Petitioner returned to Dr. Harrison at Prompt Care on December 7, 2017. He noted that Petitioner returned to him for a follow up upon his request. He again noted the consistent history of injury. He further noted, "This made her knees take most of the impact energy—with her right knee definitely getting the majority of the forces—sustaining the most injury, most swelling, and greatest amount of her pains." (PX 3). Her x-rays were reviewed. The imaging reports noted that the bilateral wrist x-rays showed no acute osseous abnormalities and mild bilateral wrist osteoarthritis. The right knee x-ray showed no acute osseous abnormalities and mild patellofemoral compartment osteoarthritis. (PX 4). Upon physical examination, Dr. Harrison noted that her right knee was still "very painful" to palpation in the peripatellar region, more towards the medial aspect of her knee. Dr. Harrison also noted edema in the same area, objective ecchymosis, and restricted range of motion. She was again diagnosed with pain in the right knee and effusion as well as bilateral wrist sprains. She had taken off several days from work due to her symptoms. Her

activities were modified, she was to continue taking over-the-counter pain medication, wear a neoprene knee sleeve, and intermittently apply ice and heat. (PX 3).

On December 14, 2017, Petitioner returned to Dr. Harrison. It was noted that her right knee was still swollen and painful. Her pain would increase each day at work and would only decrease with rest at night. She felt as if her knee was going to give out when she put weight on it to take a step, making her uneasy and uncertain about whether she would fall. She inquired about the possibility of an injection in her right knee. (PX 3). She testified that she had prior injections in her right knee that had helped following a motor vehicle accident in 2007. (T. 15). Physical examination was still positive for pain, tenderness, swelling, and decreased range of motion. Her right shoulder was improved but her bilateral wrists were still tender. She was to continue limiting her activities, apply ice and heat, and use topical corticosteroids. She was to follow up in two weeks. (PX 3).

Petitioner returned to Dr. Harrison on January 4, 2018. Her right knee was still painful and swollen. The pain would increase throughout the day, starting at a 2 out of 10 and ending as a 6-8 out of 10 by the end of the day. She was losing sleep and under a great deal of stress due to the pain and limitations. Her right wrist sprain was improved but still tender with certain activities including lifting. They discussed a possible referral to an orthopedic surgeon and beginning physical therapy. Her restrictions and recommendations remained the same. (PX 3).

On February 12, 2018, Petitioner returned to Dr. Harrison for follow up of her right knee. She still had pain and swelling in her right knee and Petitioner indicated that her knee cap felt like it was "on backwards." She reported that her wrist sprains had resolved but her right knee had not improved. Dr. Harrison noted:

> Advised [Petitioner] that now at ten plus weeks after her work injury, her knee is essentially no better at all to my exam or how she describes how it feels either one. Her knee is still swollen just about the same as it was initially, her ROM restrictions have not improved, her mobility has not improved, and her pain level has not decreased at all. Considering all of this plus knowing she has done all the conservative treatment things, based on her negative x-ray report she would be expected to be considerably better by now…but she is not so we need to get an MRI to see if there is some internal derangement responsible for her lack of improvement. (PX 3).

Dr. Harrison again recommended activity modifications and he her prescriptions remained the same. (PX 3)

On February 22, 2018, an MRI of Petitioner's right knee was obtained at SSM Good Samaritan in Mt. Vernon. Radiologist Dr. Patrick Bennett interpreted the study and prepared a report noting mild to moderate tricompartmental degenerative changes especially in the patellofemoral joint and a meniscal cyst. A probable sprain involving the fibular collateral

ligament was also noted. According to Dr. Bennett's MRI addendum report, after receiving additional information from Dr. Harrison, he noted that the increased T2-weighted signal in the prepatellar soft tissues may be associated with bursitis or mild edema/contusion. He also noted that the cartilaginous or chondral defects associated with direct injury may also have a similar appearance with advanced degenerative changes and small traumatic related cartilaginous change may also be present. (PX 5).

Petitioner testified that prior to her December 1, 2017 accident, she treated with Dr. Jeffrey McIntosh from 2007 through October of 2012. (T. 15). Dr. McIntosh administered several injections during that time frame and recommended arthroscopic surgery. (T. 16). According to Dr. McIntosh's pre-accident records, an MRI was obtained but was "not too impressive" and "inconclusive." (RX 2) Petitioner chose not to have surgery because she was able to live with her intermittent symptoms. (T. 16). After her last appointment with Dr. McIntosh in 2012, she occasionally took Advil and Tylenol whenever her right knee would bother her. (T. 16-17). She testified that her pain levels from 2012 through 2017 were dependent on her level of activity but did not require any treatment. (T. 19). However, her pain became much worse and constant after her work injury on December 1, 2017, requiring treatment. (T. 17).

On July 31, 2018, Petitioner returned to Dr. McIntosh because of persistent right knee pain after the December 1, 2017 injury. Dr. McIntosh noted that Petitioner was well known to him and was last seen by him in October of 2012 for her right knee. She had been doing well over the past five to six years, but in December she tripped over a small child in the cafeteria at work, landing in a sprawled position onto her knees. She treated with Dr. Harrison but failed to improve. An MRI revealed the presence of a meniscal cyst. Dr. McIntosh reviewed radiographs obtained that date and noted that they revealed fairly significant patellofemoral arthritis in the left knee, "but not so much in the right knee." Upon physical examination swelling was noted in the right knee as well as tenderness in the medial joint line, pain with range of motion, and an antalgic gait. Dr. McIntosh aspirated approximately 30 cc of fluid from Petitioner's right knee and injected Kenalog and Marcaine. She was allowed to continue working full duty and was to return in three weeks. (PX 6).

Petitioner followed up with Dr. McIntosh on August 21, 2018. He noted that Petitioner continued to have pain in her right knee, which was precipitated by a work injury in December of 2017. She reported that her right knee complaints initially improved with the steroid injection, but she complained of pain, stiffness, and a feeling of instability when she returned for follow-up. She had pain when walking and with prolonged standing, and her knee continued to swell, lockup, and give out. Dr. McIntosh stated that her symptoms were consistent with internal derangement. She had not improved with time, oral medication, aspiration, or corticosteroid injections. Dr. McIntosh opined that while Petitioner had arthritis in her right knee, "I think the fall has certainly exacerbated that arthritis, and it has been several years since she has had problems with the knee, and she was in a quiescent state of health." Dr. McIntosh recommended physical therapy in an effort to help her regain strength and flexibility. He further stated, "It is my opinion that this injury precipitated

her further knee pain, and by not having therapy she is actually delaying her improvement." It was noted that therapy was not initiated previously because Respondent did not approve it. He did not believe her right knee pain would improve without additional conservative care and that she would continue to suffer from her symptoms. (PX 6).

One week after seeing Dr. McIntosh, Petitioner returned to him on August 28, 2019 because of increased swelling and pain. Dr. McIntosh aspirated her knee and administered a corticosteroid injection. She was to return in three weeks. On September 25, 2018, Dr. McIntosh noted that Petitioner had improved following her last injection but the pain and swelling had returned. He wanted to try one last steroid injection before obtaining another MRI or discussing surgical intervention. A corticosteroid injection was administered on that date. (PX 6).

On October 16, 2018, Dr. McIntosh noted that Petitioner was "absolutely miserable." Petitioner had attempted aspiration, three injections, anti-inflammatory medication, bracing, and therapy, without significant improvement. He recommended an arthroscopic evaluation. (PX 6).

On November 20, 2018, Petitioner returned to Dr. Harrison because her "right knee still hurts all the time." It was noted that Petitioner had received injections with Dr. McIntosh and experienced some pain relief but severe pain had returned. According to Dr. Harrison's report, the severity of Petitioner's right knee pain had not lessened since her work injury. Dr. Harrison noted upon physical examination that Petitioner's knee was swollen and range of motion testing produced pain. Petitioner was prescribed pain medications and muscle relaxants. (PX 3).

Petitioner was seen by Dr. Harrison for various health problems on February 11, 2019. Among her complaints was right knee pain. It was noted that she was scheduled to see an orthopedic surgeon. Pain medications and muscle relaxants were prescribed. Petitioner returned to Dr. Harrison on March 18, 2019 with continued complaints of right knee pain. (PX 3).

On April 11, 2019, Petitioner followed up with Dr. Harrison for complaints of continued right knee pain. While the entire knee was painful, the most severe complaints were localized over the lateral aspect of the knee. Upon physical examination it was noted she had anterior swelling of her right knee superior and anterior to her patella as well as medial and lateral to her patella. Swelling was noted both visually and palpably. Moreover, Dr. Harrison noted that Petitioner had injured her right knee eight to ten years ago in a motor vehicle accident, but it did not cause her current symptoms, including pain or swelling. Moreover, she did not have these symptoms immediately before her work accident. He stated the swelling and pain was the result of her work accident in December of 2017. Petitioner was given pain medications and a Kenalog injection on that date. (PX 3).

On April 24, 2019, Petitioner was evaluated by board certified orthopedic surgeon Dr. Matthew Bradley. He noted that she had right knee pain since a work accident on December 1, 2017. She was working cafeteria duty when she tripped over a young child. She fell, twisting to avoid falling on the child, and struck her right knee. She underwent conservative treatment

including injections but continued to have right knee pain. Her pain was localized in the medial aspect as well as posterior and anterior and was getting worse. She denied any interval trauma or fall. Dr. Bradley noted that she was involved in a motor vehicle accident in 2007 and treated for a right knee injury after that. However, that condition resolved and Petitioner was essentially pain free and functioning normally before her work accident on December 1, 2017.

Dr. Bradley performed a physical examination and noted swelling, stiffness, and popping. Petitioner's pain was a 7 out of 10 and aggravated by standing and walking. Dr. Bradley obtained an ultrasound of Petitioner's right knee to observe Petitioner's knee while weight bearing, and noted an extruded appearance of the medial meniscus as well as mild joint effusion. The prior MRI and diagnostic films were reviewed by Dr. Bradley. He noted that the x-rays showed significant worsening of the medial joint space possibly indicative of chondrolysis status post trauma. He recommended an MRI with contrast to more completely evaluate the articular cartilage. Anti-inflammatory medications were dispensed. (PX 7).

On May 13, 2019, Petitioner was evaluated again by Dr. Harrison for continued complaints of right knee pain. He noted that she had been seen by Dr. Bradley who was considering surgical intervention. (PX 3).

On June 3, 2019, Petitioner was seen by Dr. Harrison again with complaints of severe right knee pain. It was noted that her pain was so severe she nearly went to the emergency room the night before. Her physical examination was unchanged. Dr. Harrison administered a corticosteroid injection to address her pain and swelling. On July 16, 2019, her symptoms were not improved and medications were prescribed. (PX 3).

On July 19, 2019, Petitioner was evaluated by Dr. Frank Petkovich at the request of Respondent pursuant to Section 12 of the Act. (RX 3). His deposition was obtained on October 30, 2019 and entered into evidence at trial. *Id.* Dr. Petkovich is a board certified orthopedic surgeon with a subspecialty in spine surgery *Id.* at 7. Dr. Petkovich testified that he was asked to examine Petitioner's right knee after a work accident when she "somehow slipped on some material on the floor and fell directly onto both of her knees and wrists." (RX 3, p. 11). He noted that she had immediate pain in her bilateral wrists and knees. (RX 3, Depo Exhibit, p. 2).

Dr. Petkovich reviewed Petitioner's medical records following the date of the accident and noted his interpretation of those records in his report. *Id.* at p. 2-3. He reviewed the MRI from February 22, 2018 and testified that it showed mild to moderate degenerative arthritis and a posterior medial meniscal cyst. (RX 3, p. 14). He believed there were no acute findings. *Id.* He stated that the meniscal cyst was consistent with a tear but was degenerative and would have developed over the course of months. *Id.* at 14.

Dr. Petkovich reviewed the records of Dr. McIntosh, including records from 2007 through 2012. *Id.* at 17-19. He noted that Petitioner was in a motor vehicle accident in 2007 and treated

with Dr. McIntosh until 2012. *Id.* at 17. He stated that her treatment before the December 1, 2017 accident addressed chronic osteoarthritis. *Id.* at 19.

During his interview, Petitioner reported persistent aching in the right knee. *Id.* According to Dr. Petkovich, she readily reported that she had intermittent pain complaints in her right knee before December 1, 2017, but her pain became worse after the work incident on December 1, 2017, *Id.* at 20. He reviewed pictures of her knees taken on January 4, 2018 and February 12, 2018 at Prompt Care, which showed bruising over the right and left knees. (RX 3, Dep. Exhibit. p. 2).

Dr. Petkovich's exam showed Petitioner had an antalgic gait but normal otherwise exam with no swelling. *Id.* He testified that her range of motion was normal but she did have pain on range of motion as well as tenderness to palpation. *Id.* Dr. Petkovich testified that the absence of swelling, or joint effusion, meant there was no acute process going on. *Id.* at 22. However, he stated that before evaluating Petitioner, she had received an injection with Dr. Bradley and that may have decreased the right knee joint effusion. *Id.*

Dr. Petkovich diagnosed Petitioner with a contusion of the right knee, which he believed had resolved by the time he evaluated her, and underlying degenerative osteoarthritis. *Id.* at 30. He did not provide any other diagnoses for any other body parts. *Id.* at 31. He opined that the right knee contusion was causally related to her work accident on December 1, 2017. *Id.* at 30. He believed the osteoarthritis was pre-existing and he did not "believe the degenerative arthritic changes in [Petitioner's] knee present prior to the incident on December 1, 2017, were in any way aggravated or accelerated as a result of the incident on December 1, 2017." *Id.* at 30-31, 34. He did not believe that any treatment after the four to six week point was necessary as a result of the work accident because her right knee bruise should have resolved by that time. *Id.* at 32. Dr. Petkovich agreed with the course of Petitioner's treatment to date and agreed with Dr. Bradley's recommendation for surgical intervention. *Id.* at 30.

On cross-examination Dr. Petkovich testified that he has performed over a thousand independent medical examinations in his career and advertises in directories for independent medical examiners *Id.* at 38-39. He stated that approximately 75-80% of his business involves litigated cases. He does not perform surgery any longer and could not definitively say when it was that he last performed surgery. *Id.* at 40-46.

Dr. Petkovich's understanding of the accident was that Petitioner "somehow" slipped on the floor and fell. *Id.* at 57. He was not aware of any evasive maneuvers to avoid falling on a small child. *Id.* He testified that Petitioner was candid and honest about her complaints, accident history, treatment history, and past medical treatment. *Id.* at 58. He was aware that Petitioner sought treatment with Dr. McIntosh for right knee complaints up to 2012 but did not have any indication that Petitioner sought treatment for her right knee after 2012 and before her work accident on December 1, 2017 with either Dr. McIntosh or any other provider. *Id.* at 59, 61. He believed that

she benefited from her treatment with Dr. McIntosh if she was not seen by him for over five years before her work accident. *Id.*

Dr. Petkovich testified on cross-examination that he agreed with the radiologist's report of the February 22, 2018 MRI findings. *Id.* ta 61. Dr. Petkovich testified that the study did not show any acute findings. *Id.* However, when asked about the radiologist's notations that there was evidence of trauma, Dr. Petkovich testified that he agreed there was evidence of bursitis, edema, contusion, and cartilaginous or chondral defects that could be associated with direct injury as noted by the radiologist. *Id.* at 61-62. It was his opinion that Petitioner had reached maximum medical improvement within six weeks of the December 1, 2017 work accident despite the fact that Petitioner's MRI, obtained nearly twelve weeks after the accident, still showed evidence of bruising. *Id.* at 63. Dr. Petkovich explained that there may be objective evidence of bruising "but that doesn't mean that it hasn't resolved." *Id.* He agreed that the forces associated with an impact injury that can cause bruising can be painful and confirmed that that he saw pictures of Petitioner's bruised knee from February 12, 2018, ten weeks after the accident. *Id.* at 64. Dr. Petkovich agreed that Petitioner's physical examination findings were consistent with her complaints. *Id.* at 79.

Dr. Petkovich stated that Petitioner's work related condition resolved within six weeks after the accident despite the fact that her right knee pain had not improved or returned to her pre-injury status and she was still symptomatic nearly two years after the accident. *Id.* at 66-68. He agreed that Petitioner's imaging studies showed evidence of a medial meniscus tear and that meniscal tears can be painful and could explain her symptoms. *Id.* at 69. However, he stated Petitioner's medial meniscus tear pre-dated the work accident despite the lack of evidence, subjectively or objectively, that would suggest the meniscus tear was present before December 1, 2017. *Id.* at 71. Moreover, Dr. Petkovich stated that the accident could not have worsened or aggravated any pre-existing condition. *Id.* at 80.

On August 5, 2019, an MRI arthrogram was obtained of Petitioner's right knee at St. Joseph's Hospital. The radiologist, Dr. Anthony Sodd, noted near full-thickness thinning of the articular cartilage along the posterior aspect of the patella worse along the lateral facet and involving the medial aspect of the trochlea. Osteophytes extended off the femoral condyles and tibial plateau. There was also increased T2 signal present extending through the posterior horn of the medial meniscus, contiguous with the superior and inferior articular surface suggesting meniscal tear. (PX 8).

Following the newly obtained high resolution MRI, Petitioner returned to Dr. Bradley for an evaluation on August 5, 2019. Dr. Bradley reviewed the study and discussed it with Petitioner. He observed thinning of the medial joint space articular cartilage and a large tear to the mid body and posterior horn of the medial meniscus. Dr. Bradley recommended a partial meniscectomy and chondroplasty. Petitioner was prescribed a hinged unloader brace. (PX 7).

Petitioner returned to Dr. Bradley on November 21, 2019 with complaints of continued right knee pain and mechanical symptoms. Petitioner indicated to Dr. Bradley that she wished to have an injection and continue non-operative care. Dr. Bradley administered an injection and advised Petitioner that if her symptoms did not improve she would likely need arthroscopic surgery. Her work restrictions remained the same and she was to continue use of her knee brace. (PX 7).

Dr. Bradley's deposition was obtained on August 23, 2019 and was entered into evidence at trial. (PX 9). He is a board certified orthopedic surgeon who specializes in general orthopedics. *Id.* at 4. Dr. Bradley testified that he performs 500-600 surgeries per year and estimated that approximately 75% of those surgeries are for conditions of the lower extremities. *Id.* at 7. He also occasionally performs independent medical examinations at the request of employers and insurance carriers. *Id.* at 6.

He reviewed medical records from Dr. Harrison, Good Samaritan Hospital, Dr. McIntosh, St. Joseph's Hospital, Crossroad Community Hospital, two MRIs, Dr. Petkovich's IME report, prior medical records from 2007 through 2012, and his own records. *Id.* at 8.

Dr. Bradley first saw Petitioner on April 24, 2019 because of right knee pain she had experienced since December 1, 2017. *Id.*at 9. On that date she was working cafeteria duty when she tripped over a young child, and in order to avoid landing on the child, she twisted and fell to the floor. *Id.* It was further his understanding that there was spilled fruit on the floor that caused it to become slick. *Id.* After falling to the floor, Petitioner injured both of her knees and wrists, but by the time she came under his care, her only complaints concerned her right knee. *Id.* Dr. Bradley performed a physical examination and noted that she had pain in the medial aspect. *Id.* at 11. Radiographs were obtained and revealed narrowing of the joint space as well as bone spurs that could be consistent with arthritis or trauma. *Id.* at 11-12. A weight bearing ultrasound revealed joint effusion and an extruded medial meniscus which is indicative of a meniscus tear. *Id.* at 12-13. Dr. Bradley also reviewed the MRI that was obtained in February of 2018. *Id.* at 13-14. He noted that it revealed thinning of the cartilage but also chondral defects that could be associated with direct injury. *Id.* at 14. Dr. Bradley diagnosed Petitioner with a medial meniscus tear and recommended anti-inflammatories to decrease the swelling in her knee as well as a higher definition MRI with contrast. *Id.* at 15. He believed that her complaints, physical examination, and imaging studies were consistent with the type of injury she described as occurring on December 1, 2017. *Id.* He further noted that she did not have any significant symptoms or pain in the past five years. *Id.* As such, he opined that the injury she sustained at work "aggravated, if not completely caused, her current pain and etiology." *Id.*

According to Dr. Bradley, the mechanism of injury described by Petitioner was consistent with his diagnosis. *Id.* at 16. He stated that falling straight down onto the knee as well as twisting and striking the knee could cause a meniscus tear. *Id.* Petitioner told Dr. Bradley that she was involved in a motor vehicle accident in 2007 where she injured her right knee after her car struck

a pole. *Id.* at 10. She sought treatment with Dr. McIntosh, including injections, and her pain complaints resolved. *Id.* Dr. Bradley stated that the history he received from Petitioner concerning her pre-accident right knee treatment was consistent with the prior medical records he reviewed from that period and that her symptoms were alleviated after she concluded treatment with Dr. McIntosh in October of 2012. *Id.* at 10-11, 18-19.

Petitioner returned to Dr. Bradley after the MRI arthrogram was obtained. *Id.* at 25. She had also had an injection with Dr. Harrison between her appointments with Dr. Bradley and received pain relief for two to three weeks. *Id.* Her symptoms were unchanged from when she last saw him and her recent MRI confirmed a meniscus tear. *Id.* at 25-26. Dr. Bradley believed that Petitioner suffered a meniscus tear and trauma to her cartilage as a result of her work accident and that additional treatment was warranted. *Id.* at 26. He stated,

> I certainly believe the medial meniscus tear was a direct result of the – of her fall. She very likely had some underlying degenerative changes. I think the direct trauma to her knee exacerbated those changes, certainly could have caused displacement of some of the cartilage and be contributing to a lot of the pain she has in her knee as well. *Id.* at 29.

He recommended arthroscopic surgery to repair the torn meniscus as well as the loose cartilage that was likely causing pain in the knee. *Id.* at 27. He did not believe her condition would improve without undergoing surgery and recommended light duty work restrictions. *Id.* at 30.

Petitioner testified that since the work accident on December 1, 2017, her right knee pain has not gone away. (T. 13). She wants to undergo the surgery recommended by Dr. Bradley because she wants to feel better and return to her normal activities. *Id.* Petitioner has not had any other accidents or injuries since her work accident. *Id.*

CONCLUSION

<u>In regard to disputed issue "F," the Arbitrator makes the following conclusions of law:</u>

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accidental work injury on December 1, 2017.

<u>In support of this finding, the Arbitrator notes the following:</u>

The Parties stipulated that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent. Petitioner testified credibly and without rebuttal that prior to December 1, 2017, he was working full duty with no restrictions, and was able to function on a daily basis both at work and at home without any notable or lasting pain in her right knee. Since December 1, 2017, however, Petitioner is no longer able to work full duty, escape her pain, or make it through the day without her right knee swelling and becoming even more painful.

The Arbitrator finds Petitioner's testimony to be credible in light of the medical records submitted into evidence in this case, which all support an accidental injury on December 1, 2017. While Petitioner had a history of prior right knee treatment, which included therapy and injections, her symptoms gradually improved and resolved by October of 2012. Petitioner testified that she did not have to seek any additional treatment for her right knee between October 23, 2012 and December 1, 2017. Occasionally her knee would become symptomatic depending on her level of activity but this was managed with over-the-counter medications. The imaging studies obtained after the work accident evidenced a meniscus tear and loose cartilage, which the testifying surgeons believed could account for her symptoms and pain. There is no evidence showing a medial meniscus tear before Petitioner's work accident. The Arbitrator finds that the consistent history provided to each provider as well as the described mechanism of injury of a twisting and falling injury that resulted in significant bruising contributed to or directly caused Petitioner's meniscus tear and the displacement of cartilage.

The Arbitrator relies on the credible opinions of Dr. Bradley, Dr. McIntosh, and Dr. Harrison in finding a causal connection between Petitioner's right knee condition and December 1, 2017 work accident. The Arbitrator finds the opinions of the three physicians persuasive, notably that of Dr. Bradley, given the objective findings on Petitioner's imaging studies, the consistent history in Petitioner's medical records, the lack of any significant pre-existing symptoms or treatment to Petitioner's right knee in the five years preceding the accident, and her persistent complaints of painful symptoms in her right knee since the work accident. Dr. McIntosh, who treated Petitioner several years before her work accident noted that it had been several years since Petitioner had any issues with her right knee prior to her work accident and the December 1, 2017 injury worsened her condition. The Arbitrator is not persuaded by Dr. Petkovich's opinion that Petitioner simply sustained a contusion that resolved within six weeks, when Petitioner has not yet returned to her pre-injury state of well-being nearly two years after her work-related injury. Dr. Petkovich believed that she had reached MMI nearly a month before Dr. Harrison believed it was necessary to obtain an MRI because her swelling, mobility, range of motion, and pain had not improved since the accident. Based upon the foregoing, the Arbitrator finds that Petitioner met her burden of proof regarding causal connection.

In regard to disputed issues "J" and "K," the Arbitrator makes the following conclusion of law:

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary and Petitioner is entitled to prospective medical care, specifically the surgery recommended by Dr. Bradley.

In support of this finding, the Arbitrator notes the following:

Petitioner has established by a preponderance of the evidence that her condition is causally related to her employment. Upon establishing such connection, employers are to provide all care reasonably required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

Petitioner attempted to resolve her condition conservatively with a knee brace, anti-inflammatory medications, and injections. However, despite this treatment, her condition of ill-being continued to persist and still requires additional treatment, including surgery. Respondent

shall therefore authorize and pay for the treatment recommended by Dr. Bradley, including but not limited to surgery.

Respondent is therefore ordered to pay the medical expenses contained in Petitioner's group exhibit and shall have credit for any amounts paid through its group carrier. Respondent shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

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